AMA Submission to the Legislative Council Government Administration Committee 'A'

Subcommittee Inquiry into Health Services in Tasmania

Psychiatric Services/Mental Health

August 2017

APPENDIX A

Correspondence in Chronological Order

From: Blacket, Jim (DHHS)
Sent: Friday, 19 April 2013 7:08 AM
To: (DHHS)
Cc: Fox, Christopher (DHHS); Ceh, Nina (DHHS); 'Sue Darcey, ANF' (sue@anftas.org); Draycott, Sue (DHHS); 'jgray70@gmail.com' (jgray70@gmail.com); 'darrenjiggins@gmail.com' (darrenjiggins@gmail.com); Mental Health - South Executive Assistant (DHHS); Miller, Julia M (DHHS); Rao, Anila (DHHS); Reed, Stewart (DHHS); Rinaldi, Kylie A (DHHS)
Subject: Re: PICU/DPM Re-Development.

Thank you
I think you accurately outlined the working group spirit and shared concerns
Jim

Sent from Jim Blacket iPad

On Apr 19, 2013, at 12:18 AM, "Archer, Stuart A (DHHS)" <Stuart.Archer@dhhs.tas.gov.au> wrote:

Hi Chris

Further to our signing off meeting today for the PICU/DPM Re-Development I wanted to take this opportunity to formally register my concern to you, as Chair of the Commitee, about certain aspects of the proposed plans, and hope these concerns are passed on to the relevant people.

Whilst I was happy to sign off on the plans everyone has worked so hard on to get right, I feel that both proposed wards physical location and lack of floor space within the Hospital Precinct are unacceptable. Our committee was only formed after the location of PICU/DPM had been set, which was unfortunate as wider consultation at that stage could have averted this issue. When we first began this process we were told that in the second stage of the build DPM would be expanded to the second tower and both wards could then at least be in close proximity on the same floor. It then became apparent some way in to the process that this would no longer be the case. We were also led to believe that access from the 3rd floor PICU to DPM would be as simple as going up a lift but it now seems this is not the case. My biggest concern is the lack of access to outside areas for both wards. Any modern design guide for psychiatric facilities will tell you that access to controlled outside areas is paramount. Surely a ground floor location would have been the obvious choice.

Whilst I understand this is only intended to be a "temporary" location the reality is we are likely to be there for a long time. My intent is not to try to "put a spanner in the works" but to give a voice to my colleagues and to future patients.

Yours Sincerely

Clinical Nurse
PICU

Department of Health and Human Services
TASMANIAN HEALTH ORGANISATION - SOUTH

Tasmanian Government

Mental Health & Statewide Services RHH Redevelopment Union Update

Minutes

Venue: Training Room, Level 2 Carruthers Building St Johns Park
Date: Thursday, 26 March 2014
Time: 8.30am – 9.30am

Item	Discussion	Action	Action Officer
1 Introduction			
1.1 Attendance and Apologies	Attendance: Umit Agis - Group Manager (UA) Chairperson; Dr Jim Blacket– Clinical Director MHSS (JB); Sharmayne Batt – Project Manager/ Clinical Liaison (SB); Michelle Davis – HR Consultant (MD); Chris Fox – Manager MHS (CF); Sue Darcey – ANMF (SD); Amy Boon - Staff Representative, ANMF (AB); Matthew Woolley – HACSU (MW) Tom O'Brien – NUM MHS (TO); Ann Marie Mallet - Manager Tony Steven – AMATAS (TS); Joanne Triffitt – NUM Roy Fagan Centre (JT), Kathy Morgan – Executive Assistant (Minutes) (KM.) Apologies: nil UA welcomed Joanne Triffitt (JT) to the meeting		
1.2 Minutes of previous meeting held 06 March 2014	Minutes of 06.03.2014 accepted by SD and seconded by JB.		
2 Outstanding Actions List			

Item	Discussion	Action	Action Officer
2.1 Outstanding Actions List as at 06 March 2014	ACTION SHEET - MHSS Redevelopment See attached sheet.		
3 Standing Items			
3.1 Decanting Progress Report	Helpline Training Room estimated time for builders to take possession will be the end of March and finish approximately end of April. Estimated time for Helpline to move in is May. Clozapine clinic to move into the current Helpline location early May. SB advised all plans have been accepted for Helpline as proposed. JB queried about advising clients of new addresses for the clozapine and olanzapine and SB advised this in hand. DoP - no date set as yet. PAPU – plans signed – will be out for Tender process SD voiced concerns for DoP staff about relocation TO advised that they have some survey results – can do preliminary analysis but they may need to resurvey. UA advised that a Model of Care in progress and hope to finalise next week. SD queried who is involved in Mode of Care. UA advised that there will be a draft. This will be tested on ground and staff input welcome. JB advised New Model of Care will be a wider broader document. Tom Obrien, Peter Gillies and team of nursing staff, working together on Model of Care. SD reiterated importance of staff to have input. OPMHS working on Model of Care – in progress	Progress notification of new address for Clozapine and Olanzapine	SB

Item	Discussion	Action	Action Officer
	CAMHS tweaking their Model in relation to beds at RFC (young person's beds). RFC – plans queried by SD. UA advised still cannot confirm as yet – discussions in progress. Lease – no update – JT advised negotiations happening – confirmed by SB. SD and SB queried sign offs for new government. UA advised government reviewing redevelopment – no news as yet. There are no change proposals.		
3.2 Feedback from Union Representatives	SD queried JUMIC Risk Assessment Report requirements under the new legislation and sought clarification as there were questions around whether a risk assessment is needed. UA advised that Larraine Millar is working through this. SD queried Code Blacks progress. SB advised that a meeting is being held today to discuss this in detail. SD queried smoking on site at RFC SB advised that there are many issues to work through and need to look at Site that is suitable. Various user groups discussing at present time. It was expressed that it will be hard to monitor and control. UA advised further discussions and plans need to happen to locate a dedicated area for smokers and also cessation program needs to be made available.		

Item	Discussion	Action	Action Officer
	SD queried about staffing for nurses on night duty. TO advised that preliminary plan is to have additional staffing - Ward Aides. SD advised after Nurses need an afterhours Model of Care. CF and UA advised that the processes are in early plans and developments and not locked in. MW queried safety aspect – when is risk assessment being done – the building, staffing number etc. UA advised that Larraine Millar is currently doing the building assessment and other aspects are being looked at in more detail. SD also queried Medical Cover – JB advised still under discussion. JB elaborated about there being many sub meetings about this at the moment in regards to coping with deteriorating patients, after hours, 24 hours staffing, handover and cover. JB spoke of the deteriorating patient how this will be handled in regards to transport, life support units (training in basic life support). All plans are yet to be finalised. SD queried whether the nurses will be able to be trained in Advanced Life Support – TO advised that they will be rolling out Advanced training over the next couple of months SD queried consumer career consultation in regards to plans and also user groups – UA advised MHSS Executive User Group has a consumer carer rep TS advised that Richard Benjamin has asked for a copy of minutes of this meeting to be sent to him (add to mailing list).	TO to meet with SD in regards to plans re duress To add to mail list	TO, SD KM/RF
4 Change Proposal			
5 New Business			
5.1 Nursing Staff Profile – Roy Fagan Centre	Still under discussion/in progress		

Item	Discussion	Action	Action Officer
5.2 Current establishment	Specifically for DoP being worked on. SD queried fixed term contract – TO advised 5 vacancies will be advertised.		
5.3 Fixed Term Contracts	Umit advised he looks at vacancies on a weekly basis.		
6 Next Meeting:	Friday, 21 March 2014		

Meeting closed 10.05 am.

Chairperson: _____ (signature)

Approved / Not Approved

RHH Redevelopment Rescue Taskforce

GPO Box 125, HOBART TAS 7001 Australia
Ph: 1300 135 513
Web: www.dhhs.tas.gov.au

Contact: Skye Fraser
Phone: (03) 6166 2717
Facsimile: (03)
E-mail: redevelopmentrhh@dhhs.tas.gov.au

Dr Richard Benjamin
AMA representative psychiatry and mental health
Email: ceo@amatas.com.au

Dear Dr Benjamin

Subject: Redesign for mental health at the RHH

I am writing in response to your letter to the RHH Redevelopment project's architects of 19 January 2015.

As you are aware, input from the AMA and the ANMF was important to the decision of the Taskforce to further consider the mental health design for K-Block.

The review conducted during the investigation noted the current K-Block design would deliver improved amenity over the current inpatient facility including through the provision of natural light, views through large windows, more single rooms with ensuites and scaled domestic spaces.

Notwithstanding, on the basis of stakeholder representations, the Taskforce commissioned further work which highlighted the capacity for a redesign of the inpatient facility that would better align it with contemporary care for mental health inpatients.

A key finding of the Taskforce was that the floor area of levels 2 and 3 can be increased and some of this space made available to improve the design of the mental health inpatient precinct including providing more outdoor recreational space.

These findings were based on architectural feasibility studies commissioned by the Taskforce. Now the Government has agreed to proceed with the project, more work needs to be done including clinical consultation on K-Block redesign.

The redesign process has commenced and we have a consultation meeting scheduled on Friday, 30 January 2015 which the AMA has been invited to.

I am advised by the THO-South that the current floor space of the mental health inpatient precinct is approximately 2 738 m^2.

No building works are planned to DoP (dot point three).

Benjamin, Richard G (DHHS)

From: Benjamin, Richard G (DHHS)
Sent: Monday, 2 March 2015 6:52 PM
To: Mallett, Ann M (DHHS)
Subject: bed closures

Hi Ann Marie

The AMA wrote to you on behalf of the Tasmanian Mental Health Key Stakeholders Consortium on January 22 this year, re the proposed bed closures

The letter read like this:

"Dear Ann Marie,

The Tasmanian Mental Health Key Stakeholders Consortium met on Wednesday 14 January 2015 to discuss the change proposal to close five beds in the Department of Psychiatry.

At this stage, the Consortium unanimously opposes the change proposal, access to a sufficient number of acute beds being a critical component of any mental health service. It should be noted that closing five out of 30 acute beds in psychiatry is numerically similar to closing over 80 of the Royal Hobart Hospital's 490 beds.

None of the members of the Consortium – all key stakeholders in Mental Health - were invited to any consultation session with respect to the proposed bed closures, and the group do not believe there was adequate consultation with respect to the proposal.

The Consortium firstly questions the proposal's own statistics.

The change proposal states that the average bed occupancy of the acute psychiatry ward as at December 2014 is 27.26. To run at 85% occupancy, the maximum for any acute unit, this would put bed numbers at 32, two more beds than is currently the case.

In addition, this change proposal would mean that psychiatry was the only craft group in the RHH Redevelopment to have overall bed numbers decreased. This would appear to question the 'future-proofing' nature of any such bed closures.

Finally, in relation to bed numbers, national statistics on mental health bed utilisation state that the average number of acute psychiatry beds per 100,000 is 20. For Southern Tasmania, this would be equivalent to approximately 52 beds. If the bed closures were to go ahead, there would only be 33 acute beds available, including PICU beds, leaving a shortage of some 19 beds.

The Consortium additionally questions the savings proposed; if the beds are permanently closed, then the recurrent expenditure may simply be removed from the department.

More importantly, the change proposal is internally inconsistent with respect to budgetary savings. The document states that there is a desire to, 'focus instead on optimising community care'. The document however does not state how such care will be optimised, and it does not indicate that the savings will be utilised in the community setting. Instead, it states that the savings will simply be utilised to offset the budget deficit.

The Consortium also believes that any bed closures could only be envisaged if the broader service and community were to be considered – medium term beds, community care beds (nursing staffed), supported accommodation beds (community sector staffed), public sector community mental health services, and the community sector organisation services would all need to be considered. Presumably these issues will all be carefully scrutinised in the

Government's 'Rethink' Mental Health Project, and to dramatically change any services delivered now would be premature.

Lastly, the Consortium notes that the change proposal was not accompanied by any form of risk assessment, so important when such large changes to business practice are being considered.

The Consortium suggests that Mental Health Services outlines to all relevant stakeholders and to the Consortium the algorithm that it utilises to make decisions about acute bed numbers.

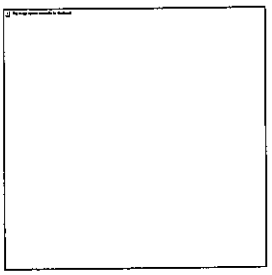
The Consortium asks that a face-to-face consultation be organised, involving all relevant parties. Such a meeting should include all members of the Tasmanian Mental Health Key Stakeholders Consortium."

I would be grateful for your urgent response; the consortium next meets this Wednesday at 330

Regards

Richard Benjamin

AMA Tasmania



10 March 2015

Mr. Michael Pervan
Acting Secretary
Department of Health and Human Services
34 Davey Street
HOBART TAS 7000

Dear Michael

I write as the CEO of the auspicing organisation for the Tasmanian Mental Health Stakeholders Consortium (list of members below) to bring to your attention some serious systemic failings in the consultation process for designs in the proposed demountable and new K Block Mental Health units.

It is apparent to all members of the Consortium from the proposed plans that basic contemporary design principle have not been utilised, and that this has come about by way of systemic failures including scope breadth of the project in mind, consultation and budgetary constraints; the Consortium believes that the units are totally unfit for purpose and that they are in fact grossly inadequate.

We are about to embark on a project that will define Mental Health Acute Care for 30 to 50 years into the future. To start from a set of principles based in 20th century seems to be fraught with danger.

I have enclosed a set of design principles drafted by and accepted by Consortium members.

We request a meeting with you urgently, to help facilitate a meeting between the Redevelopment Taskforce, Hospital and Mental Health Services Management, and all members of the Tasmanian Mental Health Stakeholders Consortium.

I await your urgent reply.

Yours sincerely

Tony Steven
CEO

Department of Health and Human Services
EXECUTIVE, MINISTERIAL AND PARLIAMENTARY SERVICES

Level 1, 99 Bathurst Street, Hobart, Tasmania
GPO Box 125, HOBART TAS 7001, Australia
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Tasmanian Government

Contact: Skye Fraser
Phone: (03) 6166 2717
E-mail: skye.fraser@dhhs.tas.gov.au
WITS No.: 86476

Mr Tony Steven
Chief Executive Officer
AMA Tasmania
147 Davey Street
HOBART TAS 7000

Dear Tony

Thank you for your letter dated 10 March 2015 regarding the acute mental health inpatient design consultation.

A number of the issues you have raised are outside of the scope of the approved RHH Redevelopment project.

As you are aware, the Rescue Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but that this can only be incorporated in future, currently unfunded, stages of the RHH Master plan.

The Tasmanian Government has committed to redeveloping the RHH to improve the delivery of health care for Tasmanians for generations to come.

I am advised that the new RHH Redevelopment project significantly improves outcomes for mental health services. A further investment of $2.4 million has allowed for the redesign of levels 2 and 3. This has significantly improved amenity and increased the available outdoor recreational space for mental health inpatients.

The new Redevelopment project also includes the installation of an $18 million temporary facility in the RHH Liverpool Street forecourt primarily so that mental health inpatients can be decanted onsite during construction – reducing clinical risk and the day to day disruption they would have experienced if they had remained on site under an alternative construction methodology.

I am advised that the RHH Redevelopment project has addressed this remit and in consultation with user groups, have agreed designs for mental health on levels 2 and 3 of K-Block and the temporary facility.

With regards to the K-Block design, I am advised that it will provide a safer, more contemporary mental health inpatient facility with:

- increased outdoor space from around 20m² to around 120m² across the two levels of K-Block
- increased single bed rooms
- incorporation of a swing area for vulnerable patients with increased bed flexibility between high dependency and the secure unit
- access to a family room, sensory de-escalation space, flex room and improved staff and visitor toilet access in the high dependency unit and

- significant operational improvements like more interview space, client and visitor lockers, improved door swings and appropriate anti-ligature fixtures and fittings; a vast improvement on the current amenity.

These improvements are consistent with the Government's decision to proceed with RHH Redevelopment project- a more contemporary floor layout for mental health inpatient wards including more outdoor recreational space within K-Block and the design of the temporary facility.

Yours sincerely

Michael Pervan
Acting Secretary

23 March 2015

Tasmanian Government

Tasmanian Health Organisation - South

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TASMANIAN HEALTH ORGANISATION SOUTH

Contact: Ann Marie Mallett
Phone: (03) 6166 0824
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E-mail: annmarie.mallett@dhhs.tas.gov.au
File:

Tony Steven
CEO
AMA Tasmania
147 Davey Street
HOBART TAS 7000

Dear Mr Steven

Subject: Change Proposal - reduction of bed numbers at the Department of Psychiatry

I am writing to you in response to your letter of 26 March 2015 and earlier correspondence where your organisation provided feedback in relation to the proposal to reduce bed numbers at the Department of Psychiatry.

I would like to take this opportunity to provide you with a point of clarification that may not have been articulated clearly in our proposal. The average bed occupancy quoted in the change proposal of 27.26 days relates to the overall bed numbers within Department of Psychiatry (DoP), which is 38, and not just the Department of Psychological Medicine (DPM).

I can advise that all the feedback received in relation to the proposal has been carefully considered by Management and a Staff Feedback and Consultation Report has now been released to staff. I have attached a copy of the Staff Feedback and Consultation Report which provides details of the feedback received and documents responses from Management in relation to the issues raised (including responses to the issues raised by your organisation).

Thank you again for your letter and if you have any further queries, please contact me on telephone 6166 0824 or email me at annmarie.mallett@dhhs.tas.gov.au.

Yours sincerely

A. Mallett

Ann Marie Mallett
Manager Inpatient Mental Health and Correctional Health Services

08 April 2015

Enc: Department of Psychiatry - Reduction in Bed Numbers, Staff Feedback and Consultation Report

Copy to: Matthew Daly, Umit Agis, Jim Blackett

Tasmanian Health Organisation – South
MENTAL HEALTH AND STATEWIDE SERVICES

Tasmanian Government

File No.: File No.

Memo

To:	All Staff, Department of Psychiatry
Copy To:	Group Manager, Mental Health and Statewide Services
From:	Ann Marie Mallett, Manager Inpatient Mental Health and Correctional Health Services
Date Prepared:	2 April 2015
Subject:	**Staff Feedback and Consultation Reports for Recent Change Proposal**

I am writing to you today to provide copies of the Staff Feedback and Consultation Reports for the recent change proposal for the Department of Psychiatry that was announced towards the end of last year. The Change Proposal outlined a strategy to officially reduce the bed numbers at the Department of Psychiatry by five.

Over the past few weeks, Senior Management has carefully considered the feedback received from staff and other stakeholders on the change proposal. The attached report provides a comprehensive record of all the feedback received and provides comments and clarification for each issue raised.

Copies of the original change proposal, along with copies of the attached report can be obtained from our intranet site at the following address:

http://www.dhhs.tas.gov.au/intranet/stho/mhss/news/recent_communiques/2015-02-25_-_department_of_psychiatry_-_reduction_in_bed_numbers

Some of the key themes that arose from the consultation included:

- Any reduction in bed numbers will significantly impact on the capacity to meet future need;
- Recent occupancy rates of the Department of Psychiatry (including the Department of Psychological
- Medicine and the Psychiatric Intensive Care Unit) do not support a reduction in bed numbers; and
- Potential impact for community based services

In responding to these issues, the Report highlights the decline in bed utilisation of the Department of Psychiatry over the past two years and highlights that since June 2014, the daily average beds occupied have consistently been below 30. The Report also highlights some recent initiatives that have assisted in strengthening community based mental health services so they can better respond to clients' needs to ensure that they are supported in the least restrictive environment possible.

Next Steps

Senior Managers from Mental Health and Statewide Services will be working closely with staff and our services to progress with the implementation of the change proposal.

Although the Department of Psychiatry has been unofficially operating with reduced beds in recent times (as occupancy rates have been less than capacity), it is anticipated that the formal reduction of bed numbers

will occur from 14 April 2015 (to align with roster periods). Up until that time, we will be working closely with staff and managers to ensure the process is managed effectively to ensure that there is minimal impact on client care.

I would like to thank staff who provided feedback on the change proposals and I look forward to progressing these important projects so that we can continue to develop and improve our services to our clients.

Enc: Department of Psychiatry - Reduction in Bed Numbers, Staff Feedback and Consultation Report

Prepared by	Mark Frohmader	Manager Projects, Mental Health and Statewide Services	6166 0856	31 March 2015
Through	Dr Jim Blacket	Clinical Director, Mental Health and Statewide Services	6166 0842	2 April 2015
Through	Umit Agis	Group Manager, Mental Health and Statewide Services	6166 0835	2 April 2015
Cleared by	Ann Marie Mallett	Manager Inpatient Mental Health and Correctional Health Services	6166 0844	2 April 2015

Tasmanian Health Organisation – South

Tasmanian Government

File No.:

Department of Psychiatry – Reduction in Bed Numbers
Staff Feedback and Consultation Report

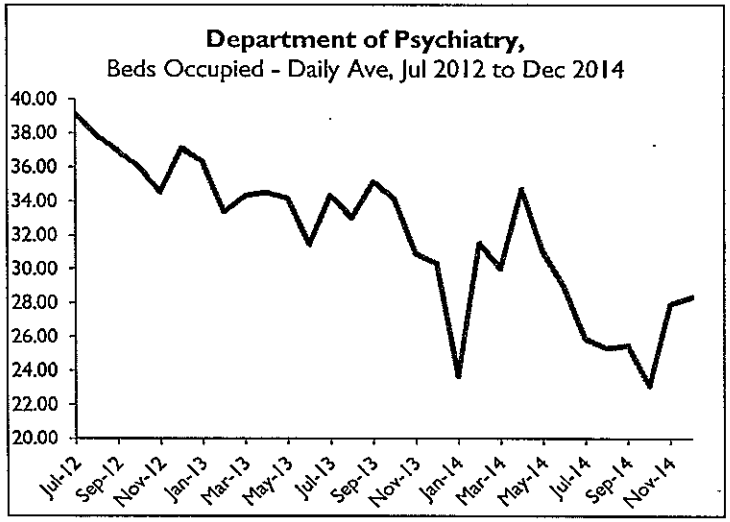
Draft - Version: 1.0

31 March 2015

Feedback

The following table provides a summary of the feedback received by staff and other stakeholders. Management comments for each piece of feedback is also provided.

TABLE 1 – Summary of Staff and Stakeholder Feedback regarding the proposed reduction of beds at the Department of Psychiatry

Date Received	Mode of Feedback	Feedback/Query Received	Management Response	Management comments/clarification
17 Dec 14	Email	• My guess is that the Change Proposal is a decision that has already been made regardless of staff consultation. • Do I think it will work? Most probably not because once the ward is full again after the departure of Dr Sharp, the pressure to open beds again will increase dramatically. • These beds will of course be opened regardless of the number of appropriately trained staff available, this will no doubt make working conditions worse in the long run. • I see this as purely a cost cutting measure, which may initially save some money but in the long run will produce little of any value.	Noted	The ongoing lower occupancy rate for DPM over recent times has essentially seen the service operate with reduced bed numbers. The change proposal aims to formalise the bed numbers in line with ongoing demand. It will be important for the service to implement strategies to address any future changes in demand. This is an issue that all health services need to address, It is recognised that the service manages some extremely complex issues in its day to day work. The effective management of these issues will only be addressed with appropriately trained and skilled staff.
22 Jan 15	Letter	• A letter was received from a group of Tasmanian Mental Health Stakeholders. The group met on Wednesday 14 January 2015 to discuss the change proposal to close five beds in the Department of Psychiatry. • At this stage, the group unanimously opposes the change proposal, access to a sufficient number of acute beds being a critical component of any mental health service. It should be noted that closing five out of 30 acute beds in psychiatry is numerically similar to closing over 80 of the Royal Hobart Hospital's 490 beds. • None of the members of the group – all key stakeholders in Mental Health - were invited to any consultation session with respect to the proposed bed closures, and the group do not believe there was adequate consultation with respect to the proposal. • The group firstly questions the proposal's own statistics. • The change proposal states that the average bed occupancy of the acute psychiatry ward as at December 2014 is 27.26. To run at 85% occupancy, the maximum for any acute unit, this would put bed numbers at 32, two more beds than is currently the case.	Noted	The following graph highlights the downward trend of the daily average beds occupied at the Department of Psychiatry over the past 2.5 years. 

Date Received	Mode of Feedback	Feedback/Query Received	Management Response	Management comments/clarification

- In addition, this change proposal would mean that psychiatry was the only craft group in the RHH Redevelopment to have overall bed numbers decreased. This would appear to question the 'future-proofing' nature of any such bed closures.
- Finally, in relation to bed numbers, national statistics on mental health bed utilisation (National Mental Health Report, 2013) state that the average number of acute psychiatry beds per 100,000 is 20. For Southern Tasmania, this would be equivalent to approximately 52 beds. If the bed closures were to go ahead, there would only be 33 acute beds available, including PICU beds, leaving a shortage of some 19 beds.
- The group additionally questions the savings proposed; if the beds are permanently closed, then the recurrent expenditure may simply be removed from the department.
- More importantly, the change proposal is internally inconsistent with respect to budgetary savings. The document states that there is a desire to, 'focus instead on optimising community care'. The document however does not state how such care will be optimised, and it does not indicate that the savings will be utilised in the community setting. Instead, it states that the savings will simply be utilised to offset the budget deficit.
- The group also believes that any bed closures could only be envisaged if the broader service and community were to be considered – medium term beds, community care beds (nursing staffed), supported accommodation beds (community sector staffed), public sector community mental health services, and the community sector organisation services would all need to be considered. Presumably these issues will all be carefully scrutinised in the Government's 'Rethink' Mental Health Project, and to dramatically change any services delivered now would be premature.
- Additionally, the group notes that the change proposal was not accompanied by any form of risk assessment, so important when such large changes to business practice are being considered.
- The group suggests that Mental Health and Statewide Services outline to all relevant stakeholders and to the group the algorithm that it utilises to make decisions about acute bed numbers.
- The group asks that a face-to-face consultation be organised, involving

The daily average bed occupancy for the DoP has been in decline since July 2012 where it has dropped from an average of 39.12 beds occupied to an average of 28.33 in December 2014. In fact, since June 2014 the daily average beds occupied have consistently been below 30, dropping to a low of 23.10 in October 2014.

The average occupancy rate for the Psychiatric Intensive Care Unit (PICU) for 2014 was 81.6% (or about 6.4 beds). PICU has 8 beds. The average occupancy rate for the Department of Psychological Medicine (DPM) was 73.1% for 2014 (or about 22 beds). DPM has 30 beds. The average length of stay at PICU for 2014 was 5.4 days and for DPM the average length of stay was 10 days for 2014.

By formally reducing the DoP bed numbers by 5, the service would be able to manage a similar demand to that experienced in the past two years. In reality, the service has been functioning throughout this period with a reduced number of beds, which essentially has seen those beds informally "closed" for that period.

In contrast to these declining daily average bed occupancy figures, staffing levels have remained the same. In the current economic environment, where there is a need to identify budgetary savings, it is not possible to sustain this arrangement.

It is important to note that the downward trend in the occupancy of DoP reflects a decrease in demand/need for acute inpatient treatment. This decrease in demand/need can be partly attributed to the concerted efforts to improve referral processes and to address systemic and program issues with the aim of strengthening community based mental health services to better respond to clients' needs to ensure that they are supported in the least restrictive environment possible.

Some of these important initiatives include:

- Ongoing development of the Psychiatric Emergency Nurse (PEN) Service within the Emergency Department at the RHH. The focus of this service is on ensuring that whenever clinically appropriate and safe to do, individuals presenting with mental health concerns are diverted for treatment and follow-up back to the community (as opposed to admitted to the mental health inpatient units within the RHH)
- New Model of Care at Mistral Place with this unit now being medically managed via community based psychiatrists and registrars as opposed to their colleagues based at the RHH. As a result this facility is now utilised in preference to the inpatient mental units based at the RHH

Date Received	Mode of Feedback	Feedback/Query Received	Management Response	Management comments/clarification
		all relevant parties. Such a meeting should include all members of the group.		for community based clients needing an increased level of observation and treatment who can be effectively managed in such a setting. • Co-location of MiCare Workers with each of the three Adult Community Mental Health Service (ACMHS). These workers – who are employed by Baptcare and funded by the Department – work with community based staff to ensure that additional non-clinical support is provided to community clients who are either at risk of inpatient admission or who have been recently discharged from an inpatient facility. • Co-location of Partner in Recovery (PIR) workers with three ACMHS teams. PIR is a care co-ordination model and PIR workers partner with mental health community staff to optimise the overall care of clients receiving support via multiple services. When this approach works well it should assist in maintaining overall mental health and therefore reduce inpatient admissions. • Plan to extend co-located MiCare and PIR workers to 4 Liverpool Street covering Community Forensic Mental Health Services and Mistral Place. • Development of a Maximising Integrated Care protocol between inpatient and community areas. This protocol is designed to optimise the provision of information and the linked continuity of care both as the point of admission to the mental health inpatient units based at the RHH and discharge from those units with the expectation of follow up via community based mental health services. Again, if this process works well, it will improve community care and reduced admissions to inpatient facilities into the future. • Strengthening of data collection and review process. In order to optimise care and treatment, Mental Health Services has focussed on the monthly collection of an extensive suite of KPI's specific to community based care. This information – which includes such data as the number of clients with an active care plan and the number of clients being provided with an occasion of service by Mental Health Services every 28 days – is then scrutinised to optimise the quality of care. • Commencement of 7 day follow up processes for all discharged and exited clients from the acute inpatient unit. The decision to formally reduce bed numbers at DoP was based on the recent demand/need for the service and the reality that the service has been managing with reduced bed numbers for an extended period of time.

Date Received	Mode of Feedback	Feedback/Query Received	Management Response	Management comments/clarification
29 Jan 15	Email	• Will a risk and security assessment be done on the proposal prior to implementation? Will this be forward to all parties? • The budget for DOP is clearly inappropriate if a deficit was made as this should be funded to the needs of patients. • Will there be ongoing monitoring of workload and security measures. • What is the projected rate of occupancy? Is it claimed there is a decreased need for DOP/PICU compared to population growth?	Noted	No risk or security assessment will be undertaken as the proposal aims to formalise what has been "informally" implemented for some time – ie the service has been operating with a reduction of 5 beds for an extended period of time. The current staffing level within DoP has remained the same despite an actual reduction in bed numbers and occupancy rate over an extended period. By more appropriately aligning staffing numbers to client numbers will assist in addressing any budgetary deficit of the service. The decision to formally reduce the bed numbers at DoP is based on the reduced utilistaion of the service over the past two years. As more effort is directed to strengthening community based services it is anticipated that the demand/need for acute inpatient mental health services should remain fairly constant (acknowledging that there will be peaks and dips in the demand for services from time to time).

AMA
TASMANIA
ABN 11 009 484 931

10th April 2015

Mr. Michael Pervan
Acting Secretary
Department of Health and Human Services
34 Davey Street
HOBART TAS 7000

Dear Michael

Thank you for your correspondence of 23 March 2015, in response to the Tasmanian Mental Health Stakeholder Consortium letter of 11 March 2015.

The Consortium is writing to you again today after a meeting in which your response was discussed, the meeting being held 1 April 2015. The member organisations of the Consortium are of the opinion that further, robust representation must be made to you about the future plans for acute mental health care at the Royal Hobart Hospital; the Consortium repeats their strongly held belief that the plans are of units that are in fact totally unfit for purpose.
It is important to first note issues with respect to bed numbers; most importantly it should be recognised that psychiatry is the only craft group to lose beds in the Redevelopment.

The National Mental Health Report 2013 states that the national average of acute mental health beds is 21 per 100,000 population; these are beds in general hospitals (not medium term beds in stand-alone psychiatric hospitals). This is equivalent to over 105 beds for the state. The draft model of care for the Department of Psychiatry K Block is for 27 beds only. The Consortium believes that the Launceston and Burnie hospitals have 39 acute beds between the two campuses; this acute bed total for the state is only 66.

The AMA on behalf of the Consortium have repeatedly asked Mental Health Services Management for the algorithm that has been used to calculate the number of beds required, but this has not been forthcoming. The above model of care document does demonstrate a gradual reduction of acute bed utilisation over time, but senior clinicians believe that this trend is not over a sufficiently lengthy period upon which a decision can be made to permanently cut acute beds, and they are gravely concerned with respect to future bed block, serious difficulties with ramping in the Emergency Department, and adverse outcomes for patients. The department's own figures clearly do not justify the cutting of PICU bed numbers from eight to five; monthly occupancy rates for PICU from December 2014 to February 2015 were 84%, 97 % and 83% at eight beds. In addition, algorithms utilised on the mainland demonstrate that other states have noted the problems relating to prior bed closure and are in fact now investing in acute beds. For example, the Consortium has been granted access to the algorithm utilised to calculate acute

bed requirements in one catchment area in NSW, the North Sydney district, utilising the "MH-CCP" algorithm.

The North Sydney area has a population of approximately 540,000. They have calculated that 167 acute beds are currently required. They look at bed numbers more realistically, on an 80% KPI, which equates to 134 beds. They currently have 113 beds, and are building more. The Consortium repeats that local Mental Health Services have drafted a document that suggests that 27 acute beds is sufficient for Southern Tasmania, when that number should be on national averages be over 50. (Please note that medium term, stand-alone psychiatric beds cannot be counted as acute beds, if so the National Mental Health Report of 2013 quotes figures of 34 beds per 100,000). The 27 beds is not only clearly below the national average, it also does not take into account any additional requirements to manage greater socioeconomic disadvantage, or intrastate transfers, a requirement of the leading tertiary referral hospital of the state, and a requirement noted in the model of care document.

Finally, it should be noted that the acute bed closures come in the context of: three beds being shut in the medium term unit at New Norfolk, with more closures planned, 10 beds being shut at the older persons unit at the Roy Fagan Centre, no additional resources being made available to adult community health teams, and well-recognised shortages in child and adolescent psychiatry.

Second, the amount of space available to patients (and staff) must be mentioned. Contemporary acute mental health units are designed with adequate space, and very carefully also to maximise the perception of space. The acute mental health unit designs for K Block and for the demountable unit fail on both counts. One contemporary acute mental health unit in Queensland at Caboolture serves as a yardstick: it has 43 acute beds over 9000 square metres. Mathew Healey wrote to the AMA on January 29 2015 and stated that the area set aside for patients in the K Block had been increased from 2173 to 2738 square metres, and that the size of the demountable set aside for the mentally ill patient was 2201 square metres. These units are grossly inadequate in size. At recent meetings it has become clear that there is not only insufficient space for patients, but the spaces set aside for staff are also grossly inadequate.

Third, the nature of the designs must be noted. Mention should be made that some contemporary principles have been incorporated, for example greater eradication of ligature points. However, "bigger picture" design principles have not been incorporated. In a recent conversation with members of the Rescue Taskforce, they even acknowledged this. Not only should all units be on the ground floor, but all units should be designed along the "palm and fingers" principles; it is this latter principle that was recently discussed and openly acknowledged as an ideal that had not been met. The principle improves patient safety via enhanced lines of sight, but it also dramatically enhances the unit design by maximising the contiguity of open spaces, which also improves the perception of space. The designs of all future units in K Block and the demountable are clearly claustrophobic. The worst example of this is the K Block HDU.

The Redevelopment team /Mental Health Services Management have repeatedly declined to provide the floor space of the current eight bed PICU, or of the Department of Psychiatry with 34 beds prior to building works. But all of those familiar with the current PICU understand that the new HDU area is grossly undersized, with many different types of spaces missing. This situation will lead to very poor outcomes for those seriously unwell patients who must be afforded both time and space to recover. The absence of an outdoor area is completely unacceptable, and in addition breaches United Nations principles on the care of the mentally ill.

The Consortium requests that the department give serious consideration to moving the shared staff amenities area elsewhere, and opening up the areas marked "shell space future expansion" on both level two and three of K Block for the exclusive use of the mentally ill. Such an expansion would allow for a greater number of acute beds. In addition, the floor space must be redesigned to incorporate contemporary design principles, especially the creation of large contiguous spaces for eating, socialising, and for recreation, that must open directly onto outdoor spaces; this is most especially important for the HDU area.

The Consortium again requests a meeting with senior representatives of the department to discuss these most critically important issues.

To continue along the current trajectory, with plans for substantial reductions in acute bed numbers, units with very small footprints and non-contemporary floor plans is in no way future-proofing the RHH.

We once again formally ask for a meeting to be convened by you between all relevant parties to help ensure the best possible outcome for the Mental Health community before it is too late.

Yours sincerely

Tony Steven
CEO, AMA Tasmania.

Tasmanian Health Organisation – South

Tasmanian Government

File No.: File No.

Memo

To: All Staff, Department of Psychiatry
Copy To: Group Manager, Mental Health and Statewide Services
From: Barry Nicholson, Director of Nursing
Date Prepared: 27th April 2015

Subject: Reduction in Bed Numbers Department of Psychiatry

I am writing to you today to advise of the next steps regarding a change proposal for the Department of Psychiatry announced in December 2014. The Change Proposal outlined a strategy to officially reduce the bed numbers at the Department of Psychiatry by five. This would effectively reduce the official inpatient bed numbers to 33 beds in DOP. The proposal acknowledged that overall the occupancy of DOP was consistently below the original 38 beds the department has at its disposal. Concurrent struggles to maintain the agreed direct care staffing levels and the impact this has had on the utilization of casual resources and overtime. Staff feedback was provided in a staff memo 2nd April 2015 'Staff Feedback and Consultation Reports for Recent Change Proposal.' On behalf of the department I would like to thank staff who did provide feedback on the change proposal.

Now that the consultation process has been finalised, the next step is to progress with the implementation of the change proposal to formally reduce the number of beds in DOP. The Change Proposal (5th December 2014) stated that in addition to the reduction of beds there will be a linked reduction of one direct care nursing staff member on each of the early and late shifts. The linked reduction of one direct care nursing position on the am and afternoon shifts applies to the area known as the Department Psychiatric Medicine (DPM). This reduction of one nursing staff member per shift does not impact on any current or part time employees of DOP.

Although the Department of Psychiatry has been unofficially operating with reduced beds in recent times (as occupancy rates have been less than capacity), it is anticipated that the formal reduction of bed numbers will occur from the next nursing period commencing 7th June 2015 where the reduced nursing coverage will be reflected in the published nursing roster.

Up until that time, we will be working closely with staff and managers to ensure the process is managed effectively to ensure that there is minimal impact on client care.

Enc: Department of Psychiatry - Reduction in Bed Numbers, Staff Feedback and Consultation Report

Prepared by	Barry Nicholson	Director of Nursing. Inpatient Mental Health Services and Correctional Health Services	6166 0844	5th May 2015
Through	Ann Marie Mallett	Manager of Inpatients Mental Health Services and Correctional Health Services	6166 0824	5th May 2015
Through				
Cleared by				

Department of Health and Human Services
OFFICE OF THE SECRETARY

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Tasmanian Government

Contact: Skye Fraser
Phone: (03) 6166 2717
E-mail: skye.fraser@dhhs.tas.gov.au
WITS No.: 86476

Tony Steven
Chief Executive Officer
AMA Tasmania

Via Email: ceo@amatas.com.au

Dear Tony

Subject: Royal Hobart Hospital Redevelopment

Thank you for your letter dated 10 April 2015 requesting a meeting to discuss the provision of mental health services and the design of K-Block.

The Tasmanian Government has committed to the RHH Redevelopment to improve the delivery of health care for Tasmanians. The K-Block design will deliver much needed, improved clinical facilities for our community. The need to redevelop the RHH has been acknowledged for some time - by clinicians, members of the public and State and Commonwealth Governments.

I would like to assure you that the work on the acute mental health inpatient facility will significantly improve the amenity for acute mental health inpatients. I would like to facilitate an opportunity for all members of the Mental Health Key Stakeholders Consortium to hear firsthand about the positive outcomes achieved by the redesign of K-Block and the temporary facility and clarify your ongoing concerns.

The former Chair of the Rescue Taskforce will convene a meeting with the RHH Redevelopment project team, Mental Health Services Executive Users Group and Consortium. This is scheduled for Thursday, 14 May 2015 at 4pm, level 1, 99 Bathurst Street, Hobart. I would appreciate it if you would advise Consortium members of these details so that they may RSVP to Skye Fraser by close of business, Monday, 11 May 2015.

I look forward to meeting with the Consortium then.

Yours sincerely

Michael Pervan
Acting Secretary

4 May 2015

Department of Health and Human Services
RHHR

Tasmanian Government

MENTAL HEALTH REDESIGN

Record of Meeting

Venue: Boardroom, level 1, 99 Bathurst Street, Hobart
Date: Thursday, 14 May 2015
Time: 4.00pm to 5.30pm

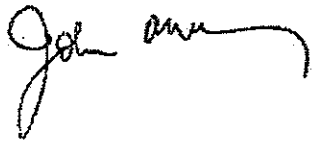
Item	Discussion
1 Introduction	
1.1 Attendance and Apologies	John Ramsay, THS (Chair), Dr Dan Norton, Rescue Taskforce/ Redevelopment ESC, Ben Moloney, Redevelopment Cheryl Carr, Redevelopment, Stuart Jones, Redevelopment, Skye Fraser , Redevelopment, Mathew Healey, One Health, Leonard Lambeth, DHHS, Jim Blacket, MHS, Ann Maree Mallett, MHS, Barry Nicholson, MHS, Tim Greenaway, AMA, Richard Benjamin, AMA, Sue Darcy, ANMF, Amy Boon, ANMF, Matt Wooley, HACSU, Dr Clare Smith, GP/ RACGP, Milfred McArthur, RANZCP, Dr Saxby Pridmore, UTAS, Connie Digolis, MHCT, Stephane Auchincloss, Registrar training *Teleconference:* Miranda Ashby, Flourish, Russell McCashney, AASW, Cecily Pollard, Australian College of Mental Health Nurses *Apologies:* Umit Agis, MHS, Michael Pervan, DHHS, Tony Steven, AMA, Neroli Ellis, ANMF
1.2 Introductions	The Chair welcomed members and asked them to introduce themselves. It was noted that the A/Secretary had been called to an urgent Commonwealth funding meeting and that a report on the meeting would be prepared for his consideration.
2 Update on the Redesign	Stuart Jones, Redevelopment project, delivered a presentation which included: the existing conditions, the new paediatrics ward which includes two secure rooms for young people with challenging behaviours, and key features of the redesign of mental health inpatient areas. A number of questions of clarification were asked during the presentation; the responses follow.

Item	Discussion
	Psychiatric Intensive Care Unit (PICU) no longer reflects the contemporary practice that is already in place at DOP utilising PICU as a High Dependency area (HDU). The new model of care allows for patients to be managed in ward areas designed for the acuity of illness. There are three levels of care: a high dependency unit within a secure ward, a secure ward and an open ward. As a tertiary hospital, the Royal Hobart Hospital will continue to accept statewide patients for care and treatment plans. It should be noted that there have been less than 10 patients transferred from other state areas in the last 12 months to the RHH tertiary hospital. Bed capacity in K-Block has been increased with approval for three additional beds. There is flexibility in the open ward where one room is 23m² and could accommodate a mother and baby for example. However, acutely unwell psychotic mothers would be accommodated in high dependency or the secure unit with the baby boarded in paediatrics. Mothers and babies from the north and northwest are generally accommodated in the St Helen's Private Hospital. Additionally, the southern perinatal service provides an early intervention service, providing support to unwell pregnant mothers in the community. Privacy issues have been addressed in the design. Windows will be fitted with interstitial venetian blinds (primarily to meet anti-ligature requirements) and their adjustment will be limited from fully closed to 45 degrees. This will maintain privacy while still providing natural light for mental health patients. The distance between the temporary facility and A-Block where the paediatric ward is located is 15 metres. The Liverpool Street forecourt facility will only be used by mental health and medicine for the duration of the K-Block construction. Importantly, it allows key acute services to stay on site during construction. The other decanting options considered were not suitable. The floor design of the temporary facility is similar to the final K Block design and will allow mental health services to test the model of care before K-Block is commissioned. It will be a properly constructed facility. Disability design requirements such as circulation space will be accommodated within the design. However, the full implementation of disability design standards is not appropriate in an acute mental health facility as it would introduce hanging points such as via hand rails. The principle applied in this instance is patient safety.

Item	Discussion
3 Issues Raised by Consortium and Responses	
3.1 Number of mental health beds	The AMA representative reiterated issues in relation to bed numbers as per their correspondence to the A/Secretary (10 April 2015). The capacity for future proofing mental health services was also raised including that other craft groups were increasing in capacity but not mental health services. The RACGP representative noted that high demand was evidenced by the increasing numbers of emergency admissions which were currently around six to seven emergency per day.
3.1.1 Response provided by MHS	K-Block has 33 beds and the temporary facility has 30 with capacity for 32 beds. Modelling over the last 12 months indicates the need for 30 beds based on 85 per cent occupancy. There are surges in activity every three to four months. This requires efficient patient flow operations including a surge plan across the entire hospital, community support and use of other inpatient mental health beds. Length of stay is approximately 10.5 days which is better than the national average. Readmission rates are monitored and there appears to be no persistent increase in the readmission rate over this period. Mental health services are the most effective unit for moving people from emergency to inpatient beds. Moreover, community assessment is the preferred approach to care rather than an emergency admission. If a significant population increase was anticipated for Tasmania, it would be necessary to consider the operations of the entire mental health system rather than one component – acute inpatient beds. There is currently shell capacity on levels two and three that could be considered in future and there is an overall RHH Master plan that guides the strategic redevelopment of the site as funding opportunities allow. This includes a specific mental health precinct. Moreover, the strategic plan being developed for mental health focuses on capacity in the community. The redevelopment allows for some additional capacity in some disciplines however this is not currently funded.
3.2 Size of units	The AMA representative reported the view of the consortium that the recreational space was small, the amount of outdoor space is an issue and the need to strictly comply with the Australian Health Facilities Guidelines.
3.2.1 Response provided by MHS	Outdoor space is very important in assisting mental health inpatients get well. Every effort has been made to maximise outdoor space however this cannot achieved in the high dependency unit in K-Block. Patients will have access to outdoor space on level three within the secure ward by staff escort. However there will be a glass atrium area adjacent to the HDU lounge which will provide light and a sense of openness.
3.3 Design of Units	The AMA representative indicated that the floor layout with beds in a row like a medicine or surgical ward is not

Item	Discussion
	consistent with the preferred new 'client centred' design; the palm and fingers design is now outdated.
3.3.1 Response provided by MHS	The redesign is a vast improvement on what is currently available for mental health inpatients. It will be modern, clean, open and bright and cannot be delayed. The Chief Psychiatrist concurred with this view also noting that it needed to be known that community resources needed to be improved.
3.4 Other Issues	A number of other issues were raised by the consortium that was not within the scope of the meeting. One member reflected that there are legacy issues because experienced people will not be around in the next few years. Additionally, the move of Clozapine unit is not preferred. Another member noted that patients should be able to smoke and therefore require access to ground floor. A member of the consortium noted that the temporary facility provided some flexibility because it allowed mental health services to trial this model and potentially make changes if evidenced. Social workers are important in discharge planning and the AASW representative noted concern with any consideration of reducing social workers. The representative from Flourish provided positive feedback about the consultation that had occurred with consumers, noted the constraints of the current footprint and requested that a de-escalation area be implemented in the Department of Psychiatric Medicine now so that staff can be trained.
3.4.1 Responses provided by MHS	MHS agreed with the importance of social work and noted that 12-25 people per month were discharged to private providers who aren't provided for by the community team. MHS noted that quotes had been sought for sensory modulation equipment for the temporary facility however the view was that it was unlikely money could be found to implement a de-escalation room now. It was also noted that this is operational issue.
4 Comments from the Rescue Taskforce	Dr Dan Norton reiterated the outcomes of the Rescue Taskforce investigation. The Rescue Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but that this could only be incorporated in a subsequent stage of the Master plan.

Item	Discussion
	The user group, executive user group and A/CEO THO-South have signed off on the redesign of both K-Block and the temporary facility. The reorientation of levels two and three of K-Block has occurred with an additional investment of $2.4 million which has provided an opportunity to improve outcomes for mental health inpatients through a redesign of mental health areas. An investment of $600 000 has also since been allocated for the three additional beds. Some shell space is available but its future use would be subject to an approved and funded business case. This is the bailiwick of the THO-South.
5 Close of the Business	The A/Secretary attended briefly to greet members and the Chair reiterated that a report from the meeting would be provided to the A/Secretary.

Chairperson: 

10 June 2015

Department of Health and Human Services
OFFICE OF THE SECRETARY

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Tasmanian Government

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WITS: 86476

Mr Tony Steven
Executive Officer
Australian Medical Association Tasmania

Via Email: ceo@amatas.com.au

Dear Mr Steven (Tony)

Subject: Mental Health Redesign

I write regarding the meeting of 14 May 2015, held with the Mental Health Consortium at your request.

The Chair of the meeting, Mr John Ramsay, has briefed me on the details of the meeting. I understand that the members benefited from a presentation on the redesign process and specifically the opportunity to clarify elements of the design and model of care.

I note that the three major issues for the consortium were presented at this meeting: design of the units, size of the units and number of mental health beds.

There is agreement that the preferred location for mental health inpatients would be in a ground floor location. This is provided for in the second stage of RHH Master plan, but not the current Redevelopment project. Clinical advice from the Clinical Director Mental Health Services and the Chief Psychiatrist communicated to members at the meeting, is that the redesign is a vast improvement on what is currently available for mental health inpatients.

I recognise the importance of outdoor space for mental health inpatients and I can assure you that every effort has been made to maximise outdoor space. It has increased through the redesign from 20m² to approximately 120m² across the two levels. Patients in the high dependency unit (HDU) will have access to outdoor space by staff escort via the secure ward. There will also be a glass atrium area adjacent to the HDU lounge which will provide light and a sense of openness.

Regarding the size of the units, there is no evidence to support the view that the amenity is not appropriate given its alignment with the Australian Health Facilities Guidelines (AHFG). I'd like to take this opportunity to provide you with some examples in this regard.

The application of the AHFG is generally operationalised ± 10 per cent. This comparison indicates that there is almost full alignment with the AHFG with the primary exception of outdoor space which cannot be realised within the floor plate of K-Block. The AHFG recommends 14m² for one bed mental health rooms. The temporary facility will provide 16-17m² and K-Block will provide between 15-20m² for one bed rooms. The AHFG recommends 10-20m² for staff stations. Staff stations within the temporary facility, of which there are three, are between 11-18m² and within K-Block, of which there are three, are between 15-16m².

Finally, I am advised that bed numbers remain a key concern for the consortium. A recent review of demand demonstrated that an additional three beds were warranted in K-Block. A business case has since been approved and funded to achieve this outcome. Any future modelling based on activity data will need to be presented to the THO-South for approval and considered within the budget process. However, it is clear that further consideration of inpatient bed numbers should occur within the context of entire mental health service system specifically in relation to an increasing focus on service provision within the community.

On this basis, I am of the view that the mental health redesign is entirely appropriate within the scope and resources available for this phase of the redevelopment. I appreciate that as stakeholders with a deep commitment to mental health that you want to maximise outcomes for patients. The construction of K - Block will be a significant step forward for mental health inpatients and I encourage your ongoing support as we move forward.

Yours sincerely

Michael Pervan
Acting Secretary

3 July 2015

Enc: Record of meeting 14 May 2015

Department of Health and Human Services

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Tasmanian Government

Contact: Mike Cain
Phone: (03) 6166 3525
E-mail: mike.cain@dhhs.tas.gov.au
File: RTI201516-003

Mr Tony Steven
Australian Medical Association Tasmania
147 Davey St
HOBART TAS 7000

Dear Mr Steven

Application for assessed disclosure under the *Right to Information Act 2009* – RTI201516-003

I refer to your application for assessed disclosure made under the *Right to Information Act 2009* (the Act).

A search of Department records has been carried out. No information relating to your application has been located.

The Asset Management Services (AMS) branch of the Department of Health and Human Services (DHHS) has carried out a comprehensive search of all current and historical systems, queried staff, and checked through physical storage areas for the original plans for the Department of Psychiatry at the Royal Hobart Hospital (RHH) from 1998.

Additionally, AMS has contacted the Tasmanian Health Services (THS) and asked for a search to be conducted for any internal plans relating to your request. Neither agency has been able to find the document or information you have requested. Given the significant period of time elapsed since 1998, we no longer hold copies of the information requested.

If you require further information, please contact Mike Cain on telephone (03) 6166 3525 or via email to mike.cain@dhhs.tas.gov.au.

Yours sincerely

Mike Cain
Senior Consultant, Right to Information
RTI Delegated Officer

6 August 2015

Department of Health and Human Services (DHHS) and
Tasmanian Health Organisations (THOs)

Tasmanian Government

Right to Information Act 2009

Application for Assessed Disclosure

Applicant's Details:

Family Name: Steven **Title:** Mr

Given Name/s: Antony

DAY TIME CONTACT INFORMATION:

Email: ceo@amatas.com.au

Postal Address: 147 Davey Street, Hobart

STATE: TAS **POSTCODE:** 7000

Telephone: Business 6223 2047 Home Click here to enter text. Mobile 0409 219 368

Email: Click here to enter text. CEO@ gmatas. com. au

Application Fee ($37.00) included (please select) **YES** ☐ **OR** **NO** ☒

Application for Waiver of Fee:

☐ **Member of Parliament**

☐ **Financial Hardship ***

☒ **General Public Interest or Benefit**

*** If claiming Financial Hardship you must attach evidence that you are in receipt of Centrelink or Veterans Affairs payments**

Proof of identity provided: ☐ For the release of your personal information, you must provide photo identification or a copy of photo identification which has been certified as a true copy by a Justice of the Peace or a Commissioner for Declarations

Description of efforts made prior to this application to obtain this information:

This information will help us to locate the information you are looking for.

Requests to the DHHS by e-mail

Information Request: To enable the Department to identify the information in its possession, please clearly outline your request below, or attach a separate sheet where necessary.

(1) What is the subject matter of the information you are seeking?
We request a copy of the original plans for the Department of Psychiatry at the Royal Hobart Hospital from 1998

(2) What time period / date range would you like us to search within?
1998

(3) Are there any other details that would assist us in locating the information you are seeking?
Floor plans of original depart foot print

Applicant's Signature: Click here to enter text.

Date: 30/06/2015

Privacy Statement

The Department of Health and Human Services collects personal information provided in this form for the purposes of processing your application for assessed disclosure under the *Right to Information Act 2009*. Personal information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by the individual to whom it relates on request to the Department.

Where should I send my application form?

You can address your application form to **Right to Information:**

By Email: ots.mailbox@dhhs.tas.gov.au

By Post: Department of Health and Human Services, GPO Box 125, HOBART TAS 7001

If you have any questions or need assistance filling in this form please contact the Office of the Secretary via email to ots.mailbox@dhhs.tas.gov.au or phone: (03) 6166 3530

The Royal Australian & New Zealand College of Psychiatrists

20 January 2016

Minister Michael Ferguson
Minister for Health
Department of Health and Human Services
GPO Box 125
HOBART TAS 7001

By email to: rethink@dhhs.tas.gov.au

Dear Minister

Rethink Mental Health – A Long-Term Plan for Mental Health in Tasmania 2015-2025

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Tasmania Branch welcomes the opportunity to provide feedback on the *Rethink Mental Health – A Long-Term Plan for Mental Health in Tasmania 2015-2025* (the Plan).

The RANZCP commends the Department of Health and Human Services for the breadth and ambition of the Plan and strongly endorses its aspirations and intentions.

As Tasmania Branch members have significant practical experience in the delivery of mental health services, the Branch has identified some issues for consideration that are likely to affect the long-term delivery of mental health services in Tasmania according to the intentions of the Plan.

These issues are detailed in the attached submission and include the need for:

- greater numbers of acute and subacute beds across Tasmania with appropriate staffing and resources
- more extended inpatient care services for a minority of consumers who have not sufficiently recovered to cope independently or in realistic levels of individual or community care
- planning for community mental health services to take greater account of the needs of people with severe and / or chronic mental illness who are not always able to advocate for themselves
- the Plan to provide a more detailed response to the issue of access to mental health services in regional areas.

To discuss any of the issues and proposed solutions outlined in the submission, please do not hesitate to contact me via the RANZCP Tasmania Branch on (03) 6270 2260 or ranzcp.tas@ranzcp.org.

Yours sincerely

Dr Milford McArthur
Chair, RANZCP Tasmania Branch

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ABN 68 000 439 047

The Royal Australian & New Zealand College of Psychiatrists

Submission in response to 'Rethink Mental Health – A Long-Term Plan for Mental Health in Tasmania 2015-2025'

RANZCP Tasmania Branch

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Background to the Royal Australian and New Zealand College of Psychiatrists, Tasmania Branch

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand and is responsible for training, education and representing psychiatrists on policy issues at the state, national and bi-national level. The RANZCP has more than 5000 members, representing about 85% of practising psychiatrists in Australia and New Zealand.

The RANZCP's Tasmania Branch (the Branch) has almost 100 members, including practising psychiatrists, trainees and affiliates. The Branch is committed to creating better mental health outcomes for the community by supporting local members in their training, continuing professional development, networking and providing input into policy areas, which shape the profession of psychiatry. It is particularly responsible for the concerns of its members practising in Tasmania and, therefore, for all matters touching the mental health of Tasmanians.

Role of psychiatrists in Tasmanian mental health system

Psychiatrists are a crucial part of Tasmania's mental health system. Psychiatrists – who have a minimum 13 years' education and medical training - are doctors who are experts in the assessment, diagnosis, formulation and management of patients with psychiatric illness.

Psychiatrists treat all types of mental illness, emotional disturbance and abnormal behaviour from mild or episodic conditions to those that are severe, persistent and life threatening, and work with people of all ages and backgrounds. They work in private, public, academic or community settings and play pivotal, leadership roles in the teaching, research, administration and delivery of mental health care.

Psychiatrists also work in collaboration and partnership with consumers, their families and carers as well as general practitioners (GPs) and other health professionals to best meet the mental health and emotional needs of their patients. At its core, psychiatry involves listening carefully and sensitively to people's most personal thoughts and feelings, understanding patients' mental state and working with them to identify and implement appropriate treatments and interventions.

Introduction

The Branch welcomes the opportunity to comment on the final version of *Rethink Mental Health – A Long-Term Plan for Mental Health in Tasmania 2015-2025* (the Plan) and strongly supports the Government's commitment to develop an integrated Tasmanian mental health system that provides support in the right place at the right time and with clear signposts about where and how to get help. The Branch further commends the Department of Health and Human Services for the breadth and ambition of the Plan and strongly endorses its aspirations and intentions.

As Branch members have significant practical experience in the delivery of mental health services in a wide range of settings, the Branch would like to raise some relevant issues for the Department's consideration – issues that have the potential to affect the long-term provision of mental health services in Tasmania in accordance with the intentions of the Plan.

BRANCH'S RESPONSE TO THE PLAN

The Branch's comments on the Plan are organised in order of the key headings in the document.

Message from the Minister

The Branch commends the Minister for his recognition of the need for broad social supports in promoting mental health within the community, and his appropriate focus on services to those who require care, while recognising the importance of health promotion and prevention.

The Branch also recognises that the Minister's Department has responsibility for welfare services and housing and is, therefore, in a position to implement broader measures towards improving mental health in the Tasmanian community.

However, in the context of under-resourced services to those people who have developed mental illness, the Branch suggests that it is not desirable that appropriate social measures to enhance the welfare of the general community should be included in the budget as specific to mental health.

Tasmania's Mental Health System

Consumers, their families and carers (p. 6)

As noted in the Plan, consumers, their families and carers are the most important stakeholders in Tasmania's mental health system.

The Branch strongly supports consumer and carer engagement in the Tasmanian mental health system and considers that a collaborative, respectful and healthy dialogue with patients and their representatives is absolutely critical at all levels, from treatment to management for future planning.

At the same time, the Branch considers it important to recognise that – in some particular situations – consumers may temporarily or – in some cases – permanently lack the insight and judgement to make decisions in their own best interests. In these situations, it may be necessary for consumers to receive appropriate care and treatment under the *Mental Health Act 2013* (TAS) (the Act) in the least restrictive manner and setting possible in accordance with the principles of the Act.

The Branch also considers it important that people who may be seeking to join the proposed peer workforce should be assessed on the basis of their total qualifications, skills and abilities and, most importantly, their abilities to offer support to other consumers of mental health services.

Tasmanian Government (p. 7)

The Plan's listing of public mental health services includes the following:

> *24 hour acute units located at three public hospitals and 24 hour specialist extended treatment units located in the South and providing services to people across the state.*

However, in the Branch's view, the psychiatric wards of the three general public hospitals have insufficient beds to permit adequate duration of inpatient care and that the current planning for the Royal Hobart Hospital proposes a reduction in the number of beds at that location.

From the Branch's perspective, this has created an impression that fewer inpatient beds are needed than is actually the case.

Yet, it is reasonable to predict that within the ten years envisaged by the Plan, there will be an increase in the need for inpatient beds as a result of such factors as:

- the ageing and emergent needs of the first cohort of patients from the era of 'deinstitutionalisation';
- the even more apparent ageing and departure of parental carers, and the geographical mobility of potential carers of the same generation
- the emergence of the victims of widespread social acceptance of drugs that may cause, precipitate or exacerbate major mental illness.

While the 'specialist extended treatment units located in the South' do indeed have state-wide responsibility, the Branch notes that the address of the majority of their patients is in the southern region where less than half of Tasmanians live. The Branch suggests that separating patients requiring long term hospitalisation from the community in which they live will not be of maximum benefit for the mental health care, treatment and ultimate recovery of those patients. Consumers who require longer stays in hospital have a greater need for contact with home and carers compared to those patients who need only brief admissions to hospital.

The Branch also considers that it would be valuable to undertake a survey of user satisfaction of the Mental Health Services Helpline.

Community Sector Organisations (p. 7)

The Branch notes that the activities of some Community Sector Organisations (CSOs) are subject to fluctuations in funding resulting from fiscal constraints and changes in government policy. Therefore, CSOs are often unable to make and implement long-term plans for the services they aim to provide. The result is apparent in the development of time-limited programs in an attempt to meet the needs of patients with long-term conditions. Time-limited 'individual packages of care' may be appropriate when patients are capable of significant rehabilitation, but in some cases patients' needs are indefinite, and they may not be best served by repeated changes of policy and support personnel.

The Branch recognises that the funding of CSOs is predominantly a Federal Government issue but the limitations and the partial failure of the present policy must inevitably impose an additional burden on the State service.

Therefore, the Branch recommends that in negotiations with the Federal Government, the Minister should seek to have a greater proportion of the Federal funding for mental health available to the State service.

Australian Government (p. 7)

'Better Access' initiatives have greatly increased affordable access to psychologists and other accredited mental health professionals but have resulted in burgeoning costs to the national health system, without significant benefit to people who have complex and / or severe mental illnesses.

'Headspace' is a valuable service that needs to be expanded beyond the major population centres. As an innovative project, its longevity is uncertain. As a necessary part of mental health services, the services it offers may possibly change, as a result of change in Federal policy.

***National and State Mental Health Context** (p. 8)*

The 'shift from institutional to community care' carried the promise that services would be provided in the community to largely replace long term institutional care while enhancing the quality of life of those who would formerly have need of it. For a significant number of patients, this promise has not been kept.

Community-based services have tended to diminish by attrition in times of financial restraint. Community teams are frequently understaffed for their case loads, professional members are inadequately covered when on leave or otherwise unavailable, and not always replaced if they resign or retire.

While the Branch does not advocate a return to the era of institutional care, the Branch believes that there remains a need for more extended inpatient care for a minority of people who have not sufficiently recovered to cope independently or in realistic levels of individual or community care. In many such cases, there is a need to establish an effective and sustainable treatment regimen before returning to life in the community. This can generally be achieved within two to six months, but a few will need more extended care - some indefinitely. The future number of such patients is difficult to predict at this time due to changes in lifestyle within the community, patterns of drug abuse, advances in treatment, and the ageing and geographical mobility of potential family carers. Yet, in the Branch's view, the number of acute and subacute beds available is, at present, insufficient and, based on current planning projections, likely to become more so.

New Direction for the Next Decade (pp. 10-11)

Overall, the Branch regards this section as an excellent statement of aspiration but has some questions regarding the practical implementation of this section. The Branch:

- seeks further information about the cost implications of the proposed peer mental health workforce given that the current Tasmanian mental health system already has difficulty in maintaining appropriate professional staffing levels for the delivery of mental health services
- considers it important that people who are part of the proposed peer workforce receive appropriate training to enable them to effectively communicate and collaborate in the interests of patients

In regards to the *'ten key directions for reform'*, the Branch wishes to make specific comments on the implementation of Reform Direction One, Two, Three and Four as set out below.

Reform Direction One: Empowering Tasmanians to maximise their mental health and well-being (p.16)

The Branch supports all measures to increase 'health literacy' in the community. Recent educational experiments in enhancing children's resilience should be evaluated and extended to all schools when found effective, and the use of schools to engage parents in educational activities affecting mental health and well-being should be extended.

A mental health system that increases collaboration between consumers, their families and carers and staff will demand clear directives regarding patient confidentiality and its necessary limitations, and also appropriate protection of the confidentiality of informants acting in good faith.

The Branch also refers to comments on the 'peer workforce' above.

Reform Direction Two: A Greater Emphasis on Promotion of Positive Mental Health, Prevention of Mental Health Problems and Early Intervention (p. 17).

The Branch welcomes the measures outlined in this statement, which involves fostering positive social change at almost every level.

The Branch also recommends that the Plan needs to provide a more detailed response to the issue of access to mental health services in regional areas where the public health system is often the only available support. This is due to factors such as:

- fewer non government organisations (NGOs) in rural areas or that NGOs do not generally work with more complex patients
- fewer private psychiatrists
- other overlapping services such as geriatrics are missing in some parts of Tasmania.

In the Branch's view, these factors have helped contribute to a disparity in the provision of mental health services in Tasmania – that is, mental health services are not always located where there is demonstrated demand for these services.

For instance, the Older Persons Mental Health Service in the North West has had more referrals last financial year than the South in spite of having less than half the population.

If these issues are not addressed, the Branch considers that the outcome will be mental health professional burnout, expensive and changing locum cover and an ongoing negative impact on patients and mental health services.

Reform Direction Three: Reducing Stigma (p. 18)

The Branch welcomes the supporting statement, which eloquently outlines the problem of stigma in relation to people with mental illness. However, in the Branch's view, this section would benefit from clear statements on how stigma can be reduced. The Branch suggests that reducing stigma involves public education, commencing at an early age.

The Plan also refers to the continuing effects of 'the history of institutional care'. This will fade with time, although it continues to be fostered by ongoing portrayals in films and other media.

However, the limited quality of current provisions for care in short-stay hospitalisation and in the community, and increased community contact with the mentally ill have – from the Branch's perspective - unfortunately helped increase stigma of people with mental illness rather than decrease it in practice.

Reform Direction Four: An Integrated Tasmanian Mental Health System (p. 19)

An integrated system

Notwithstanding the growth of Hobart and its region, the Branch submits that an integrated state system must recognise that a majority of Tasmanians still live in other regions. Provision of mental health services has never reflected this fact. The Branch considers that 'a single lead agency' must not continue to reflect such centralisation.

A person-centred and recovery focused approach

Much current planning for mental health services is based on a philosophy termed 'the recovery model'. Essentially, this codifies what have always been the aspirations of mental health professionals working with patients who are competent to act in their own interests.

The development of the 'recovery model' has been informed by consumer groups. As these groups represent community members with lived experience of mental illness, the submissions of such organisations are very important and a positive aspect of the movement has been its influence on government policy to take account of the needs of consumers, their families and carers.

However, the Branch also considers it is important that the needs of people with more severe and chronic mental illness are also taken into account by policy makers as this group of people may not always be able to effectively advocate for their own needs. The Branch considers that this issue is particularly important in the context of planning for community mental health services.

Key areas of the system for integration

Public Mental Health Services – In the Branch's view, 'fragmentation' and 'variations in models of care' are products of inadequate staffing and resources, particularly in the North and North-Western regions, but also in the South.

The Branch considers that all services (regional or specialist) need clinical directors empowered to lead them by close and regular contact. The long experience of all health services in Tasmania has demonstrated that a single Hobart-based directorate cannot effectively provide the clinical leadership needed to ensure services of the necessary standard.

Alcohol and drug mental health services - The Branch strongly supports the re-integration of alcohol and drug services with mental health services given the prevalence of co-morbidity of drug and alcohol abuse and dependency with other mental disorders.

Currently, there can be major differences in philosophy and management policy between drug and alcohol services and other mental health services that need to be addressed, with a clear decision on

the primary clinical responsibility for the care of particular patients, in preference to a 'shared care' arrangement.

Shifting the Focus from Hospital Based Care to Support in the Community (p. 22)

While the Branch fully supports community based mental health care, we note that there continues to be a lack of staffing and resources across Tasmania to enable this ideal to be reached. Further, it also must be recognised that some Tasmanians with mental illness have severe and / or complex needs that may require inpatient or hospital treatment.

Therefore, the Branch submits that hospital-based services will continue to be essential for the acute and subacute care for consumers and it is essential that there should be no withdrawal of resources from that sector.

As illustrated by recent research, Australia acute hospitals are facing excessive demand for mental health beds (Allison and Bastiampillai, 2015).

Yet, as shown by Organisation for Economic Community Development (OECD) research, Australian acute hospitals contrast poorly to other OECD countries for psychiatric care beds per 100,000 of population. Australia has 39 beds per 100,000 people compared to the bed average of all OECD countries (69 beds per 100,000 people) or the United Kingdom (54 beds per 100,000 people). As the OECD has noted, 'Australia should make sure that high-quality mental health care is accessible for the whole population' (OECD, 2015)

Given these findings, the Branch is concerned about the Government's ongoing cuts to acute bed numbers in Tasmania. By contrast – in other states and territories – governments are taking steps to increase their acute bed numbers. Accordingly, the Branch considers that we need more – not less – acute and long-stay beds and appropriate staff resources as a matter of urgency.

In the Branch's view, other related urgent priorities for Tasmanian acute mental health services are:

- an arrangement to ensure continuity between inpatient and community care in all cases of patients who have required hospitalisation
- accommodation for people who need very high levels of support - jointly run by the State Government and CSOs - including with nurses to assist people who have severe and / or complex mental health needs and less prospect of recovery.

Getting in Early and Improving Timely Access to Support (p. 23)

The Branch welcomes the Government's goal in this context – to take action to intervene early to reduce the incidence, duration and severity of mental ill-health in Tasmania and to improve access to mental health support.

However, in the Branch's view, Tasmanian child welfare and protection services are inadequate to meet current demand, that they are largely occupied with more urgent cases and often unable to intervene before more serious problems become apparent. Such services need to be adequately staffed to encourage notifications and referrals from antenatal and postnatal services and from schools with a reasonable expectation of appropriate investigation and intervention.

The Branch also believes that effective intervention early in life requires a focus on the antenatal period and the first two years of a child's life. For this to be achieved, perinatal and infant mental health services are required across Tasmania. At present, there is a small service in the South but very limited services in the North and North West of Tasmania. In order for these services to be effective, there also needs to be enhanced Child Health and Parenting Services that have a capacity for regular and ongoing involvement with high risk families and an adequately staffed and trained child protection workforce.

Private-Public co-operation

There is an additional element that the Branch believes that the Plan needs to incorporate to enhance mental health outcomes for Tasmanians – that is, utilising the expertise of Tasmania's private psychiatric sector. This can be accomplished through cross sector collaboration, ensuring early referral from GPs and encouraging private psychiatrists to contribute to public psychiatric services on a sessional basis. Another option could be conjoint psychiatric appointments to facilitate co-operation between the two sectors.

A particular area of interest for the Branch is consumers who transition from the public to the private sector in a shared care service model, involving psychiatrists, GPs and psychologists. The Branch believes that ensuring continuity of services and communication between psychiatrists, GPs and psychologists will help improve the delivery and integration of mental health services and, in turn, enhance outcomes for Tasmanians with a mental illness.

To facilitate this process, the RANZCP has produced Professional Practice Guidelines: Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists (the Guidelines, 2014).

The Guidelines outline best practice steps in referral, communications and shared care arrangements between GPs, psychologists and psychiatrists who are the main providers of community mental health care. They aim to assist communication flow, clarification of patient management and patient care and safety between all practitioners involved in the shared cared service model.

References

Allison S and Bastiampillai T (2015) Mental health services reach the tipping point in Australian acute hospitals 203 (11) *Medical Journal of Australia*: 432-434.

Organisation for Economic Co-operation and Development (2015) Australia at the forefront of mental health care innovation but should remain attentive to population needs, says OECD. Available at: www.oecd.org/els/health-systems/MMHC-Country-Press-Note-Australia.pdf

ANMF
TASMANIAN BRANCH

7 April 2016

Michael Ferguson
Minister for Health
PO Box 537
Launceston 7250

Our Ref: WOR 21 0097
Contact: Neroli Ellis
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Dear Minister

Re: Department of Psychiatry, RHH Redevelopment

The Australian Nursing and Midwifery Federation (Tasmanian Branch) writes to provide further information following a meeting attended by ANMF Tas Branch Secretary Neroli Ellis, yourself and Ms Cat Schofield in which the matter of the reduction of beds since 2014 in the Department of Psychiatry at the RHH was raised.

We discussed that in the temporary forecourt building there will be a total of 30 beds (14 open unit, 10 secure unit, 6 high dependency unit) and in the K Block that will increase slightly to 33 beds. These figures are inclusive of the varying units that comprise the new Department of Psychiatry.

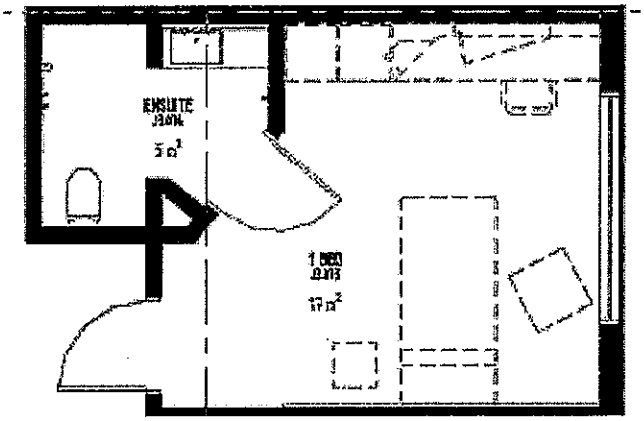
In the meeting, it was put to you that these numbers have reduced from 43 across the Department of Psychiatry in 2014 and indeed from the current 33 beds. There exists a lack of future proofing, in conjunction with no plans as to how the facility will cope with fewer beds when bed block in the Emergency Department is already an issue.

This claim was refuted by Ms Schofield who advised you that the predominantly single rooms in the new buildings will be able to in fact house two (2) beds in each room.

Ms Schofield's claims are refuted by the ANMF Tas Branch on a number of points, as follows:

1. There has never been a mention of the single rooms being able to house more than one inpatient during any of the redevelopment discussions.

2. The Australian Health Facility Guidelines for a 2 bed bedroom in a mental health unit require 28m2.
3. The single bed bedrooms in the new facility vary from 16m2-17m2 – this is the size of a conventional residential bedroom, or 4x4m.
4. There are two larger single bed bedrooms in the secure unit at 27m2, however these have been specifically designed to meet the needs of people with a disability or vulnerable patients, as these two rooms are inclusive of a lounge area.
5. The diagram below is taken exactly from the final RHH Redevelopment Building plans for the temporary forecourt building. As you can see, after the single bed, basic furniture and swing spaces for the doors are taken into consideration, it is not plausible to be able to accommodate two bed and furniture set-ups within one of the single bed bedrooms.



The ANMF has strongly supported safe patient care for the Tasmanian public, and do not believe that there is any capacity to fit extra beds into the existing building plans. The Department of Psychiatry has already reached capacity, prior to a further reduction in beds, which has in recent times been resolved by opening "closed" beds (which were shut in the early stages of the "Decant"). The ANMF hold serious fears for the safety and well-being of those Tasmanians needing Mental Health services and also for the risk to staff safety such bed pressures will create.

We also would like to draw to your attention that there has been little increase to any Community Mental Health Services (apart from Child & Adolescent). Community Mental Health services risk being further strained and their efficiencies adversely affected if services are not increased prior to the reduction of beds.

In addition, Ms Schofield asserted that the "Seclusion Room" could be utilised as a bedroom. The High Dependency Unit (previously the 8 bed PICU) is a 5 bedroom facility with 1 "swing" unit and 1 Seclusion room. The Swing unit is named in the model of care as being predominantly a bedroom (making for a 6 bed unit) or a second seclusion room if needed. The designated seclusion room is not intended to be a bedroom. Apart from the trauma-informed care and evidence-based best practice of a patient not experiencing their bedroom as a seclusion room, there are other considerations. If the ward is full and a patient using the seclusion room as a bedroom,

but another patient needs to be secluded, considerations such as infection control and disrupting acutely mentally unwell patients could lead to restraints by a code black team for up to 45 minutes whilst the room is made ready – this is not an acceptable risk to patients or staff.

The ANMF requests your urgent attention and reconsideration of the findings from our meeting in light of the information provided within this letter.

Yours sincerely

Neroli Ellis
Branch Secretary

Cc: Dan Norton, Chair RHH Redevelopment project
Dr Richard Benjamin, Australian Medical Association
Dr David Alcorn, CEO THS

The Royal Australian & New Zealand College of Psychiatrists

Tasmanian Branch

7 June 2016

Dr David Alcorn
Chief Executive Officer
Tasmanian Health Service
Level 1, Northern Integrated Care Service
41 Frankland Street
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Email: ceo@ths.tas.gov.au

Dear David

Royal Hobart Hospital Redevelopment – new Psychiatric Unit

The Tasmanian Branch of the RANZCP has recently lobbied that a more contemporary and better Psychiatric Unit be built in the new hospital for Hobart than the one currently planned.

We made submissions to Senior Project Officer, John Ramsay (a former Secretary of Health) who was very supportive and to the Secretary DHHS, but in the end our submission was not supported by the two most senior Mental Health Services people, Psychiatrist Jim Blacket and Group Manager Umit Agis. Both of these Administrators have now left the service and it seems that no-one in MHS is advocating for improvements in the yet to built new Psychiatric Unit and that the original proposal appears to have been accepted as appropriate.

We asked that the Psychiatric Unit for the next 20 or 30 years be better than or at least equal to what we have now. Sadly apart from fresh paint and new fittings we believe the people of Tasmania will have a Psychiatric Unit which is less capable and the community will be worse off than currently.

The proposal that fewer in patient beds will be needed in the future seems very unlikely.

In particular the new Psychiatry Unit spread over two floors will have:

- Less in-patient beds
- Not be of contemporary design with inadequate open/green space

- The HDU/PICU has little open space
- Less psychiatry registrar offices which will reduce their integration into the ward environment and make accreditation more difficult
- Less consultant psychiatrist offices who will have to be off the unit in the future
- No training room facilities in the Unit as we currently have
- Consultation-Liaison not integrated with the Psychiatric Unit and off site
- Clozapine clinic downgraded

We are seeing already the effects of the reduction in bed numbers with most weekends resulting in psychiatry patients having to spend hours to days in the Emergency Department as there are no in patient vacant beds.

The Tasmanian Branch recommends that consideration be given to reverting to the original model of care regarding the management of PICU and the Psychiatric Unit. In that model, there was a half time PICU consultant and full time PICU registrar rather than the three teams managing PICU as well as Psychiatric Unit in-patients and the Emergency Department patients.

Perhaps a review of the number of violent incidents, the need for long term security staff and staff morale could be assessed against the previous model.

Also when the Psychiatric Unit (Department of Psychiatry) was part of the RHH rather than MHS, there was a psychiatric registrar who was responsible for the Emergency Department patients and acting as a Senior Registrar on the ward.

The net result has been a reduction in a half time consultant and two psychiatry registrars servicing the RHH complex.

The Tasmanian Branch has other concerns about the lack of a Director for Psychiatric Unit. The post was advertised earlier in the year but not filled. When this issue was raised the response from MHS Administration was that there was no vacancy even though they advertised to fill the vacancy.

It was distressing that the genuine concerns of the local Branch of RANZCP about the future care of psychiatric patients were not taken seriously considering the weight of experience and knowledge that local psychiatrists have about the issue.

The Royal Australian & New Zealand College of Psychiatrists

Tasmanian Branch

We suggest that this recent article from the Medical Journal of Australia provides insight into the issues we have raised. https://www.mja.com.au/journal/2015/203/11/mental-health-services-reach-tipping-point-australian-acute-hospitals

The Tasmanian Branch of the RANZCP respectfully requests that a review be conducted by nationally recognized experts who have knowledge and experience of working in state of the art Psychiatric Units and in optimal care of patients in an acute unit so they can advise on space allocation, bed numbers (including reviewing the in patient bed needs for the next 20 to 30 years) and general design of the proposed new Psychiatric Unit to be built in the new hospital.

Yours sincerely

Milford McArthur
Chair
Tasmanian Branch
RANZCP

Cc: Mr Craig Watson, DHHS

RANZCP Tasmanian Branch Committee

Benjamin, Richard G (THS)

From: Watson, Craig A (THS)
Sent: Wednesday, 8 June 2016 3:41 PM
To: Benjamin, Richard G (THS); Carr, Cheryl L (THS); Moloney, Benjamin L (THS); Office of the CEO - Tasmanian Health Service (THS); Stephane Auchincloss (stephauchincloss@bigpond.com); McArthur, Milford L (DPM) (THS); Lambeth, Leonard G (DHHS)
Cc: Greenaway, Tim (THS); Tony Steven
Subject: RE: RHH Redevelopment/RANZCP/AMA meeting re K block plans for Mental Health

Hi Richard

Slight correction to these bits:

Craig Watson explained that all of the shell space on the second and third floors had been taken by other craft groups – hyperbaric medicine and a gymnasium for allied health – and there was very little chance that these decisions could be reversed, as the decisions had been formally signed off by Cabinet and the Executive User Group, respectively.

Craig Watson further explained however that the master plan for a stage three, much better designed, mental health facility on the corner of Campbell and Collins St was still very much desired and something we will continue to pursue funding for.

cheers

Craig

Craig Watson
Chief Operating Officer
Tasmanian Health Service
Ph: 03 6166 8500

From: Benjamin, Richard G (THS)
Sent: Wednesday, 8 June 2016 1:05 PM
To: Carr, Cheryl L (THS); Moloney, Benjamin L (THS); Office of the CEO - Tasmanian Health Service (THS); Stephane Auchincloss (stephauchincloss@bigpond.com); McArthur, Milford L (DPM) (THS); Lambeth, Leonard G (DHHS); Watson, Craig A (THS)
Cc: Greenaway, Tim (THS); Tony Steven
Subject: RHH Redevelopment/RANZCP/AMA meeting re K block plans for Mental Health

Hi all

Having attended numerous such meetings in the past, I am aware that minutes are not always formally kept or circulated for comment in draft form

I have therefore taken the liberty of making something of a record and I would be grateful if there are any misconceptions that these be corrected, or if there are any major omissions that these be added

All of those in the invite list above were present, excluding those AMA officials in the copy to section

Craig Watson explained that all of the shell space on the second and third floors had been taken by other craft groups – hyperbaric medicine and a gymnasium for allied health – and there was very little chance that these decisions could be reversed, as the decisions had been formally signed off by the RHH executive body

Craig Watson further explained however that the master plan for a stage three, much better designed, mental health facility on the corner of Campbell and Collins St was still very much possible and affordable

Ben Moloney explained that any changes to the current K block designs would be expensive as the plans had been agreed to, however if any changes needed to be made it would be still cheaper to make these changes sooner rather than later

Drs Auchincloss and McArthur from the medical/registrar training committee perspective explained that for accreditation and ancillary purposes that office and interview space needed to be made available for nine doctors. Cheryl undertook to clarify where the interview spaces were, and Craig Watson guaranteed that quiet office space for doctors would be made available very nearby to the new units, and that this might possibly be in E block

Dr Benjamin explained his concerns re lack of available beds and bed block, and Dr Alcorn stated that it may be possible to organise some funding for overflow beds elsewhere and that a proposal should be put about this to management

Dr Benjamin explained his concern that the overall footprint and design for the units was inadequate, and that the proposed HDU unit particularly was not all appropriate in size or design – especially with respect to no outdoor space at all – and that this would lead to many unacceptable outcomes with respect to aggression and use of medication. Cheryl Carr undertook to investigate options for creating extra space

Cheryl Carr undertook to set up another meeting as soon as possible

Kind regards

Richard Benjamin

AMA Tasmania

AMA
TASMANIA
ABN 11 009 484 931

15th July 2016

Dr David Alcorn
Chief Executive Officer
Tasmanian Health Service
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Dear Dr Alcorn,

The Australian Medical Association (the AMA), the Australian Nursing and Midwifery Federation (the ANMF), and the Royal Australian and New Zealand College of Psychiatrists (the RANZCP), hereafter referred to as "the parties" to this correspondence, write to you today to ask that you urgently seek an independent review of the design of the acute mental health units in K block of the Royal Hobart Hospital Redevelopment, as the above parties believe that the units are unfit for purpose.

The parties believe that the review should be completed by those who have expertise in both contemporary acute mental health unit design, and in providing optimal care to patients in contemporary, state of the art, acute mental health units.

The parties request this review for the following three reasons primarily:

1. The units have insufficient bed numbers,
2. The units are manifestly too small,
3. The units are not designed along contemporary principles.

The parties also believe that the THS needs to urgently identify additional space for the care of those acutely mentally ill patients requiring inpatient care in Southern Tasmania, and, following a review, that experts in contemporary acute mental health unit design be urgently sought to re-design both levels of K block, and any additional space allocated to mental health.

<u>The units have insufficient bed numbers</u>

Prior to de-institutionalisation, much in the way of mental health care was delivered via inpatient treatment in large, stand-alone psychiatric hospitals. In Tasmania, this type of care was provided by the Royal Derwent Hospital in New Norfolk, open for over 170 years, with well over 1000 patients at its peak. With the belief that the newer psychotropic medications would be effective in treating mental illness, and to help de-stigmatise those suffering from mental illness,

more and more patients were treated outside of the larger institutions and in the community from the 1960's and 1970's, "mainstreamed" into society. This mainstreaming included treating seriously ill patients in acute mental health units in general hospitals and the beds in these units have to a large extent replaced those in the larger, stand-alone psychiatric hospitals across the Western world.

The Organisation for Economic Co-operation and Development (OECD) keeps records of psychiatric bed numbers across its 34 member countries: the average number of total psychiatric bed numbers in 2011 was 68 per 100,000 population, and Australia ranked 26th of those 34 countries, at only 39 beds per 100,000 (OECD Health Statistics, 2013). This, for example, is 44 beds per 100,000 less than Norway, and 15 beds per 100,000 less than the United Kingdom. Importantly, the average length of stay is also low in Australia, at 17 days, in comparison to 30 days in the United Kingdom, nearly double; the higher number of beds and the longer lengths of stay contribute to much lower re-admission rates in the United Kingdom, a measure of the effectiveness of admission.

In an article published late last year, Stephen Allison and Tarun Bastiampillai noted the release of the National Mental Health Commission (NHMC) report on the Australian mental health sector, 2014 (Allison, S et al, MJA, 203 (11), p432-434). The report recommended a shift of $1 billion from acute care hospitals to community programs over five years. The authors of the article also noted that expert bodies like the RANZCP and the AMA suggested that, "cuts to acute bed numbers could cost lives". They say that the expert bodies have further suggested that, "Australia's mental health sector has reached the tipping point of high bed occupancy and extended Emergency Department (ED) waiting times", further suggesting that Australia needs to commission more acute psychiatric beds to maintain bed occupancy rates below 85%, "in order to guarantee safe functioning of acute hospitals".

The authors added that the NMHC report recommending bed closures would begin from a low base by international standards (see above). They also quoted the South Australian (SA) experience of cutting acute beds in 2011, "Over this period, SA was the only state decommissioning recently mainstreamed beds; other states were increasing bed numbers in line with population growth". By 2014, the authors state that SA was 20% below the Australian average for acute beds for 18-65 year olds, with double the average number of community beds. These community beds could not however manage patients with high risk presentations, and as a result patients needing acute care spent longer times waiting in ED. In fact, approximately one in every six mental health patients spent more than a day waiting for a psychiatric bed in an ED in SA in 2014. In response, the state government was forced to re-open 20 beds, to bring SA back to the national average.

Up until quite recently, the Department of Psychiatry (DoP) and the Psychiatric Intensive Care Unit (PICU) at the Royal Hobart Hospital housed 42 acute mental health beds. This number has been reduced to 33, and will be reduced further to 30 for the acute mental health units in the temporary demountable building in the Liverpool St Forecourt. The original K block plans were for 30 beds only also, however the bed numbers were eventually increased to 33 again, following pressure on the state government to do so from relevant lobby groups.

Since January 2016, the last six months of occupancy of these two acute mental health units (currently 33 beds combined) has been 29.45, 31.41, 29.77, 29.97, 31.97 and 31.13; this equates to an average of 30.62, or approximately 93%. This number is also artificially low, because when beds in the acute mental health units are full, patients seen in the ED are then "admitted" under psychiatry, in either the ED, the Emergency Medical Unit (EMU), or the Assessment and Planning

Unit (APU), but these numbers, although available on the hospital's electronic patient flow manager system, are not considered in the total number of admitted psychiatry patients. Even at 93%, this is 8% above the recommended 85% occupancy for efficient hospital management.

The result of the bed cuts has been significant bed pressure, increased waiting times and bed block in the ED, which of course affects all patient groups. In addition, there are also the significant risks of increased morbidity and increased mortality, as patients who should be treated within acute mental health units either wait in the ED or are declined inpatient care; anecdotally, adverse events are already occurring.

The usual calculation used in Australia for acute public mental health bed numbers for 18-65 year-olds is 24.3 per 100,000 of the relevant catchment population (Allison, S et al, ANZJP, 48 (10), p 952-956). In Southern Tasmania, with a recent catchment population of 159,389; this equates to 38.7, or, approximately, 39 beds. It can be seen that at 42 beds, the DoP and PICU, catering primarily for Southern Tasmania, but partially also for Northern Tasmania with respect to PICU, was slightly above the national average. With this number of beds, bed block and extensive waiting times in the ED were rare. At 33 beds, bed block and extensive waiting times are becoming common, and at 30 beds, all issues will be substantially exacerbated. (Please note that the OECD figures and the figures for beds for public 18-65 year olds cannot be compared, as there are differing age groups, patient groups etc).

It should finally be noted that bed numbers are averages only, and they do not take into account other variables, for example Tasmania's poorer socio-economic and health indices, in comparison to mainland states.

It appears that the government's recent decision to permanently cut 21% of Southern Tasmania's acute mental health beds is out of step with both important national and international trends.

<u>The units are manifestly too small</u>

Contemporary acute mental health units are always built on the ground floor wherever possible. This assists with safety issues, and provides greater access to outdoor and green space with the greatest efficiency, which also enhances the overall footprint of the unit. The units in K block are not on the ground floor, which is therefore a safety concern, but the above ground placement by necessity minimises the access to larger areas of space, including outdoor and green space.

In addition, the floor space over the two levels is only 2738 square metres, increased from 2173 square metres in response to pressure from relevant lobby groups. This overall footprint, even with the increase in size, contrasts starkly to the footprints of the previous DoP and PICU units, before recent building works. The state government has been unable to supply the plans for these units, but the parties to this letter believe that the units covered approximately 4400 square metres for the 42 patients. In addition, a contemporary acute mental health unit in Caboolture, in South-East Queensland, a similarly socio-economically deprived area, houses 43 beds over 9000 square metres. It can be seen therefore that the K block units are small in size, averaging just 83 square metres per bed, in comparison to the units they are replacing, approximately 105 square metres per bed, and to a contemporary unit in Queensland, at 209 square metres per bed.

Such small units contravene the principles of the Australian Health Facility Guidelines (AHFGs) for Adult Acute Mental Health Inpatient Units (Australian Health Facility Guidelines, Adult Acute

Mental Health Inpatient Unit, Revision 5.0, 11 April, 2012). These guidelines repeatedly note that, "the need for space cannot be overemphasised as a means of reducing the potential for aggressive behaviour, by way of wide corridors and recreation areas large enough to avoid crowding". The High Dependency Unit (HDU) on level three is the worst example of overcrowding in the designs. These units are built to accommodate the most seriously unwell patients, who are frequently both psychotic and agitated. In order to safely manage this patient group, the unit needs large, contiguous dining, socialising, recreational and outdoor areas. Instead the unit has been designed in an "L" shape, with two very small areas for recreation at the end of corridors, and no outdoor space of any kind. This unit has a footprint of 415 square metres, in comparison to the current PICU unit of 750 square metres. Such a footprint and such a design will lead to increased agitation levels in patients, which will in turn lead to more aggression, more assaults, both patient to patient and patient to staff, which may in turn lead to a greater use of antipsychotic and sedating medication, more transfers to the secure mental health unit on the Risdon Prison site (the Wilfred Lopes Centre), more illness and injury in staff, higher rates of workers compensation claims, and higher staff burnout rates. The suggestion in one letter from government that the "Patients in the HDU will have access to outdoor space by staff escort via the secure ward" (Mr Michael Pervan, Acting Secretary, DHHS, July 2015), shows a fundamental misunderstanding of the nature of nursing that this type of patient requires.

The units are not designed along contemporary principles

The General Assembly of the United Nations wrote their "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" in 1991 (United Nations General Assembly, A/RES/46/119, 1991). The principles are many, but some of those most relevant for inpatient care include, "All persons have the right to the best available mental health care", "Each patient shall have the right to be treated in the least restrictive environment", and "The environment and living conditions in mental health facilities shall be as close as possible to those of normal life of persons of similar age, and in particular shall include facilities for recreation and leisure activities, facilities for education...". The AHFGs further elaborate upon these principles. The guidelines state that each zone within a unit requires its own recreation and activity area, and outdoor areas with weather protection. They further state that, "Mental health facility design requires a conscious balancing of the requirement to provide an effective therapeutic environment for acutely mentally ill consumers with the need to provide consumers, carers, visitors and staff with a pleasant, spacious, light-filled, comfortable and non-threatening facility".

The parties do not believe that this has been achieved with respect to the K block plans. The parties further believe that the original footprint made available, and the design brief were at fault, and that attempts to remediate the plans, although made, were never going to be achievable because of the limitations imposed upon the architects.

The major issue relates to the style of unit, in its linearity; the plans having situated the bedrooms along the building perimeter, and the recreational areas primarily at the ends of corridors, as if the architects had designed medical or surgical wards, and added patient lounges. According to the AHFGs, "bedrooms should be grouped into clusters or pods for distinct consumer groups". Also, many contemporary acute mental health units are designed along the "palm and fingers" concept, with the "palm" including contiguous dining, socialising, recreational and outdoor areas, and the "fingers" including clusters or pods of beds. This arrangement maximises contiguous space, and in so-doing it also maximises the sense of space. By co-locating various areas, the design also helps achieve the principle of making the environment and living conditions "as close as possible to those of normal life". The

arrangement also generally helps provide good sightlines for nursing staff, which assists in risk management.

It should also be noted that the "palm and fingers" design is, however, no longer however contemporary itself, and that "person-centred care principles" should now be considered in designing units (Golembiewski, JA, ANZJP, 49 (3), p 203-206). Proponents of this type of principle note that acute mental health unit designs generally reflect the need to manage suicide risk and aggression, and to enhance the efficiency of staff routines. An emphasis on the above-mentioned sightlines, for example, "enforces asymmetric relationships by anchoring the locus of control with the staff on duty...This attentional focus on the staff station contributes to the 'honeypot syndrome', where patients loiter around staff stations". The article goes on to state that when staff stations are removed, evidence shows that both staff and patient behaviour improves. Client-centred units allow staff to move between staff and patient areas whilst maintaining visual connection, without bringing attention to the asymmetry of the relationship, empowering the client and inherently de-escalating behaviours.

Neither "palm and fingers" principles, nor "person-centred" principles have, however, been utilised in the new designs for K block, there are essentially no open spaces where multiple functions come together to maximise both space and the sense of space, there has been almost no attention given to the use of outdoor and green spaces, so very critical in the care of the mentally ill, and therefore the designs do not approach the "best available mental health care", "the least restrictive environment", or "be as close as possible to those of normal life". As such, the parties believe that both the United Nations Principles and the AHFGs have been seriously contravened in the design of these acute mental health units.

Additional issues

The parties believe that no allowance has been made for the special cultural need of Indigenous Tasmanians in any part of acute mental health units to be able to access outdoor space at all times.

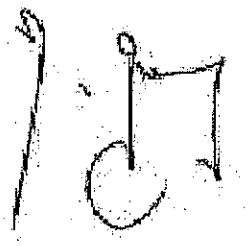
The parties believe that the models of care and staffing for these acute mental health units is suboptimal. In previous models of care, there has been a Clinical Director on-site. Such a position is critical in providing oversight and support to the unit. In previous models of care, a part-time specialist and dedicated training registrar also managed patients in the PICU. Such a model of care allowed for more timely assessment and treatment of the most seriously unwell patients, and led to better outcomes.

Conclusion

The parties appreciate that the government have met with stakeholders regarding the above matters, and that some changes have resulted, but have concluded that the future acute mental health units for K block are not of contemporary standard, and remain unfit for purpose. The parties to this letter reject the claim of government that, "The construction of K block will be a significant step forward for mental health inpatients" (Mr Michael Pervan, Acting Secretary, DHHS, July 2015), but rather believe that the plans reflect units designed by those with an insufficient understanding of the needs of the acutely mentally ill, on a footprint which is unsuitable.

The parties would appreciate this matter being given your urgent attention, and that a response could be made within four weeks.

Yours sincerely,



Professor Tim Greenaway
President
AMA Tasmania

Dr Milford McArthur
Branch Chair
RANZCP Tasmania

Ms Neroli Ellis
Secretary
ANMF Tasmania

Tasmanian Government

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Professor Tim Greenaway
President
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147 Davey Street
HOBART TAS 7000

Dear Professor Greenaway

Subject: Royal Hobart Hospital Redevelopment Project

Thank you for your correspondence dated 15 July 2016 regarding the Roya Hobart Hospital (RHH) Redevelopment project.

The issues you outline have been addressed previously. Most recently this occurred at the briefing where I was in attendance, along with your representatives and representatives of the Tasmanian Health Service (THS) and the RHH Redevelopment team including the project's design consultants. I believe the briefing provided comfort to the attendees as expressed by them at the time.

As such, I will provide a brief response only to the issues raised.

The K-Block mental health inpatient design was developed and signed off by users including the Chief Psychiatrist. The RHH Redevelopment's design consultants are experienced in mental health inpatient facility design.

There is no net operational loss in mental health inpatient beds. Further, inpatient capacity should only be considered in the context of the mental health system including community service provision.

The bedrooms, along with all the ward areas, are consistent with the Australian Health Facilities Guidelines.

Mental health inpatient design has moved forward considerably since the RHH wards were commissioned. The need for the contemporary design that will be achieved in the temporary facility and K-Block is pressing and should be progressed.

I understand that the investigations to further increase the outdoor space in K-Block have occurred and that an attempt to meet with your representatives to discuss this has been made.

Yours sincerely

Dr David Alcorn
Chief Executive Officer

29 July 2016

Copy to: Dr Milford McArthur; Ms Neroli Ellis

AMA
TASMANIA
ABN 11 009 484 931

Mr Ben Moloney
Tasmanian Health Service
ben.moloney@ths.tas.gov.au

26th October 2016

Dear Ben

Thank you for the meeting about the K Block HDU plans held recently at the RHH.

Both the AMA and the RANZCP have discussed the meeting and we would like to jointly feedback the following.

Both organisations still hold concerns about the overall footprint size, the number of available beds, and the layout of the units, and particularly so with respect to the HDU.

The organisations however appreciate that there are significant limitations in K Block with respect to the building envelope, and that the project team and the architects have been attempting to alleviate the problems, and that some of the work completed has been helpful. Both organisations also believe that their members will do their best to make the units as functional as possible; however they still hold significant concerns with respect to this.

Both organisations still believe that significant design changes should be made to the K Block plans.

The HDU area is particularly small and claustrophobic, and will be a very difficult and potentially unsafe area in which to nurse acutely agitated psychotic patients. It is also understood that the project team has been informed that for reasons relating to the care of especially vulnerable patients that this area must also include a separate quiet area/lounge. From the perspective however of experienced clinicians, this detail obscures the bigger picture – that there is no safe shared space in this unit for any patient. To redesign this unit to assist with the highly claustrophobic nature of the shared areas it would be advisable to consider:

1. Cutting the number of beds to five,
2. Moving the quiet area/lounge to the far end of the accommodation area, or removing it altogether,
3. Enlarging the unit to include the interview rooms,
4. Moving the seclusion area to the far end of the corridor, on the other side of the outdoor/indoor courtyard,
5. Turning the tribunal room into an activity room,
6. Clearing a larger single shared space for socialising, dining, and recreation, which would also include the new indoor/outdoor space.

These changes would significantly enhance both the space and the sense of space for the sickest patients in the entire system, those who are usually involuntary, almost always psychotic, and very often agitated.

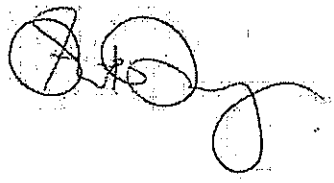
To help deal with bed number difficulties, both organisations also believe that additional beds should be commissioned, perhaps at the Millbrook Rise Centre; neither organisation believes that arrangements with the private sector will be effective.

Ultimately however, because of the inherent issues relating to the available footprint in K Block, both organisations firmly believe that the third stage acute psychiatric unit in the master plan, the unit on the corner of Campbell and Collins St, should be fast-tracked.

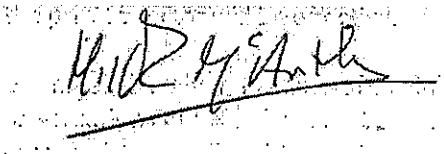
We await your feedback.

Yours sincerely

Signature



Dr Stuart Day
President AMA Tasmania.



Dr Milford McArthur
President RANZCP.

CC: Dr David Alcorn, CEO THS

Professor Len Lambeth, Head of Dept, Adult Mental Health, THS South

Neroli Ellis, Secretary ANMF

Sue Darcey, ANMF

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Dr Stuart Day
President AMA Tasmania
AMA Tasmania
147 Davey Street
HOBART TAS 7000

Dear Dr Day

Subject: Revision of K-Block HDU design to include Indoor/Outdoor area

Further to your letter dated 26 October 2016 and my response of 31 October 2016 requesting advice as to whether the letter was in response to, or was prepared prior to the issue of the plans by Cheryl Carr on 25 October 2016.

I understand that the letter was prepared prior to the issue of the plans by Cheryl Carr on 25 October 2016 and that the plans issued generally addressed the changes requested.

To review the plans, a meeting was held on 6 December 2016 attended by:

- Barry Nicholson
- Ben Moloney
- Cheryl Carr
- Len Lambert
- Milf McArthur
- Stephane Auchincloss
- Richard Benjamin

A range of broader issues were discussed, including the limitation of designing the mental health unit within the available space offered by the K-Block footprint. However, in relation to the design changes to incorporate an indoor/outdoor courtyard within HDU, it was agreed that the attached option was accepted.

The attendees supported the improvement recommended by Cheryl Carr to reduce the area of the oversized seclusion room to the area recommended in the Australasian Health Facilities Guidelines and to use the space gained to increase the area of the courtyard, which was expected to receive greater use and provide more benefit. It was also discussed and agreed that the fit out of the HDU indoor/outdoor courtyard would be similar to that of the other mental health unit courtyards.

In relation to need for more publicly provided beds to be available in the community, this is not a matter that the Redevelopment Project can comment on as the project responds to the operational requirements defined by the Tasmanian Health Service.

Regarding the fast-tracking of the next stage of the master plan to redevelop the site, the Redevelopment Project is working very hard to make the current stage a success. Delivering the benefits of the first stage is considered to be crucial in securing support for the next stage.

Yours sincerely

Ben Moloney
Project Director

9 December 2016

cc:

CEO, Tasmanian Health Service, David Alcorn

Barry Nicholson

Len Lambert

Milf McArthur

Stephane Auchincloss

Richard Benjamin

Benjamin, Richard G (THS)

From: Moloney, Benjamin L (THS)
Sent: Friday, 9 December 2016 8:36 AM
To: 'ceo@amatas.com.au'
Cc: Mallett, Ann M (THS); Carr, Cheryl L (THS); Benjamin, Richard G (THS); McArthur, Milford L (DPM) (THS); Nicholson, Barry EW (THS); 'stephauchincloss@bigpond.com'; Lambeth, Leonard G (THS); Alcorn, David A (THS); Burgess, Alyssa J (THS)
Subject: Revision of K-Block HDU design to include Indoor/Outdoor area
Attachments: SKMBT_C454e16120908401.pdf; OPTION 1 MArkup.pdf

Please find the attached response to Dr Stuart Day, President AMA Tasmania and a copy of the corresponding plan marked up after the meeting held on 6 December 2016.

Thanks,

Ben Moloney
Project Director
Royal Hobart Hospital Redevelopment Project

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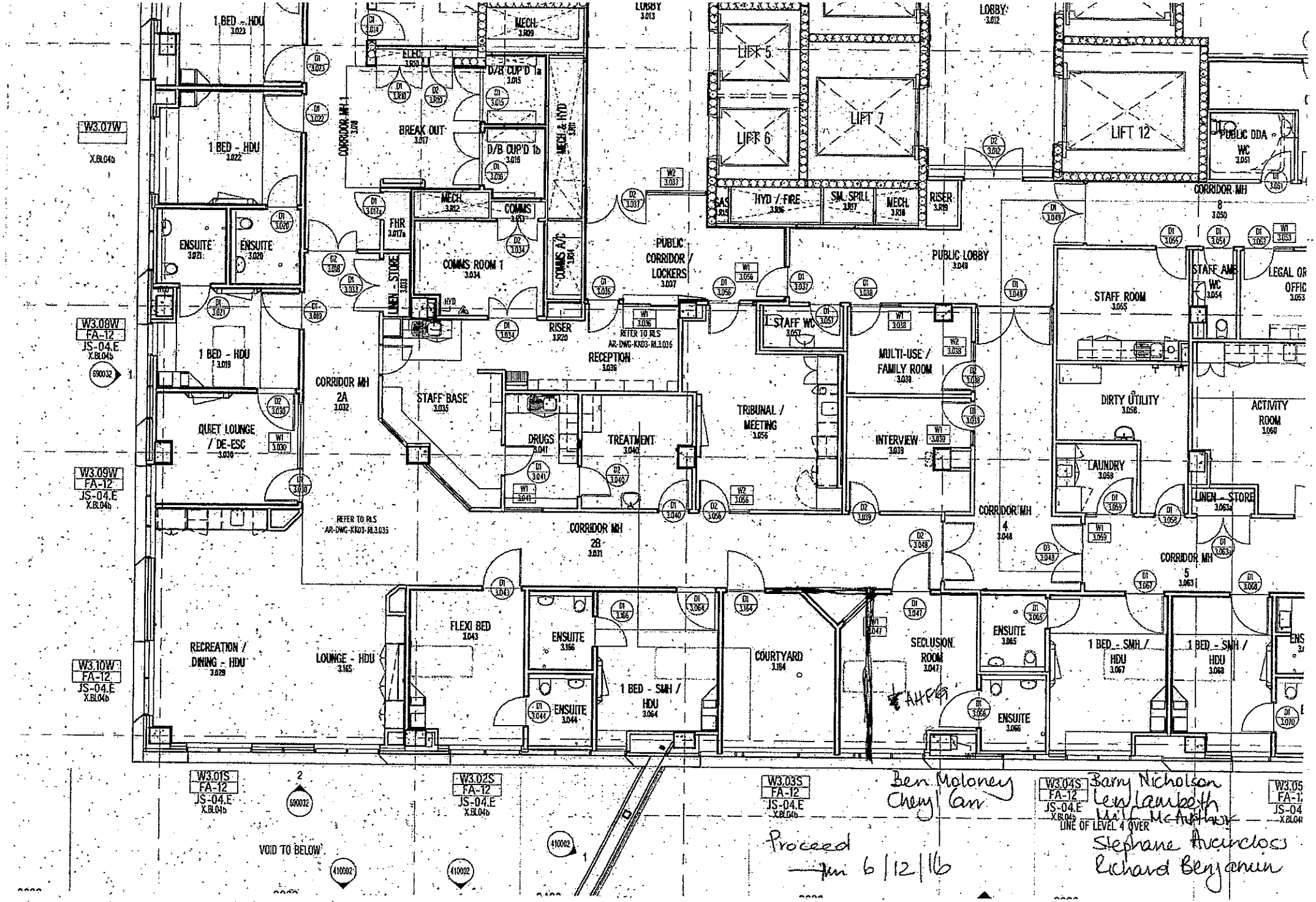
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LOBBY 3.013
LOBBY 3.012
LIFT 5
LIFT 6
LIFT 7
LIFT 12
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W3.07W
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BREAK OUT 3.017
D/B CUP'D 1a 3.015
D/B CUP'D 1b 3.016
CORRIDOR MH 1 3.018
MECH & HYD 3.011
GAS 3.015
HYD / FIRE 3.006
SM. SPILL 3.007
MECH. 3.010
RISER 3.019
CORRIDOR MH 8 3.050
ENSUITE 3.021
ENSUITE 3.020
FHR 3.017a
MECH. 3.012
COMMS 3.013
COMMS ROOM 1 3.014
COMMS A/C 3.004
LINEN - STORE 3.003
PUBLIC CORRIDOR / LOCKERS 3.037
PUBLIC LOBBY 3.049
STAFF AMB WC 3.054
LEGAL OFFIC 3.053
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MULTI-USE / FAMILY ROOM 3.038
CORRIDOR MH 2A 3.032
STAFF BASE 3.035
TRIBUNAL / MEETING 3.056
DIRTY UTILITY 3.058
ACTIVITY ROOM 3.060
QUIET LOUNGE / DE-ESC 3.030
DRUGS 3.041
TREATMENT 3.040
INTERVIEW 3.039
LAUNDRY 3.059
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ENSUITE 3.066
RECREATION / DINING - HDU 3.029
LOUNGE - HDU 3.165
ENSUITE 3.044
1 BED - SMH / HDU 3.064
COURTYARD 3.184
SECLUSION ROOM 3.047
ENSUITE 3.065
1 BED - SMH / HDU 3.067
1 BED - SMH / HDU 3.068
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JS-04.E
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FA-12
JS-04
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LINE OF LEVEL 4 OVER
Ben Moloney
Cheryl Carr
Barry Nicholson
Lew Lambeth
Ian McArthur
Stephane Ancelocs
Richard Benjamin
Proceed
Jun 6/12/16

ANMF Australian Nursing & Midwifery Federation Tasmania

24 April 2017

Tony Bradley
Nurse Unit Manager
Emergency Department
Royal Hobart Hospital

PDF via email: Tony.bradley@ths.tas.gov.au

Our Ref: WOR 21 0122
Contact: Tristan Streefland
Phone: (03) 6223 6777
Email: tristan.streefland@anmftas.org.au

Dear Tony,

Re: Bed block involving Department of Psychiatry Patients

ANMF met with members at the Emergency Department of the Royal Hobart Hospital on Friday April 21 in relation to concerns about the increased length of stay of patients admitted under the Department of Psychiatry (DoP) bed card occurring.

Members realise that this is a complex problem, largely involving bed block, however they ask that some short term solutions are considered. Members present at the meeting asked ANMF to put forward the following short term solutions when there is increased acuity or volume of DoP patients in ED:

a) Access to the casual pool of Mental Health Nurses to take a patient load of those patients allocated to Psychiatry
b) Support for the Psychiatric Emergency Nurse (PEN) by the provision of Mental Health Nurses from the established pool
c) Better integration of Drug and Alcohol services in ED to liaise with the PEN
d) PEN be delegated the responsibility for assessing the need and quantity of Mental Health Nurses to be utilised in the ED
e) The creation of a dedicated Mental Health Assessment Unit within the ED

Members feel that these short term solutions will help alleviate the pressure on already stretched services in the ED.

On the behalf of members the ANMF would like a response in regards to the five short term solutions that have been put forward, and request a meeting with management to discuss the long term solutions put forward by members. We seek a response to the suggestions above by no later than Wednesday 3 May 2017.

Australian Nursing & Midwifery Federation Tasmania

ANMF will continue to visit ED on a regular basis to monitor the situation and look forward to working with you towards an appropriate outcome.

If you have any concerns or questions you would like answered please contact Tristan Streefland, ANMF Organiser via email; Tristan.Streefland@anmftas.org.au.

Yours sincerely,

Emily Shepherd
Acting Branch Secretary

CC: Trish Allen, Assistant Director of Nursing - Critical Care - Royal Hobart Hospital

Tasmanian Government

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TASMANIAN HEALTH SERVICE

Contact: Tony Bradley
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File:

Ms Emily Shepherd
Acting Branch Secretary
Australian Nursing and Midwifery Federation Tasmanian Branch
Email: c/- tristan.streefland@anmftas.gov.au

Subject: Bed block involving Department of Psychiatry Patients

Dear Ms Shepherd

Thank you for your letter of 24 April 2017 regarding the Royal Hobart Hospital Bed block involving Department of Psychiatry patients, resulting in increased length of stay for admitted mental health patients in the Emergency Department.

Access block requires multifactorial, evidence-based sustainable solutions, primarily related to increasing capacity through efficient patient care, and implementing system wide improvements so that appropriate patients can be managed in the community while also ensuring there is sufficient capacity to meet demand within the acute setting. The majority of solutions regarding the Psychiatric Emergency Nurse and Alcohol and Drug services lie outside of the Emergency Department setting.

As such, we have forwarded your letter to the Manager of Inpatient and Correctional Health Services (Mental Health and State-wide Services) for response.

Please contact me on 0438 213 097 if you have any further queries in relation to this matter.

Yours sincerely

Tony Bradley

Nurse Unit Manager

Emergency Department

27 April 2017

Copy to: Trish Allen – Assistant Director of Nursing – Critical Care
Ann Marie Mallett – A/Group Manager – Medical Services
Barry Nicholson - Manager - Inpatient Mental Health and Correctional Health Services
Susan Gannon, Executive Director of Nursing and Midwifery – Tasmanian Health Service

Tasmanian Government

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File:

Ms Emily Shepherd
Acting Branch Secretary
ANMF Tasmanian Branch
182 Macquarie St
HOBART TAS 7000

Dear Ms Shepherd,

Re: Bed Block involving Department of Psychiatry Patients.

Thank you for your letter of 24th April 2017 which outlined member's concerns regarding the increased length of stay of patients assessed and admitted under the Department of Psychiatry (DOP) bed card. Your members concerns are correct in that this is complex and multi layered issue when demand for inpatient beds exceeds availability. Your involvement in a solution focused approach is appreciated and welcomed.

Southern Mental Health Services closely reviews and monitors how services are provided to consumers and those in need. This is particularly relevant as the Tasmanian Health Services (THS) evolves into a State-Wide Mental Health Service model where all services provided regionally will be integrated and have a whole of State focus.

The function and operation of the Royal Hobart Hospital's (RHH) Emergency Department (ED) is the primary responsibility of the Medical Services Group. Currently this group manages a number of specialist services with the ED environment triaging all presentations. The Psychiatric Emergency Nursing Service (PEN) is a service which is currently managed by ED. However, you will be aware that there is a current recruitment process in place to permanently recruit Registered Nurses to PEN positions which will be managed and operated by Adult Mental Health Services – Department of Psychiatry into the future. The governance and operational needs will be met by the Manager of DOP when the transition to permanent appointment has occurred.

Members have identified some potential solutions and these will be considered by Mental Health Services in collaboration with ED given the current line management processes in place.

a) Access to the casual pool of Mental Health Nurses to take a patient load of those patients to Psychiatry.

Mental Health Services works closely with the RHH Roster office (RO) on a daily basis. There is opportunity to review how the RO can support PEN during surge or peak demand periods. Identifying casual staff who have the required skill set and who are available is one potential solution in supporting PEN. Formatting this with the RO would create an identified pool to facilitate this. One method is Mental Health RN's who are open to new experiences could be identified through an EOI process and this information is held and maintained by the RO.

b) Support for the Psychiatric Emergency Nurse (PEN) by the provision of Mental Health Nurses from the established pool.

As stated above identifying these RN's with the appropriate training and experience in Acute Mental Health could address peak demand periods. In conjunction with this there is a potential for the afterhours Manager for RHH and the On Call Manager for MHS to work collaboratively to support PEN as and when this is required. Currently this occurs in relation to bed management and patient flow needs.

c) Better integration of Drug and Alcohol services in ED to liaise with the PEN.

Mental Health Services recognises the merit in this suggestion. Involvement of the Drug and Alcohol service in ED will necessitate discussion with representative service areas as to how this can be facilitated and operationalised.

d) Pen to delegated the responsibility for assessing the need and quantity of Mental Health Nurses to be utilised in the ED

Currently the PEN service is managed by Medical Services. MHS has no influence regarding delegated roles and responsibilities however MHS is open to discussion regarding the governance and delegation of the PEN service once the permanent transition of PEN to MHS has occurred.

e) The creation of a dedicated Mental Health Assessment Unit within the ED

The idea of a dedicated and specific area in ED for Mental Health presentations is a very good suggestion and one which has merit. MHS recognises the potential here regarding consumers who have sudden / crisis driven needs which may require short term acute mental health intervention (24 to 72 hour stay). A dedicated area in what is already a very busy environment presents some challenges, however this idea will be incorporated into discussions regarding patient flow management of Mental Health presentations.

MHS recognises that members are focussed on providing the highest level of care to those who present to ED with Mental Health issues and these suggestions illustrate their commitment and dedication to enhancing the service currently provided which is able to meet surge and critical demand periods.

Thank you for forwarding these ideas and suggestions for consideration and response.

Yours Sincerely,

Barry Nicholson
A/- Manager
Inpatient & Correctional Health Services
5 May 2017

Copy to-

Adrienne Gibbons, Group Director, Statewide Mental Health Services
Mark Frohmader, A/ Group Manager, Mental Health & Statewide Services
Ann Marie Mallett, A/ Group Manager, Medical Services
Tony Bradley, Nurse Unit Manager, Emergency Department.

Attachments
ANMF Letter
Letter from Tony Bradley to ANMF

Australian Nursing & Midwifery Federation Tasmania

15 May 2017

Dr David Alcorn
Chief Executive Officer
Tasmanian Health Service
Room 2, Level 1, Northern Integrated Care Service
41 Frankland Street Launceston TAS 7250

PDF via email: ceo@ths.tas.gov.au

Our Ref: WOR 21 0112
Contact: Tristan Streefland
Phone: (03) 6223 6777
Email: tristan.streefland@anmftas.org.au

Dear David

Re: Royal Hobart Hospital (RHH) Bed Block involving Department of Psychiatry (DoP) Patients

The Australian Nursing and Midwifery Federation (ANMF) received the attached response from Barry Nicholson, A/Manager, Inpatient and Correctional Services, MHSS in relation to bed block and the increasing length of stay in the Emergency Department (ED) of patients admitted under the DoP bed card.

Initially the ANMF approached Tony Bradley, NUM of the Emergency Department for a response to the letter the ANMF had written on behalf of its members. Mr Bradley acknowledged that this issue is multi-factorial and required input from the Department of Psychiatry, so forwarded the concerns on to Mr Nicholson for response.

In his response, Mr Nicholson agreed that the issues are complex when the demand for mental health beds exceeds the availability however was unable to offer any strategies to address the concerns. He did make reference to the current management structure of the Psychiatric Emergency Nurses (PEN) which is not the cause of the bed block issues. In fact it has been identified that the PENs improve the situation for mental health patient presentations to ED.

Suggested short term solutions by ED were supported by Mr Nicholson but there is no apparent indication of any urgency as he states; *'these will be considered by Mental Health Services in collaboration with ED given the current line management processes in place.'* It is the belief of the ANMF that most reasonable people would expect that the majority of the suggested short term solutions would have already been in place.

Unfortunately the request for management of DoP to meet with ED staff was not responded to.

Australian Nursing & Midwifery Federation Tasmania

Members had hoped to discuss other suggestions for consideration into the future at the requested meeting and include;

1) Support and resourcing for community mental health to provide services to meet the increasing demand felt by bed loss on DoP, which may reduce the need for acute presentations to the RHH
2) Increased availability of lower acuity and community beds outside of the RHH to facilitate bed movement within DoP
3) The creation of a dedicated Mental Health Assessment Unit within the ED; this was included in the initial planning stages of the RHH redevelopment. ANMF is not aware of the reasons this plan has apparently been discarded.

It was reported at the May MHSS Industrial Consultative Forum that ten (10) DoP inpatients were remaining in the acute facility due to having no known address to be discharged to. This again demonstrates the need for availability of Inpatient and Extended Treatment Service (IETS) to accommodate patients with complex discharge needs, who may no longer need the acute services.

It is disappointing that our members have had no success when raising this issue within internal channels, and are required to continue to seek external support to ensure that their concerns are being raised and addressed appropriately.

Our members are requesting your assistance with addressing both the short and long term solutions put forward in order to relieve the current bed block that is being experienced in emergency in regards to patients under the DoP bed card. We seek a response to this letter by no later than COB Friday 19 May 2017, it is the preference of members that a meeting be set up to discuss this matter in an attempt to seek some solutions to the problem.

If you have any concerns or questions you would like answered please contact Tristan Streefland, ANMF Organiser via email; Tristan.Streefland@anmftas.org.au.

Yours sincerely,

Neroli Ellis
Branch Secretary

CC: Ann Marie Mallett, Group Manager, Medical Services,
Trish Allen, ADoN, Critical Care, RHH,
Tony Bradley, NUM, Emergency Department
Barry Nicholson, Barry Nicholson, A/Manager, Inpatient Services, MHSS
Adrienne Gibbons, EDoN, MHSS
Trish Spence, HR Manager

Tasmanian Health Service
Mental Health Services North

PO Box 1963, Launceston TAS 7250, Australia
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Contact: Bernie Brown
Phone: (03) 6777 4306
Facsimile:
E-mail: ceo@ths.tas.gov.au
File:

Ms Neroli Ellis
Branch Secretary
ANMF Tasmania
182 Macquarie Street
Hobart Tas 7000

Neroli

Dear Ms Ellis

Re: Royal Hobart Hospital (RHH) Bed Block involving Department of Psychiatry Patients

I am writing to you in response to your letter of 15 May 2017 where you raised concerns in relation to bed block and the increasing length of stay in the Emergency Department of patients awaiting admission to the Department of Psychiatry.

Firstly I would like to thank you and your members for providing strategies to improve the current issues faced by the Emergency Department and the Department of Psychiatry. Like you, the Tasmanian Health Service is strongly committed to improving services for our clients and to reduce the stress and pressures on our workforce.

In your letter, you indicated that a recent letter from Barry Nicholson, A/Manager, Inpatient Mental Health and Correctional Health Services indicated that there is no apparent indication of any urgency to address the bed block issues involving patients of the Department of Psychiatry. I wish to assure you that this is not the case.

The Tasmanian Health Service and Statewide Mental Health Services are acutely aware of the current demands on the Emergency Department and the Department of Psychiatry and the impact this has on both mental health clients and our staff.

As you indicated in your letter, a proportion of the pressure for the Emergency Department can be attributed to patients with a mental health illness who are awaiting admission to the Department of Psychiatry. To alleviate this pressure, Statewide Mental Health Services are drafting a comprehensive plan to improve patient flow for the Emergency Department and Mental Health Services (including those provided by the community sector). The Draft Plan is expected to be finalised in the coming weeks at which time there will be will a consultation process undertaken around any changes which may impact on staff and current practices. This will include consultation with yourself and other relevant union officials.

The Plan has a range of strategies, some of which include:

Short Term Strategies

- Improved communication between the Emergency Department, Department of Psychiatry and other Mental Health Services by:

- ensuring staff have secure out of hours access to an on-call senior manager within Mental Health Services who can facilitate the transfers of clients as required into available or likely to become available beds;

- immediate notification to relevant clinicians to advise when the Department of Psychiatry is reaching capacity to alleviate any further pressure on the service; and

- inclusion of relevant Mental Health Services beds (including step-down beds) on Patient Flow Manager, an electronic real time monitor of bed usage that permits timely and appropriate clinical transfers.

Medium Term Strategies

- Improve the ability to directly admit to the Department of Psychiatry (unless there is an obvious medical problem or a specific reason that requires Emergency Department treatment of care);

- Reviewing extended care services accessed by consumers of the Tasmanian Health Service with a view to improving flexibility to build patient flow across the mental health service system;

- Increase the capacity of services to manage demand with additional step-down and step-up bed capacity;

- Renew a previous Memorandum of Understanding with The Hobart Clinic which could provide another referral option for patients requiring intensive support at times of high demand;

- Review of procedures to support more timely client handover of care between specialist Mental Health Services;

- Working with relevant government and non-government services to identify accommodation options for existing patients who are homeless to facilitate clinically appropriate discharge;

- Ensure consumers' general practitioners and primary health services receive adequate support to manage Tasmanian Health Service's consumers with a mental health problems; and

Long Term Strategies

- Working with Tasmanian Health Service Emergency Department colleagues, assess the feasibility of establishing an Observation Unit within the Emergency Department for people presenting with a mental health problem (this will be dependent on identifying an available space).

In relation to the Psychiatric Emergency Nurse positions at the Royal Hobart Hospital, these positons will transfer to the governance of Mental Health Services. The purpose of this transfer is to allow for better utilisation of mental health staff from the Department of Psychiatry and Casual Pool to improve the responsiveness to people presenting to the Emergency Department with possible Mental Health issues. This should permit increased Psychiatric Emergency Nurse staffing as and when necessary, by Mental Health trained nurses.

I note that you provided some suggested strategies in your letter that will likely be covered by the strategies outlined above. As indicated earlier, when the plan is finalised in the coming weeks, Statewide Mental Health Services will undertake a consultation process around any changes which may impact on staff and current practices. This will include consultation with all appropriate union officers and, of course, relevant consumer groups.

I remain confident that the proposed strategies will have a positive impact for our consumers and our staff.

Yours sincerely

David Alcorn

David Alcorn
CEO
Tasmanian Health Service
24 May 2017

The Royal Australian & New Zealand College of Psychiatrists

Tasmanian Branch

A/Prof Len Lambeth
Head of Department
Adult Mental Health Services
Level 2, Carruthers building
St John Park
New Town
Tasmania 7008

Dear A/Prof Lambeth,

I write to follow up numerous previous emails and discussions with you re DOP. The Branch Training Committee (BTC) began trying to work with you to improve the situation for trainees in DOP in 2016- whilst we have had numerous interactions, the situation has not improved, indeed, our concerns for trainees on DOP have progressively increased.

As you are aware, the role of the BTC is to oversee and administer the Regulations of the College's Fellowship Training Program at the local level. The BTC is directly responsible to the Binational Committee for Training.

One of the responsibilities of the BTC is to accredit and co-ordinate rotations at the local level in accordance with the RANZCP regulations. The BTC has been concerned about patient numbers in DOP for many months, and despite discussion with you, no actions have been taken to address our concerns. The BTC is aware that the number of patients in DOP (and admitted to DOP but ' housed' in the Department of Emergency Medicine) has escalated over the past several months. We are aware that at times 10 or more patients have been 'admitted' in DEM, and that DOP registrars are expected to assess and manage these patients in addition to those actually in beds in DOP.

As a result, The BTC has grave concerns for trainee welfare and safety. Our (stage 1) trainees are being expected to manage an excessive number of patients, within a very short length of stay, placing the trainee in an extremely pressured and risky situation (and exposing patients to sub-optimal care and risk of adverse outcomes). We note consultant psychiatrists in DOP and other staff are also in a similar situation and expect those responsible for their wellbeing will have similar concerns.

This situation means that aspects of the Tasmanian RANZCP Training Program do not currently meet some of the RANZCP Accreditation Standards, in particular *Standard 3: organization, monitoring and support of trainees* (see attached). Standard 3.5 requires *adequate processes at institutions or services that assess, monitor, promote and deliver trainee safety, welfare and wellbeing in the workplace*. The situation in DOP does not meet this requirement-and the specifics of 3.5.1, 3.5.2 and 3.5.3. In addition the requirements of 3.5.3 are not met with respect to the current after hours situation for <u>all</u> trainees.

As Chair BTC I am required to notify the Committee for Training of the situation. I shall have no choice but to do this unless:

TASMANIAN PSYCHIATRY TRAINING PROGRAM, 4 Liverpool Street, Hobart, Tasmania, 7001
Phone: 03 616 60490 Fax: 03 6233 9427, Email: jenette.strang@dhs.tas.gov.au

The Royal Australian & New Zealand College of Psychiatrists

[1] A fourth registrar is assigned to DOP whilst the patient numbers exceed the 32 beds. Given the training imperatives of other registrars this will require additional FTE, presumably a locum in the first instance.

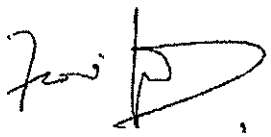
[2] If the 4th registrar is an accredited RANZCP Trainee, additional consultant FTE must be assigned to DOP for the same time period to ensure the 4th registrar has appropriate support and supervision as per RANZCP CBFT Regulations.

[3] The after-hours workload and inappropriate expectations placed on registrars by after -hours managers is addressed as a matter of urgency.

Given the prolonged period in which discussions about DOP have taken place, and the escalating problems identified we require this to be addressed immediately. Please advise by COB 16 June 2017 what arrangements have been made.

As you are aware, notifying CFT of the situation will trigger a review of the Tasmanian Training Program by the RANZCP Accreditation Committee.

Kind regards



Prof Fiona Judd
Chair, Tasmanian Branch Training Committee, RANZCP

14th June 2017

cc
Dr David Alcorn CEO
Ms Adie Gibbons, Clinical Executive Director - Mental Health Services
Prof Ken Kirkby, Acting Chief Psychiatrist
Dr Milford MacArthur, Chair Tasmanian Branch Committee RANZCP
Dr Richard Benjamin, AMA Tasmania Psychiatry Representative
Dr Tony Xabregas, Executive Director Medical Profession

Standard 3 – Organisation, Monitoring and Support of Trainees		
Accreditation Standards **The following are required:**	**Details of this Standard**	**Specific Requirements Linked to this Standard**
3.5 Adequate processes at institutions or services that assess, monitor, promote and deliver trainee safety, welfare and well-being in the workplace.	**3.5.1** The workload for trainees within each post is such that clinical service delivery does not compromise training and trainee welfare. **3.5.2** The working conditions for trainees within each post are such that the working conditions are conducive to training and trainee welfare. **3.5.3** Fatigue management programs are in place to diminish the impact of fatigue on the training experience, incorporating automatic mechanisms for sending trainees home or considering shift or night duty options.	a) Work rosters do not expose trainees to prolonged periods of duty, inadequate time off duty between work periods, inappropriate speed and direction of shift rotations, irregular work schedules or night shifts undertaken following a long period of duty. b) Working conditions and workload for trainees within each post are monitored by the BTC/DOT to ensure there is no interference with training. c) There is evidence to confirm that fatigue management programs are in place, and their effectiveness is regularly monitored by the BTC/DOT and the results available to trainees. d) Safe, secure and private amenities are provided for trainees required to work extended hours/overnight shifts.

AMA
TASMANIA
ABN 11 009 484 931

Tuesday 28th June 2017

Hon. Michael Ferguson
Minister for Health
Parliament House
Hobart TAS 7000

Dear Minister Ferguson,

Re: Care of acutely mentally ill patients in Southern Tasmania who require hospitalisation.

The AMA is writing to you today to seek some clarification regarding the future care of those acutely mentally ill patients in Southern Tasmania who require hospitalisation.

As you are aware, the AMA has been concerned about the provision of this important type of care for several years, in the context of the Royal Hobart Hospital Redevelopment. The AMA has repeatedly raised concerns about the number of beds, the size of the ward footprints, and the overall designs, in both the demountable J block wards, and the K block wards. This concern has never changed.

Since the 10 acute mental health beds at the Royal Hobart Hospital have been cut, there have been many serious problems. The most important was the death of "Mr S", which the Coroner ruled was directly related to the loss of beds; "Had sufficient beds been available in the mental health ward at the Royal Hobart Hospital then doubtless he would have been admitted and it is likely that he would not have taken his life." Because acutely mentally ill patients are now unable to be admitted into safe and specialist care in a timely manner, many staff fear that more lives will be lost. Many patients now also spend long periods of time awaiting a psychiatric bed, as the current wards are almost always running at 100% occupancy, and the craft group is now perpetually in bed crisis. Frequently there are four to six "admitted psychiatric" patients in the Emergency Department, or surrounding areas, and on occasion this number is even higher. These patients may wait up to two to three days for a bed, in an environment which is completely unsuitable, and potentially harmful, for their condition.

In your recent ABC television interview (June 1, 2017), your comments about bed numbers appeared to be inconsistent. You stated, "Every suicide is a tragedy...the service must always adapt to meet the needs of the community." You also stated, "Whatever people will want to say about the number, the professional advice was that this is the appropriate number to meet the needs of the community, because you must also factor in the care, which numbers in the hundreds, of community beds and supported accommodation." Finally, you stated, "Shift more of the care into the community, so we can actually provide more appropriate care, but when hospital care is called for, it should be provided."

The AMA also predicted that the new units would be unfit for purpose, as they were too small in footprint, of inferior design, not situated wherever possible on the ground floor, lacked well-designed social and other therapeutic spaces, and lacked easy access for all patients to outdoor spaces; the AMA cannot stress enough that the design of and the spaces within an acute mental health unit are vital for the recovery of acutely mentally ill patients. Information received from staff to this point indicates that the new units are too small and that they are not fit for purpose. This is particularly relevant with respect to the new High Dependency Unit, which is not only too small, with insufficient social, therapeutic and outdoor spaces, but the design is such that it is also inherently very noisy. Both junior and senior medical staff find the units unfit for purpose, and grave concerns are held regarding recruitment and retention of staff in these areas. The concerns of the training psychiatric registrars and the local training committee are such that the Federal training body of the RANZCP has been formally notified that the unit does not currently meet RANZCP Accreditation standards, and it is expected that an investigation will be undertaken, and that accreditation for psychiatric training at the Royal Hobart Hospital could be affected.

In an ABC television interview in November 2016, you however stated, in reference to the new units, that, "Ensuring that our patients are receiving the best possible care, with no corners cut, no compromise." In parliament you recently stated that, "(The unit) has since proven to be very successful. It is a vastly superior mental health inpatient facility." Clearly these comments are at odds with feedback to the AMA.

The AMA will be approaching the Opposition and the Greens with seeling their policies in these areas prior to the next state election, and the AMA would be grateful if you could provide responses to the following questions so that the government's position can be clearly understood.

1. It is the AMA's considered opinion that the number of acute mental health beds at the Royal Hobart Hospital is inadequate. Do you have alternate advice that the number of beds required for those needing hospitalisation with acute mental illness at the Royal Hobart Hospital is adequate, for J block, and for the future K block?
2. Are you open to seeking further independent advice regarding current and future bed requirements?
3. Would you acknowledge that the new units in J block, whilst designed and built with good intentions, may actually be unfit for purpose, and at best are a compromise, pending the completion of other units?
4. Would you now acknowledge that the units proposed for K block, whilst designed with good intentions, may not have been designed following important contemporary principles for acute mental health unit design?
5. In previous Royal Hobart Hospital Redevelopment meetings, it was noted that the plans for K block included some "shell space" marked, for future potential expansion. Is there any scope to increase the number of beds in K block for the acutely mentally ill patient?
6. Can you acknowledge that there is a master plan for a third stage acute mental health unit, to be built on the corner of Campbell and Collins St?
7. Does any third stage master plan include a greater number of beds?
8. Does any third stage master plan involve a unit that might be developed more closely following contemporary design principles?
9. Will you and your government give an undertaking to provide the capital funding necessary for the completion of a third stage acute mental health unit, prior to the next state election?
10. Will you and your government give an undertaking to for a timeline to complete a third stage acute mental health unit, prior to the next state election?

11. Will you and your government give an undertaking to seek expert independent advice regarding optimal contemporary acute mental health unit size and design for a third stage acute mental health unit, prior to the next state election?

The AMA will continue its advocacy for all patients that have little voice within the public health system.

The AMA would be grateful if you could provide a response by COB Friday 14 July.

Yours sincerely,

Tony Steven
CEO AMA Tasmania

AMA
TASMANIA
ABN 11 009 484 931

Tuesday 4th ~~June~~ 2017 ?

Hon. Michael Ferguson
Minister for Health
Parliament House
Hobart TAS 7000

Dear Minister Ferguson,

I write to add to our letter addressed to you on the 28th June 2017.

As stated in that letter the AMA holds major concerns over the psych unit at the RHH with the current bed pressures due to loss of beds during the redevelopment. Now additionally there is apparently a lack of consultant and management direction at all levels within MHS.

We have been contacted by members who have been attempting to provide some support to the first year trainees who in turn are being expected to essentially run the ward at present, apparently largely without consistent consultant input (due to leave, locums etc) placing training outcomes at risk. They are also being expected to run programs such as the Clozapine Clinic. This is a specialised area of psychiatry and not appropriate for first years to be running unsupervised.

We understand management are also at a loss as to what to do as this is systemic issue and needs to be addressed by senior management. We understand that RANZCP have been made aware and have been requested twice to undertake an urgent review of the suitability of the RHH for training.

The AMA would be grateful if you could provide a response, along with those listed in our first letter, so we can report to member's measures that the THS are taking to relive the situation.

Yours sincerely,

Tony Steven
CEO AMA Tasmania

AMA Tasmania, 147 Davey Street, Hobart TAS 7000 Ph: 03 6223 2047 Fax: 6223 6469 www.amatas.com.au

The Royal Australian & New Zealand College of Psychiatrists

7 July 2017

Dr Diana McKay
Chair, Accreditation Committee
309 La Trobe Street
Melbourne, VIC 3000

By email to: Diana.Mckay@health.nsw.gov.au

Dear Dr McKay

Re: Threat to trainee welfare in Tasmania

The Trainee Representative Committee (TRC) wishes to express its grave concerns regarding the welfare of psychiatry trainees in Tasmania, in particular the first year trainees working in the acute adult rotation at the Royal Hobart Hospital, in the state's south.

We understand that the Tasmanian Branch Training Committee has written to the Accreditation Committee regarding this matter, and the TRC supports an immediate review of the situation by the Accreditation Committee.

The TRC is aware that the three first year trainees on the ward are both mentally and physically exhausted as a result of the high workload and working conditions. Critically, they are at risk of burnout. The TRC understands that they are receiving suboptimal supervision, in part due to locum cover and illness leave of their consultants, and have not being able to attend training requirements such as journal club. The TRC has been told that the trainees are working unpaid overtime and beyond their scope of practice; on one occasion a first year trainee ran a clozapine clinic with only distant support. The backlog of 140 incomplete discharge summaries over an eight week period goes some way to convey the current immense workload and disorganisation.

The TRC has been informed that the current acute situation has been born out of longer term system inadequacies, such as a lack of key clinical management roles being filled (such as the Chief Psychiatrist position); in addition to the redevelopment of the psychiatric department in the Royal Hobart Hospital; reduction in bed numbers; increased turnover on the ward and medical staff illness. The Tasmanian Branch Training Committee is to be commended for their efforts over many months to agitate for improvement. However, despite this, the situation in Tasmania has gone from bad to worse in recent months and we are gravely concerned.

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ABN 68 000 439 047

The TRC is aware of the Accreditation Committee, and the College's commitment to trainee welfare, as evidenced by the new Accreditation Standards relating to trainee welfare. In light of this, we are requesting that the Accreditation Committee intervene to assist the Tasmanian Branch Training Committee on behalf of the current registrars in Tasmania.

Yours sincerely,
On behalf of TRC

Dr Hannah Kim
Chair
Trainee Representative Committee

Dr Rebecca Graham
Deputy Chair and Tasmanian Representative
Trainee Representative Committee

Dr Amro El Sholkami
Northern Territory Representative and AC Member
Trainee Representative Committee

Cc: Dr Warren Kealy-Bateman, Chair, Committee for Training via email to warren.kealybateman@gmail.com
Prof Fiona Judd of Tasmania BTC via email to fiona.judd@dhhs.tas.gov.au
Dr Milford McArthur of Tasmania Branch via email to milford.mcarthur@dhhs.tas.gov.au
Dr Patrick Galloway, Tas AMA DiT representative via email to patrick.galloway@ths.tas.gov.au
Mr John Wells, Accreditation Officer by email to john.wells@ranzcp.org

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Tasmanian Branch

A/Prof Lambeth
Head of Department
Adult Mental Health Services
Level 2, Carruthers building
St Johns Park
New Town
Tasmania 7008

Dear A/Prof Lambeth,

Re: conditions for trainees in DOP

I write to follow-up correspondence to you from the Tasmanian Branch Training Committee (BTC) of 14th June. We acknowledge your response to that letter dated 28 June, and BTC replied to that on 5 July.

The concerns raised by the BTC, and the registrar group were discussed in the Committee for Training (CFT) teleconference last week, and will be further discussed at the CFT face-to-face meeting on 3rd and 4th August. The CFT was particularly concerned about the impact of the situation on trainee welfare and noted that trainees have highlighted sequelae such as loss of satisfaction, therapeutic nihilism, burn-out and potentially drop-out from training resulting from their experience in DOP.

If the situation in DOP is unchanged, and these concerns are not allayed when discussed further at the face-to-face meeting, we anticipate the CFT will make an urgent site visit to Hobart.

A site visit will involve careful assessment of the situation against College Accreditation Standards. If the situation in DOP does not meet these standards then DOP will be disaccredited as a site for trainees. This will have a range of repercussions including the service being unable to recruit any first year trainees for 2018 as we will have no facility to provide trainees with their stage 1 mandatory 6 month acute in-patient psychiatry experience.

The BTC remains committed to working with you to address the problems. As per previous correspondence, at the very least, BTC requests that a fourth registrar and consultant psychiatrist be assigned to DOP (or to DEM to manage 'admitted' patients there) so that the three registrars in DOP can return to a more appropriate and manageable work load.

As always, we are available to meet with you to discuss these matters, and if possible would prefer to reach a solution without the need for a CFT site visit.

TASMANIAN PSYCHIATRY TRAINING PROGRAM
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Email: jenette.strang@ths.tas.gov.au

Kind regards

Prof Fiona Judd
Chair Tasmanian BTC

Dr Nicolle Ait Khelifa
Deputy Chair, Tasmania BTC

Dr Stephane Auchincloss
Director of Training

Wednesday 19th July 2017

CC
Dr David Alcorn CEO
Ms Adie Gibbons, Clinical Executive Director - Mental Health Services
Dr Milford McArthur, Chair Tasmania Branch Committee RANZCP
Prof Ken Kirkby, Acting Chief Psychiatrist
Dr Tony Xabregas, Executive Director Medical Profession
Dr Warren Kealey Bateman

TASMANIAN PSYCHIATRY TRAINING PROGRAM,
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The Royal Australian & New Zealand College of Psychiatrists

Tasmanian Branch

The Royal Australian & New Zealand College of Psychiatrists
309 La Trobe Street
Melbourne
VIC 3000
Australia

Attention: Dr Diana McKay

Chair of the Accreditation Committee

Dear Dr McKay,

Re Problems in Hobart

We write to let you know of problems in Hobart, emanating from service issues, which are adversely impacting trainees working within the Acute In-Patient Unit.

Over the past several months, the Branch Training Committee (BTC) has been meeting with the Clinical Director Adult Psychiatry, attempting to address issues related to the workload of stage 1 trainees working in the Adult In-Patient Psychiatry Unit, which the BTC believes have adversely impacted the training experience and wellbeing of these trainees.

Initially some progress was made, however, over the past few months the situation has again deteriorated. Most recently the BTC asked that the trainee workload be addressed as a matter of urgency, and we requested that additional FTE registrar and consultant psychiatrist time be allocated to the In-patient Unit to ameliorate the situation. Unfortunately, there has been no response to our correspondence, let alone any changes made as requested.

The BTC believes that the situation in the Adult In-patient Unit does not currently meet the College Accreditation Standards, and that urgent action is required for this to be rectified. In view of this the BTC seeks your review of the situation and advice.

Kind regards

TASMANIAN PSYCHIATRY TRAINING PROGRAM. 4 Liverpool Street, Hobart, Tasmania. 7001
Phone: 03 616 60490 Fax: 03 6233 9427, Email: jenette.strang@ths.tas.gov.au

The Royal Australian & New Zealand College of Psychiatrists

Prof Fiona Judd
Chair Tasmanian BTC

Dr Nicolle Ait Khelifa
Deputy Chair, Tasmania BTC

Dr Stephane Auchincloss
Director of Training

21st June 2017

cc: A/Prof Len Lambeth, Clinical Director Adult Psychiatry, THS-South
Dr David Alcorn, Chief Executive Officer
Dr Warren Kealy Bateman, Chair Committee for Training RANZCP

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

7 August 2017

Dr Len Lambeth
Head of Department
Adult Mental Health Services
Level 2, Carruthers building
St John Park
New Town
Tasmania 7008

By email to len.lambeth@dhhs.tas.gov.au

Dear Dr Lambeth

Re: Royal Hobart Hospital Adult Inpatient Psychiatry Unit training post accreditation

The Committee for Training (CFT) have been made aware of concerns regarding training posts located at the Royal Hobart Hospital Adult Inpatient Psychiatry Unit by both the Tasmanian Branch Training Committee and others.

After careful consideration at the 4 August 2017 CFT face-to-face meeting, the Committee are deeply concerned about the safety of registrars occupying these posts. From the information provided, the Committee agreed that the College Accreditation Standards, in particular *Standard 3: Organisation, Monitoring and Support of Trainees,* are not being met in these posts.

Despite all attempts by the Tasmanian Branch Training Committee to address the concerns with yourself, no resolution appears to have been met. As such, the CFT decided unanimously to withdraw accreditation for all training posts at the Royal Hobart Hospital Adult Inpatient Psychiatry Unit effective immediately.

In addition, an urgent site accreditation visit will be organised (by the CFT) to review the Royal Hobart Hospital Adult Inpatient Psychiatry Unit the week beginning 11 September 2017. No RANZCP trainees will be able to occupy these posts until accreditation has been re-established.

It was noted that registrars are scheduled to commence their next rotation at the Hobart Adult Inpatient Psychiatry Unit on 7 August 2017. No trainee shall be disadvantaged by the decision to remove accreditation from these posts. As such, affected trainees can undertake a community acute term to meet the Stage 1 adult acute requirements until further notice.

The CFT can be contacted via the College Training staff (training@ranzcp.org).

Yours sincerely

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The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Dr Warren Kealy-Bateman
Chair, Committee for Training

cc: Dr Margaret Aimer, Chair, Education Committee
Dr Diana McKay, Chair, Accreditation Committee
Prof Fiona Judd, Chair, Tasmania Branch Training Committee
Dr Stephane Auchincloss, DOT Tasmania
Dr Milford McArthur, Chair, Tasmanian Branch Committee
Dr David Alcorn, CEO

Attached: RANZCP Accreditation Standards