THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO THE ROY FAGAN CENTRE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON FRIDAY 6 MAY 2022.

IN ATTENDANCE

Hon. Jeremy Rockliff MP, Premier, Minister for Mental Health and Wellbeing.

CHAIR - Welcome, Premier and your team. For your benefit and others who may be watching, this is a public hearing. It is subject to parliamentary privilege. Please be aware everything you say before the committee will be recorded and transcribed. We are also broadcasting. The protocol around mask wearing is that you can remove it speak. This is a short inquiry process, it is not a full-blown inquiry. Government Administration Committees have the opportunity do a targeted, specific follow up of a report or other aspect of government services.

We will be seeking your feedback about the reviews that have been done of the Roy Fagan Centre and responding to the Coroner's reports - one that had recommendations and one that didn't. We are trying to understand your actions in regard to those recommendations, progress made or other aspects you believe are important. There has been a bit of a passage of time since we sent you the questionnaire asking for some feedback. If the other members of the table could take the statutory declaration, I will then invite you to make an opening comment about the Roy Fagan Centre and the progress you are making.

Ms KATHRINE MORGAN-WICKS, SECRETARY, DEPARTMENT OF HEALTH; **Mr DALE WEBSTER**, DEPUTY SECRETARY, COMMUNITY, MENTAL HEALTH AND WELLBEING, DEPARTMENT OF HEALTH; **Dr AARON GROVES**, CHIEF PSYCHIATRIST, COMMUNITY, MENTAL HEALTH AND WELLBEING, DEPARTMENT OF HEALTH.

CHAIR - Over to you, minister, thank you. I should probably call you Premier, but it will take me a minute to get to that.

Mr ROCKLIFF - That is fine. I am the Minister for Mental Health and Wellbeing. It is my direct responsibility as I was Minister for Mental Health and Wellbeing in December 2020. I take it everyone has introduced themselves? We have others available here including Cat Schofield, Director of Services, Statewide Mental Health Services, and George Clarke, General Manager, Mental Health, Alcohol and Drug Directorate.

We all know why we are here and I appreciate the reasons for this short inquiry process. As a government, we are committed to ensure that the Roy Fagan Centre provides a safe and quality service to its clients. In 2021 the Secretary of the Department of Health appointed a panel under the Tasmanian Health Service Act to examine the standard of patient care at the Roy Fagan Centre. The review made six recommendations, all of which the secretary and the Tasmanian Government have accepted.

It is important to note that the recommendations go beyond the Roy Fagan Centre, and provide a framework for a contemporary older person's mental health service with emphasis on care in place rather than transfer to a specialist facility. The review followed an incident in December 2020 involving the care of a patient. It found that the standard of care provided to

the patient involved in the 24 hours prior to the event did not meet the required standards or expectations with a culmination of factors that, when combined, led to this incident occurring. I stress that what occurred is not a reflection on any of the hardworking staff working at the Roy Fagan Centre.

Importantly, immediately following the incident changes were made to resourcing processes and procedures at the Roy Fagan Centre, including: increases in staffing; increase in consultant psychiatrists - one full-time equivalent for the service; additional nursing staff of 1.4 full-time equivalent - that is eight-hour shifts, seven days a week; additional ward aides of 2.8 full-time equivalents; and the development and implementation of a new protocol for wound care, including training for all nurses; new systems for checking on individual hygiene needs, and how to assist patients who may be resistive during care; updated processes for open disclosure; revision of care plans to include comprehensive summaries available to all staff; new protocols for documenting care given by assistants in nursing or ward aides; and improved handover practices.

As a Tasmanian Government we have developed a broad implementation plan for the review recommendations, which has been publicly released. When implemented, I am confident this work will significantly improve the level of care and treatment provided to older Tasmanians and better meet the needs and expectations of the Tasmanian community. A project control group with representation from key stakeholder groups including consumers; families; the Roy Fagan Centre and Older Persons Mental Health Service; Council on the Ageing; Mental Health Council of Tasmania; Flourish; Mental Health Family and Friends; and the University of Tasmania, has been established to provide advice to the Deputy Secretary Community Mental Health and Wellbeing, and support implementation of the review recommendations.

In addition to the immediate actions taken, the department allocated $1 million in 2020-21 to support the initial implementation of the long-term actions identified in the report, and this initial funding has allowed continuation of an onsite medical officer; provision of an additional nursing shift at Roy Fagan Centre; and has supported the employment of resources to develop the longer term implementation plan. The department has made a budget submission to support implementation of all recommendations over the next four years. Thank you, Chair.

CHAIR - Okay. If we could go through the recommendations one by one . You said you're committed to addressing all of them and adopting all of them. Has there been any further progress since the report was provided, or the response to our questions was provided?

Mr ROCKLIFF - Yes, certainly. I can go to the relevant area here where I have quite a comprehensive table. If I could go through each recommendation and the actions associated with that, and if more detail needs to be provided, Chair, then the people that I have at the table may well be able to support extra information. I mentioned before a project advisory group to support implementation of the recommendations of the review report - the project advisory group was established in November 2021, and I'm advised it has met three times. Without wanting to be repetitive, I've detailed all the people on that project advisory group.

Recommendation two - there should be a statewide program within Statewide Mental Health Services with its own dedicated leadership. Recruitment of a speciality director and group director is underway to lead the establishment of a comprehensive system of governance

across Older Persons Mental Health Services. Statements of duties for these positions are in a consultation stage.

Older Persons Mental Health Services should be funded to deliver the full range of service elements found within a contemporary statewide older persons mental health services, that's recommendation three.

The $1 million was allocated in the 2020-21 Budget to support - or in 2021 - to support the initial implementation of the review recommendations. Further funding requirements for the implementation of all recommendations in the development of a contemporary best practice older persons mental health service are being considered as part of the state Budget process.

Recommendation four - the Roy Fagan Centre should undertake a project over the next 12 months to develop a model of care based on the new level of resourcing adequate to undertake the roles it will need to deliver in the next ten years. On commencement, the program manager will establish a series of representative working groups to develop operational service models to underpin the inpatient and community models of care of a person's mental health services.

Recommendation five - the community of a person's mental health services should meet to develop a model of care that meets the needs of the Tasmanian community, based on similar programs elsewhere in Australia. In addition to what I have just said, in respect to recommendation four, working groups will seek input from a wide range of stakeholders and consider exemplary models of care elsewhere in Australia.

Recommendation six - that Older Person's Mental Health Services should develop a project as part of the broader Tasmanian Mental Health Reforms that ensures they are able to take advantage of processes that will assist them in attracting suitable workforce. Key action to that recommendation - responsibility for the implementation of recommendations has been assigned to the Tasmanian Mental Health Reform Program Team. And Older Persons Mental Health Service is able to leverage the specialist recruitment resources within Mental Health Reform Program who are focused on recruiting full time equivalents to support the broader statewide Mental Health Service reform.

That is it in a nutshell and of course, we will be able to expand in more detail should further questions require.

CHAIR - Sarah is keen to follow up on this and I will go to her first.

Ms LOVELL - Thank you Chair. Thank you Premier. To follow up on particularly recommendations four and five, you spoke about working groups being established. Recommendation four talks about a project over the next 12 months. Can you just provide an update for the committee on time frames and how that is being met?

Mr ROCKLIFF - Certainly, I can do that.

Mr WEBSTER - It has taken us a while to get that established and the reason is we decided to actually go with a package early to stabilise the workforce at Roy Fagan to ensure we had sufficient staff on particular shifts, particularly ward aides and nurses.

In addition to that, the Minister has mentioned one of the issues was GP services, because we have a number of long-term residents at Roy Fagan we have now established a full time GP on staff at Roy Fagan. And that will be continuing.

We did all of those things rather than focus on the project. And of course, the implementation plan was then issued in September.

We have a program manager starting. I think the other important thing is, the working groups are not the traditional internally focused government working groups. It is picking up representatives from Flourish, from Mental Health Family and Friends, from COTA, so they have input into developing that. In designing a process, we have deliberately slowed it down to make sure we are actually involving all of the parties that we think should have a say.

The important key there is we think our process will give us a better outcome than speeding it through in 12 months.

Ms LOVELL - How long are you expecting that process to take?

Ms WEBSTER - We would expect that by December of this year. We are well on the way. The idea would be we are actually implementing it in the winter period next year, because we have to acknowledge we will have recruitment lag in this area. We do not want to set up a process that says we are starting the year and then find that we haven't the staff to do it. We want to make sure we work through the staffing alongside the model of care to make sure when we switch over to the model of care, we are actually staffed to be able to do that. Both those things have to work in tandem.

Importantly, we have a program manager starting literally next week on the detailed work, the statewide specialty director. The delay there in the consultation area again is we are putting that through COTA, Mental Health Council and Mental Health Family and Friends, to make sure we have got all of those people on board with the directions we are taking.

CHAIR - This is broader than just the Roy Fagan Centre the work you are doing, which was picked up in the review as Older Persons Mental Health Services is not just Roy Fagan. We appreciate some feedback on that, but we would also like to focus in on the work being done at Roy Fagan which is particularly the subject this inquiry process.

Ms MORGAN-WICKS - Just to claify there is an operating model of care that currently is in existence at Roy Fagan. The real thrust of the report was to identify the lack of a contemporary model that we can do better in Tasmania in relation to older persons mental health service provision and looking at also at the infrastructure currently in place at Roy Fagan. We have included that into our planning for the Royal Hobart Hospital Master Planning stages. It has clearly fallen within Stage 3 of the Master Plan of what is going to happen in terms of a repatriation and rehabilitation and our older persons mental health precincts et cetera.

We are trying to work within a facility at the moment that also needs additional infrastructure works. Model of care ties to that, it ties to the infrastructure in which you are able to either supervise older persons depending on their state or deterioration. Certainly, walking around Roy Fagan, and we have had another walk through this week to check on the implementation and how the staff are going. They are reporting great improvements we have put in terms of the infrastructure with sound baffling, for example, as one of those. We have

also identified some other improvements which we need to assess and put in to determine what happens for the next 5 years whilst we look at that next stage of older persons' care within Tasmania.

The department is committed to that examination and noting the development of that contemporary model of care also has to sit alongside the infrastructure we have in Tasmania to provide that type of care.

CHAIR - On this point, if we could, Premier, it would be helpful to understand a bit about the funding that is available.

You have talked about the million dollars put into drive some of the recommendations that have been made, but we are talking about the care of older people. The federal government obviously has a level of responsibility in funding some of that care. Can you outline the funding arrangments and how that intersects? The secretary has already made comment about the capacity of the building and the facilities and the need for more work. Where does the funding and resourcing fit for all of that?

Mr ROCKCLIFF - I can go into some infrastructure improvements and how that intersects. I know our budget has increased well over $3.2 m over the last five years. The current annual budget is $10.7 m for the Roy Fagan Centre. How that intersects with other funding sources -

Mr WEBSTER - The way it works is residential aged care is, as you said, a responsibility of the federal government, but what you see at the point where there is acute care needed, there is a transfer back to the public health system and that applies within mental health also.

It is that intersection, where you move from being able to treat in the residential aged care by a primary care provider to needing acute care, that is when it switches across. Older Persons Mental Health Services care is primarily an acute service, particularly Roy Fagan. But secondly, there is a level of mental health care in residential aged care facilities which are not funded by the federal government and again that falls to the state government. That is where we have our community teams in place and they are working into residential aged care facilities as though they are part of the community.

When we refer to our community teams they are providers not just to home care, but also providers to residential aged care facilities and that creates that interface, which is why the report goes into the whole of older persons mental health.

As the Premier said earlier, the focus is on treatment beyond Roy Fagan, almost a hospital avoidance process. Part of hospital avoidance in this process for this kind of report is in fact keeping them at the aged care facility and providing the mental health service to the aged care facility.

CHAIR - Like an inreach type of provider.

Mr WEBSTER - Yes, as an inreach model or a consultant liaison kind of model into the aged care facility and I think that is important. We need to develop a model that does that

hospital avoidance, because we see Roy Fagan as a hospital environment in that sense, because it is the acute end.

CHAIR - Just to the infrastructure, Premier.

Mr ROCKLIFF - Yes, certainly.

CHAIR - Of Roy Fagan.

Mr ROCKLIFF - To more broadly in terms of plans to update the infrastructure associated with Roy Fagan Centre, or indeed the Older Persons Mental Health Service. The centre is owned by the Szabo group [TBC] and has been leased by the Department of Health for around 25 years. It's an older building, but works have recently been undertaken to increase comfort and also to reduce the impact of noise at the Rosewood unit. That unit provides care for men with dementia and was fitted with sound dampening material to improve the unit's acoustics. Due to the nature of the patients' condition, noise could increase the likelihood of patients experiencing discomfort and becoming agitated, and this in turn risks their own safety, as well as that of the staff.

Once the sound dampening material was installed, I'm advised that the number of behavioural incidents dropped and the clinical team reported quite a large improvement in the level of behavioural disturbance of consumers in Rosewood. Based on this outcome, the service undertook works to install sound dampening to the remaining three units as a priority, and this has been completed. New fixtures and fittings have been installed, with new curtains in the Heather unit and new dining tables and outdoor furniture in both the Magnolia and Heather units. I understand the Jasmine unit will also soon have certain fixtures and fittings replaced. Touch-free taps have also been installed for better ease of access.

Any future Older Persons Mental Health Services infrastructure developments are being considered within the context of the Royal Hobart Hospital development, and will be informed by clinical service planning currently underway.

Ms MORGAN-WICKS - We've also installed the duress alarm system replacement, and new call monitors within all of the hallways within the unit. In speaking to staff, they're very pleased with that replacement.

CHAIR - In your view then, Premier, does this meet the requirements of a contemporary unit, or does the state still need to look at a new facility to deliver contemporary care to people who require an acute mental health service who are older?

Mr ROCKLIFF - The unit is of some age, of course, and so there would be more contemporary designs to support consumers that are required to be at the Roy Fagan Centre. For example, we have had initial discussions around future infrastructure provision, Chair. Dale, if you would like to add some further value to that.

Mr WEBSTER - One of the fantastic features of Roy Fagan is in fact the garden setting, and that is the most contemporary of settings. We don't want to lose that by suddenly designing something in the middle of the CBD, because staff and clinicians find that patients that are transferred from residential aged care into the Royal because they need to be stabilised et cetera, their behavioural doesn't stabilise at the Royal - their medical stabilises. But within a short

period of time being exposed to the environment at Roy Fagan, their behaviour starts to stabilise as well. A lot of that has to do with that ready access to quieter spaces, gardens, and things like that. The Premier's comments around the sound baffling, that has improved the facility a thousand per cent, in my view. The sound is completely different now when you go out there.

Is it contemporary? It is not; it's a 1980s design built in the 1990s, so internally it's always going to have constraints. But as an environment, it's very contemporary, and so our planning is about making sure we replicate the best features of Roy Fagan, but also contemporising some of those features that are there. They are things like the type of lighting, the fact it was built without that sound baffling - we have had to retrofit it at some cost - all those sorts of things. We need to consider that in our design going forward, so it is balancing those two things.

CHAIR - The comments you made earlier around the models of care that are being developed and the new projects, I think it was referred to, Premier, I assume they are to be implemented in the current setting with its limitations. Despite the physical environment that is difficult to change, and acknowledging the benefits of the nice garden setting and the upgrades that have been done to the building itself, will that get it to a level where you can stand up and say, we are providing a quality mental health service for older people and it is contemporary in terms of the level of expectation our community has? Particularly with the ageing population we have and, sadly, increasing rates of some of these mental health conditions in our older people.

Mr ROCKLIFF - It is certainly my intention. Given the infrastructure Mr Webster has said - design of the 1980s, built in the 1990s - notwithstanding the infrastructure improvements that need to happen, notwithstanding the good setting it is in in terms of what I would call, in layman's terms, a good therapeutic environment with the garden setting and the like. It is my expectation that there are continual improvements to be made.

CHAIR - The model of care, how will that overlay with it?

Mr WEBSTER - Premier, the first thing I would say as the secretary said, there is a model of care and it is actually quite a contemporary model of care and the staff out there. The constraints are things like we have turned staff areas into activity areas, so we have really constrained staff in terms of spaces. We have converted part of one of the wards to a palliative care suite which includes overnight facilities for families to stay. You get compromises when you try to squeeze all of those things into an existing building.

What I would say is that, whilst the palliative care unit is not used a lot, it has allowed for people who are dying, in what is their home. The feedback from families is that it's a great facility . We have been able to do that by creating different entries so families can come and go as they please during that period.

The other major feature out there -and, again, it reflects a bit of compromise and how we have to reuse space - is that there is a wonderful day centre attached to Roy Fagan as well. It is part of our community team, but it allows us to use the staff on site to do some of the monitoring of people. These are people who have dementia and mental health issues - the private sector day centres are challenged by their behaviours. By taking them to Roy Fagan, the staff are able to use the onsite psychiatrist to give advice in the day centre and things like that.

We have a contemporary model, it is constrained by a building, but I think when you go through the facility you are hit by the fact that it is not the patient areas that are compromised, it is the staff areas.

Ms LOVELL - Premier, my question has partly been answered there. I wanted to explore a little further whether there were constraints around the refurbishment work that can be done, given that the building isn't owned by the state; whether that lease arrangement has constrained that in any way? Also, to confirm - I presume that the state is bearing the costs of those refurbishments? And the terms of the lease? I know you mentioned that we have been leasing that building for 25 years. Is there a lease in place for many years into the future? How does that lease arrangement work?

Mr ROCKLIFF - All very good questions. The first part of that question I will throw to Ms Morgan-Wicks.

Ms MORGAN-WICKS - In terms of the lease to the Szabo Group [TBC] my understanding is that we only have another couple of years to run. While I am answering, perhaps Dale will look up the expiry date for that lease. We did have quite a conversation and have been having ongoing conversations with staff, because you have to trade off between our own investment in a leasehold with a couple of years to run, versus whether we actually look at an extension of the lease or a brand new lease. Usually with landlords coming with an incentive to spend to upgrade facilities. Do we renovate that facility, add on to that facility? Because, whilst it has beautiful outlook in terms of the bushland beside it, we are quite close to neighbouring fence lines. Do you build up in an aged or older persons' facility with the use of lifts et cetera or do we need to look at a brand new greenfield potential development, subject to all our state budget funding processes?

It is also difficult if we do pick a renovation option, to do that with a working facility on site. And we note those issues, healthy use to those in terms of renovating hospitals or adding on. But, it makes it difficult, particularly where we have older patients where noise is an issue and construction works are very noisy.

We are at the moment, as part of our master planning for the Royal Hobart Hospital site - which Roy Fagan is part of - looking at those options to try to compare and our available health assets and the land which we already have. Whether there may be a potential. Noting we need to also have those discussions with our landlord, in terms of the time remaining on our lease. We would still need to have potentially a further extension anyway, noting the time to construct if we did choose to leave that site. I would say that conversations are ongoing and importantly, we need the staff who are actually involved to help us co-design. They have lived and breathed Roy Fagan for many, many years. They know exactly what they want and every time I talk to them they take you through the list. But it does not mean we do not invest in the last couple of years. We need to make sure that we do stay up, in terms of the improvements that Roy Fagan needs in this interim period while we look at a longer term solution.

Mr WEBSTER - The lease is to 2024, but there is a five-year option that we can exercise.

Mr DUIGAN - Thank you, Chair. This is somewhat away from infrastructure. I am interested in recommendation one, where we are implementing the Older Persons Mental Health Services, statewide service. What is actually the function of that? And it needs to be

delivering a full range of service elements. What does that mean in practice and what does it look like?

Mr ROCKLIFF - Thank you, Mr Duigan. I will probably make some opening comments and more detail can be delivered by the people at the table here. But it consists of the Roy Fagan Centre and then three older persons mental health community teams in Burnie, Launceston and Hobart, in terms of the Older Persons Mental Health Services.

The community teams address the needs of older people with mental health issues in a community setting, which includes residential aged care settings. I expect as the review report recommendations and implementation plan rolls out, there will be an increased focus on building up these teams and their capacity to provide more services in the community. That is generally what they are doing across our health service anyway, in terms of acute care delivery, hospital in the home's settings. COVID@home would be a good example of that. But in terms of the recommendation's implementation plan for the review report, clearly that would allow more people to remain close to home and their support networks for as long as possible.

In the month of April this year, there were 90 registered clients for older persons mental health in the north; 90 for older persons mental health in the north-west; 402 clients for older persons mental health in the south. The combined statewide budget for the three community teams is over $4.5 million and this in addition to the Roy Fagan Centre funding which we have spoken about earlier today. Aaron would you like to add any value to that?

Dr GROVES - Yes, Premier, I would be more than happy to add to that.

Mr Duigan, Older Persons Mental Health Services, in terms of what is being described at the moment, the Premier has outlined, they also provide a Huntington's Disease service, which is a separate services component part of that. That is important because we have a high rate of Huntington's Disease in Tasmania.

In terms of your question in relation to what a comprehensive older persons mental health service might include, it would also include a consultation liaison service into hospitals. For example, staff from the Roy Fagan Centre already go into the Royal Hobart Hospital and go into the geriatric and acute geriatric unit there and other parts of hospital. They go to see people who might be presenting with acute mental health problems or problems associated with dementia where they have severe psychological behavioural problems which geriatric medicine units deal with a lot, but do not deal with them at the severe end where mental health expertise is needed.

That is a consultant liaison where you have that throughout the state, but it's still in fairly early stages. Mr Webster has already described the range of services in the Roy Fagan Centre and I can add to that.

Generally, Older Persons Mental Health Services have three target groups of people they see. We have spent a lot of time talking about people with dementia and in the group of people with dementia and Mr Webster has already described how the Commonwealth has a responsibility for aged care services, but when people have the most severe forms of what I would call BPSD, which stands for Behavioural and Psychological Symptoms of Dementia they are often needing to be given hospital care from the public hospital system and that is where we have a key role.

In relation to that, there is a diagram in chapter five of the report in relation to what is called Brodaty's Triangle. Henry Brodaty is a pyscho-geriatrician Professor of Psychiatry in New South Wales. In the early 2000s, he described this triangle which describes the types of symptoms at the very extreme end which he calls tier seven. Immediately under it is tier 6, generally looked after by the hospital system and geriatric medicine and psychogeriatric medicine. Tier 7, the most extreme end, of which we might only have six or seven people in Tasmania at any one point in time, requires an incredibly specialised response.

A majority of those people go to the Roy Fagan Centre, but sometimes because of delays in getting them to the Roy Fagan Centre or the centre not having the staff previously to look after them there, they might still be in the acute hospital system where it is incredibly difficult to manage. Their behaviour is often very intrusive with what happens in a hospital setting.

One of the recommendations in the report and what has happened in most mainland states is, is the development of what is sometimes called a neural-behavioural unit or something like that for that very small group of people who have highly distruptive behaviours in any environment, including the Roy Fagan Centre. That is one element we currently do not have.

The other element we do not have, that would be seen elsewhere in Australia, is an acute older person's assessment unit. Generally, these are on general hospital sites and they have a range of geriatric and psychogeriatric speciality staff to be able to make rapid assessments with easy access to imaging and all the things that general hospital site does. A full assessment and commencement of treatment of a person can be done in a period of seven to fourteen days.

At the moment, that occurs in the geriatric units at the RHH with inreach from the Roy Fagan Centre. That is probably a little bit less intensive than what would be the case on the mainland. We need to complete the planning which the secretary and Dale talked about to actually indicate how much we need of that in this state. Because again that would be highly specialised, where we do it so they would have access to those types of service across the state.

These are two bits which are really important. The other bit, that Mr Webster's talked a little bit about before, is the community teams and what they actually do when they are in the community. One of the issues has been they have been somewhat limited to looking after older people who have mental illness rather than being able to do a consultation liaison role with residential aged care facilities where people with dementia and BPSD might happen to be.

Sometimes, we will see people in Tier 5 who are in those nursing homes who are getting worse and will come to Tier 6. Our services in inreach and providing that consultive liasison might sometimes be able to keep them in nursing home facilities longer. By virtue of the very nature of dementia they might deteriorate and their level of need would drop back and so they might have been able to be looked after the whole period of time in a residential aged care nursing setting, and not go into an acute hospital.

Again, that's an important element that we would want to be able to have in a comprehensive older persons mental health service.

CHAIR - Who makes that assessment? As an elected member, you hear some things that go on inside of our aged care facilities that when you look at this triangle are coming fairly

well up the tiers. Who makes the decision that they will require that level of care that will warrant some assessment by someone from Roy Fagan, for example?

Dr GROVES - That would be the staff of the residential aged care facility. That could be anybody from the manager of the service, to one of the senior staff, to a GP who might be providing services. They would make a referral to the Roy Fagan Centre, and then they would prioritise that referral. When it comes to the tiers - you were talking about the tiers - that's clinical decision-making, it's the level of behavioural disturbance that justifies what tier within that triangle.

CHAIR - Do you believe that all our aged care staff and even our GPs, and those who support our aged care facilities around the state, are equipped to make that judgement?

Dr GROVES - The judgment about whether they should be referred?

CHAIR - About whether they need to be assessed by a specialist in the field.

Dr GROVES - My review wouldn't be able to tell you about the GPs, but my experience from what I saw was that the referrals that come to Roy Fagan Centre from GPs for nursing homes were highly appropriate, they were excellent. There's been a lot of criticism of the aged care sector in Australia - and sadly, I've got form in this, in relation to the Oakden Report. But one of the things that I think is good is the way in which the current funding arrangements for aged care, developed by the Commonwealth over many years now, have meant that nursing homes have become incredibly sophisticated in understanding and screening and making assessments so they can maximise their funding from the Commonwealth to support them. They have become very good at assessing the level of disability of people, and so most of them are appropriate in their referrals.

CHAIR - Sure. Is that okay, Nick?

Mr DUIGAN - Yes, thank you, I appreciate that.

CHAIR - Is there anything else that anyone wants to add on that question?

Dr GROVES - I hadn't quite finished.

CHAIR - Sorry, I didn't mean to interrupt.

Dr GROVES - The only other aspect to mention is that there is, of course, a group of people who have significant mental illness - I'm talking about severe mental illnesses like psychosis and severe depressions - who don't have dementia, and that's very much still the core of the older persons mental health services as well. When we think about an older persons mental health service, we shouldn't just think about it in terms of people who have dementia or are in residential aged care facilities. A lot of people live in their own homes and are quite independent, but then they get a mental illness which needs treatment - much like they might have had happen to them if they're 40; it just happens to be that they might be 75. I think we need to understand that where they would need care would be manifestly different than if they're 40, and if they were in an acute inpatient unit at Royal Hobart Hospital, that's not an environment, it's a little scarier for a 75 year old than it is a for 40 year old.

CHAIR - Sure.

Mr WEBSTER - If I just explain Roy Fagan and how it's set up to match with what Dr Groves has just explained. Effectively, Roy Fagan has six units - four inpatient units, the palliative care, and the day centre. The four inpatient units are set up as a geriatric unit with challenging behaviours, so it's more focused on dementia; then two dementia units, which are dementia with mental health overlay, and they are separated into male and female; and then finally the last unit, which is the unit which is mental health unit with very little dementia overlap.

CHAIR - Sure, thank you. Meg?

Ms WEBB - Thank you, Chair. Coming back to the Roy Fagan Centre and perhaps a slightly different avenue on it - noting a finding from the report around the level of care, that it was overall satisfactory, but there was variance between residents and some that could have improvement. You've described some measures taken around staffing and processes and so on that have been put in place since. I'm interested to hear a little bit about what would the clients there be experiencing differently, as a result of the changes that have been put in place since the review? Alongside that, how is that being monitored or measured to ascertain that they would be experiencing the improvement in the care they are receiving there?

Mr WEBSTER - The first thing they would experience is the change in sound. We can't under-emphasise that, particularly in the male dementia ward. If you had one gentleman who was making a lot of noise, you would generally see the entire ward would become unsettled within a short period. The first thing you would see since December 2020 is the change in the sound. The second thing is that you would see is changing the call arrangements. They are easier for dementia and mental health patients to use. Instead of being the traditional hospital ones, they are mounted on walls in more visible spaces.

The other thing you would notice is the level of staff that are actually on the ward at any one time - ward aides as well as nurses - in the critical period,, which is the afternoon shift. We have increased the staffing so you have that interaction between them. As the secretary says there is regular walk around of the facility by senior people.

Ms WEBB - Can I interrupt you there for a minute because I framed the question to focus on not what I might notice as someone visiting or the rest of us might notice, but what the clients there would be experiencing differently. I would like you to reflect on it from that perspective. It is a tweak in perspective, but it is important. Rather than tell me there are more people there in the afternoons - what does that mean for a client, what would they experience differently? The second part of the question was about how are we checking to see if clients are experiencing things as improvements and differently.

Mr WEBSTER - Yes, I take that point and I will rephrase it. The sound, from the patient point of view, would mean that generally the whole day is more settled. More staffing means that they are actually intersecting with the staff more regularly, getting more one-on-one time and, importantly, the continuation of care, because we changed the way we do handovers from one shift to the other there is a continuation.

That also results in them getting more activity time and more time outside, more time experience in the environment. How we check on that is that Roy Fagan is part of an

accreditation process, so there are short notice assessment panels who come in and have a look. Importantly, we have had a snap around consumer experience in the last 12 months and we were commended on our consumer focus across mental health services including Roy Fagan. Those snaps when they focus on the consumer's standard are really important in doing that.

The other thing is that tweaks in that environment change the whole nature of the environment. All of those things together have changed Roy Fagan. The report does not say it was bad before December 2020 - in fact, it says it was good - but I think we have improved it, and that is important to emphasise.

The last thing I would emphasise is having a GP alongside our psychiatrist means that we have a focus on both medical and psychogeriatric on site on a daily basis.

Ms WEBB - That is all useful information. Could you be a little bit more descriptive about how you are monitoring and measuring consumer and client experience? You mentioned you have had these snap reviews and that the results have been good, and I accept that and I am pleased to hear that. I want to understand more what are the measures there to check in on what the clients are actually experiencing.

Mr WEBSTER - The first thing is making sure we have an open environment. The reason - and the Premier emphasised this upfront why we are taking it slowly and involving COTA, Mental Health Family and Friends, Flourish, Mental Health Council - it is not an internal process we are going through with the department judging itself. There are external bodies that are there alongside us, including UTAS and the Office of the Chief Psychiatrist - more for an expertise basis there. Those four groups are around the consumer and making sure the consumer and the families have a voice in what we are doing. That is an important monitoring process, the fact we have opened up to those groups to be part of the reform.

CHAIR - Can I add to that. As Dr Groves pointed out, we have got patients there - we do call them patients?

Dr Groves - Yes.

CHAIR - Who have dementia, who may be unable to participate effectively in a questionnaire - for example - or an interview, but you also have older patients with mental health issues - serious mental health unwellness, but still able to participate. Do you do patient surveys or reviews of the patients who are able to participate? And for those who are not able to individually participate, do you do that with the families?

Ms WEBB - Thank you, that is getting towards more of what I was asking about.

CHAIR - Yes, I thought so.

Ms WEBB - I was going to do one more follow-up to try and get to that, but you have done beautifully, thank you.

Mr WEBSTER - The short answer from me is yes, but Dr Groves will give a more fulsome response.

Ms WEBB - Sure, thank you.

Dr GROVES - Thanks. Perhaps, if I can go from the broadest and go down to the narrow. We have a National Mental Health Service performance framework in this country which looks at tier three of health service performance. There are six domains we measure. One of those is on personal experience. In that, there are now two national measures, one is called YES and the other one's called CES. The YES is the 'Your Experiences Service', that is given to consumers - we call them consumers, not patients. I like to call them people - but nevertheless, we give them to those people who are in patient services and also access our services elsewhere and for them to give their experience of their service. That is a way of them doing that and is a standardised tool used across Australia, gaining momentum in the last few years. That is able to be robustly, reliably filled out by people who have the cognitive wherewithal to do that. Those people in the Roy Fagan Centre who are able to would be able to fill that out. In addition, we have the CES that stands for the, 'Carers' Experiences Services.' That is where family members and others can come in and give feedback about that.

In addition to that, we have a couple of other independent groups who will also have a role in influencing giving feedback. One of them is the official visitors. That is an independent process that applies to all mental health units, and even though not everybody in the Roy Fagan Centre is subject to the Mental Health Act, the unit is approved, therefore official visitors visit. I know that is part of Mr Connor's role, but the particular person - Phil Donnelly - who does that on his behalf will regularly go to the Roy Fagan Centre and he can raise things either with me, certainly with the service itself if he any concerns, and he meets with me regularly. He has informed me he has been very impressed by the way in which the Roy Fagan Centre has approached any recommendations that have come from him during the last year and a half or so. In addition to that, we have people who are under guardianship with legislation, and because of that the Public Guardian and his guardians also act for people and have that ability to also advocate on behalf of people. There are a number of ways of independently looking at that.

CHAIR - Is that reported back to the department, back to the minister?

Dr GROVES - The official visitor provides an annual report as does the Public Guardian. I do not know whether the Public Guardian's report goes into that amount of detail and comes back to either the minister or the Premier as that clearly sits in another portfolio.

CHAIR - What about the CES and the other one?

Dr GROVES - The YES and the CES?

CHAIR - Yes.

Dr GROVES - They are collected and go into the service for the service to use as a process of service improvement.

CHAIR - Would it be possible for the committee to actually be provided with a recent one, a sample of each of those, just to see what sort of things (inaudible) is getting?

Dr GROVES - I do not know whether that is possible, because sometimes the numbers are so low that it becomes identifying of particular individuals, but there would be a possibility, I would have thought, for the service to provide something that would be a rolled-up summary

of the types of things that would be coming. That would be for the deputy secretary to talk about. I would not have thought recent ones would be possible purely because the numbers -

CHAIR - I appreciate the numbers of people we are talking about. It would be helpful for the committee to see some overall outcomes from those personal accounts.

Dr GROVES - There was one other aspect I thought would be fulsome and that is the service also can collect an enormous amount of information about the progress in relation to conditions that people have. They would collect information, for example, if somebody has depression about how much that is improving, about their medical care and a range of things. That is all collected and reported. There are a number of ways in which you could look at the service and see whether overall patient care, as I defined in my report, is improving over time.

CHAIR - Minister, are you able to shed any further light on getting some feedback to the committee?

Mr WEBSTER - Yes, we will be able to do that. We will provide that.

CHAIR - I think Nick had a follow up here.

Mr DUIGAN - I did, thank you Chair. Talking about customer satisfaction. What does the service do in terms of dealing with families? What happened in December 2020. I think if you have a loved one in the Roy Fagan Centre it is probably a stressful experience for the family. Incidents like December 2020 heighten that stress.

Since the report has come out, has there been a focus on communicating with families of customers?

Mr ROCKLIFF - Very good question, thank you, Dale.

Mr WEBSTER - Importantly, in the time period directly after this became a public thing, every family was contacted by clinicians and by senior clinicians to talk them through what had occurred, what we were doing, those sorts of things. We have continued to have that and we have given feedback. When the report was released last year, we did that again. We made sure the families, particularly the current families, were directly connected to what was occurring and explained to them.

As Dr Groves has said, the cares or the CES or carer surveys also apply.

The other thing is the involvement of Mental Health Family and Friends, which is the representative, the advocacy body for families within this area of health. Right from the start, the previous CEO who has just retired, Maxine Griffiths, was informed about what was going on and was kept informed. As we have said, they have also agreed to be part of the ongoing process of reform. That was important. But, we had that external advocacy group directly involved in what we were doing. That is how we have dealt with the family side of this since the event.

The other major thing is that, as I said, we try to emphasise that Roy Fagan, whilst a closed unit, is an open environment. We do encourage family visits and an environment that has the families there.

It has been difficult through COVID-19, but we have managed.

CHAIR - I was going to ask about that. How has COVID-19 impacted on that?

Mr WEBSTER - We have reduced numbers to allow us to continue to keep those sorts of things happening, but it does actually impact. I cannot say it does not.

Ms MORGAN-WICKS - The staff are to be commended for the efforts they have actually put in to try to keep visitation going as long as they could during COVID-19. Obviously, we have a very vulnerable cohort within Roy Fagan, particularly since borders reopening 15 December 2021. The efforts that staff have put in, in terms of infection prevention and control, allowing visitation to continue. We have had one unit which we did designate for COVID-19, which also then meant we had to reconfigure the other remaining wings of Roy Fagan but we are in the process of opening those 10 beds back up to also then increase occupancy for Roy Fagan. The staff have done a tremendous job in managing through a really challenging time of COVID-19 on top of also seeking to improve the service.

Mr ROCKLIFF - My advice is that in April, 32 clients at the Roy Fagan Centre; 29 April the occupancy rate was 61.6 per cent due to COVID-19 isolation; but it is about to lift.

Mr WEBSTER - That is right, Premier. Literally, last Friday, we decided to reopen the beds and not keep them just for isolation. On the occasion where we may need an isolation bed we are going to use the palliative care bed if it is required.

CHAIR - Influenza is obviously an issue too.

Mr WEBSTER - Because I like to talk about vaccines, just to mention we did actually do the vaccines onsite for influenza.

Ms WEBB - Has COVID-19 had an impact on access that clients and the patients in Roy Fagan might have had to other external services, like an external advocacy service or those sorts of things? Has that been impacted or restricted through COVID-19, and has there been less availability of those sorts of lines of support?

Mr WEBSTER - The short answer is, no we didn't. Across all of our health facilities, through COVID-19 we did say that there were certain visitors that, provided they met the screening, would continue. That included external advocacies like official visitors, and for our staff it included our unions. There were probably only very small windows where we closed down everything while we were doing assessments, but mostly we kept our services open to external scrutiny.

CHAIR - We will follow up on the response you provided in relation to staffing. We asked since the 2020 public release of the coronial inquest, have any reviews been conducted regarding the adequate number and type of nursing, allied health and medical staff? You have responded in your opening comments around some of the increases there. In the response you provided you said allied health resources are to be reviewed. I am interested in what the outcome of that review was and what decision has been made around allied health? I know allied health professionals are not easy to come by in any part of the health system.

The other point you have made is an increase in the consultant psychiatrist FTEs. I am interested in more detail around that. You also talked about the establishment of a nurse unit manager on a fixed term; I am not sure why you would create a fixed term rather than a permanent position for that. If we could talk about those - assuming that the numbers that you have provided here in terms of other nursing staff, registered nurses and ward aides have not changed from the information provided.

Mr WEBSTER - At the Roy Fagan site, the reason the new nurse unit manager was fixed term was to allow us to do the full review. I can report that nurse unit manager is still in place, so it's not as though we put it in and took it out, it's still there. We hope it will become a permanent feature. In terms of allied health, we now have an occupational therapist on site for the mental health patients and the dementia ward. I should emphasise that the Jasmine ward - which is the acute geriatric ward - has a number of allied health professionals or allied health provided directly from the Royal, because they're still seen as inpatients of the Royal Hobart Hospital. On the mental health side, there is a challenge with the recruitment of allied health. We were trying to provide that in from the Royal, but we've found that it stretched that too far. At the moment, we've contracted with private physiotherapists and speech therapists to provide in-service there while we continue to work on a long-term workforce plan to increase the number within our service. I should emphasise that besides looking at Roy Fagan, we have also increased the number of case managers within the community since this by an initial five.

CHAIR - How many were there originally?

Mr WEBSTER - Originally, we had 28.6 FTE case managers across the community. I had to add it up, I apologise..

CHAIR - It's a significant increase.

Mr WEBSTER - Yes, a significant increase of an additional five. The process is underway to recruit them and we've targeted two of those to be allied health and three to be nursing staff. That's the community team in addition to staff that we have put into the Roy Fagan.

All of the staffing that's listed in the written response that the Premier gave to the committee have continued. Again, we are looking to make those long term.

CHAIR - Can you provide that to the committee as a document if it's easier, about the current staffing levels, and looking at the staffing levels in 2020 and then the current staffing levels. I know there are some you're still recruiting. If you could include those positions that are still being recruited that would be helpful. We will write to you and ask for that, it's probably easier than reading out all the numbers.

Mr GAFFNEY - I imagine staff within the Roy Fagan Centre have professional development opportunities. I'd like to understand what they are, and also how they're incorporated into the system to upskill the people that are there. When you have different behaviours and different conditions coming into the unit, how are staff upskilled in that particular condition? That would be helpful.

Mr WEBSTER - The report, and the event, emphasised the need to include in our continuing professional development (CPD) the medical as well as the psychiatric CPD and that occurred very rapidly. We will continue to do that. It's added to our need for CPD and crystallised our thoughts around what CPD needed to include in this type of unit.

Importantly, for me, was the inclusion of the GP ongoing at the site, which means we do have that level of expertise on site to inform staff as well. Each of our professional streams - doctors, allied health, nurses - have CPD built into their professional accreditation as well as into awards where we provide that time for them to undertake CPD. It's important that there is an ongoing structure for our professions.

Dr GROVES - I'm sort of loath to make comments that I didn't have in the report, but I perhaps will in relation to this question, and that is in relation to the nurses.

They spoke very favourably of the nurse educator on the availability of the education he provided, notwithstanding that they recognised that there were gaps in what they would have liked to have had some training in.

As my report indicates, one of the things that was really impressive about the management of Roy Fagan Centre and Statewide Mental Health Services was that during the review, they were conducting their own review identifying these issues and addressing them. By the time I had finished the review, the nurses were confident in saying, "We are now having access to things like better wound care training," and so on and so forth.

Those sorts of things were picked up and were responded to immediately, and that was very impressive.

Mr GAFFNEY - Ok, thank you.

CHAIR - Meg, on this or is it something else?

Ms WEBB - No something different, so if you come back to me.

CHAIR - I appreciate that, because you can't keep your registration if you don't do CPD. But the mechanisms that were identified and some of the things that you spoke about, Premier in your response, like the new protocol for wound care for nurses and checking on hygiene needs and things like that. How have the outcomes of those professional development or extra training for staff been measured - or have they, at this point? Is there a register of wound management and that sort of thing, or those areas that were clearly areas that the staff needed a bit of extra support in? How have the outcomes of that been measured?

Mr WEBSTER - Importantly, it ties into the level of documentation. As the report says, it is making sure our documentation follows through on those. It wasn't like we weren't doing wound care, it is just that we probably weren't documenting it to the level that it should be -

CHAIR - As in, the document didn't happen?

Mr WEBSTER - Exactly.

CHAIR - There used to be a sign on the wall in our office that said that.

Mr WEBSTER -That's the importance and that is how we monitor it - monitoring the quality of our documentation going forward and making sure that occurs. The handover process is incredibly important and why the additional resources -

CHAIR - How has the handover process changed?

Mr WEBSTER - I will throw to Dr Groves in a moment, but importantly, it is providing the resources to make sure there is time to do it.

CHAIR -Paid time for the cross over.

Mr WEBSTER - Yes, exactly. For that afternoon shift, it was very important that we had that additional resource because we identified that was the shift that was important.

Dr GROVES - I think Mr Webster has really described well what the problem was. Because of the number of staff, particularly shift changeovers were the difficulty. Staff handing over to the next staff exactly what had occurred across that many people during the shift, when there were so few staff, was very difficult. We've already identified the issue that sometimes the documentation was missing on a shift, and if what had occurred wasn't handed over that made it very difficult to identify whether something happened - particularly if a nurse might then be off for a couple of days. What I can say though, was if there was something missing from the shift, then often the next shift then said what it did and gave a report that was clear about what had happened around wound care. The difficulty is if you're going back and doing the review and you're trying to look at documentation some months beforehand and you say, "What happened on that day?" and there is nobody around and there is nothing documented, you don't know what happened. That was the problem. You really need to have it; but it didn't mean that it wasn't happening.

CHAIR - I accept that. If it's not documented, it didn't happen, in the eyes of a court. How are records kept, are they electronic now? Have you got iPads near the patient to record what care is given or do you have to go back to the central station to report it - in terms of efficiency and contemporary timeliness of reporting, so you, as the nurse, don't forget stuff? Could that perhaps be improved, is the next question?

Mr WEBSTER - You put some ideas in there but generally we are going back to a central spot in this type of facility and again, the central spots are not that far away in terms of how it's structured. It's not a 40-bed unit; it's four by 10 beds with a nurse's office, rather than station, because the nurses generally spend their whole time out on the floor. There is a spot within each unit which is directly off the day room where staff go to do that sort of thing. Roy Fagan uses the department's digital medical record system and IPM system, so it's part of that sharing information right across health through our DMR.

CHAIR - I'm sure it's quite a challenging environment at times. You've provided some patient care; you're about to record it; you've got to go to another place to do that and in the meantime, you get intercepted by another patient. That is quite likely, and it's not someone you can say, "I'll be back in a minute," to. Maybe these are things that could be looked at as well.

Ms MORGAN-WICKS - This really underscores the need for investment in relation to digital health. Certainly, from my observations on walking around Roy Fagan, there is quite a bit of paper involved in terms of records. Yes, we do have DMR or IPM et cetera, but probably that lack of an integrated platform which is something we are currently examining within the department in our formulation of a digital health strategy and outlining a road map to really transform, both from a staff experience and from a patient experience. Just the real need for investment in terms of online health provision and recording.

Ms WEBB - I wanted to follow up on the question I asked before about access to external support or advocates, because in terms of correspondence we have received, it seemed a little at odds with the answer you provided and I am just looking for a bit more detail. We have heard from Tristan, correspondence from Advocacy Tasmania, and it seems their observation is there remain substantial barriers for those within Roy Fagan Centre to reach out and access support. They point - in addition to that - to a significant change which occurred in June 2021 that substantially limited the Your Say access - that is their advocacy service, I gather - and contact with people who are on involuntary orders under the Tasmania Mental Health Act, including in Roy Fagan Centre. I wanted to follow up with you on that to see whether that change they are saying occurred in June 2021 has had an impact on people in Roy Fagan Centre to their access to that independent external support through an organisation like Advocacy Tasmania. It may or not be related to COVID-19 and I am not sure the details of that change, perhaps it was a change of process.

They also point to not being able to facilitate online access of information sessions within the Roy Fagan Centre in a similar way they were able to do in aged care facilities during the COVID-19 time. Having done some face to face sessions in October-November in 2021 they have not been able to access Roy Fagan for face to face sessions since that time. Having an external group like that raise issues on access to those sorts of services, could you revisit your answer from before and see if you can address some of that?

Mr WEBSTER - I will revisit that question, I emphasised we had tried to keep Roy Fagan as open as possible through COVID-19 and through this period. I am not aware of the particular issue raised by Advocacy Tas. I do emphasise it is only one of the external bodies that can provide advocacy and the difficulty in a facility like Roy Fagan is unlike residential aged care facilities is you are talking about a large number of people with decision-making disability. It is not a case of they can readily access externals, which is why it is important we have official visitor schemes, that we are open to family and friends and things like that. I am happy to have a look at what the issue is for Advocacy Tasmania in particular, but I am not aware of it at this time.

Ms WEBB - My understanding is that there has been correspondence through to the now Premier - who was at the time, it looks like deputy premier - around the change that occurred last year in relation to access for people who are on involuntary orders under the Mental Health Act, which would potentially include some in Roy Fagan. Perhaps, that is correspondence that has not yet been followed up on.

Mr ROCKLIFF - I will follow up on that, Dale.

Mr WEBSTER - As Chief Psychiatrist, Dr Groves does monitor this also, perhaps-

Dr GROVES - Thanks. I cannot comment about all the other aspects of the correspondence as I have not seen it, I am aware of what happened in June last year. The situation is that until that point in time, Advocacy Tasmania had been getting information from what is now TASCAT Mental Health Stream about those people on orders. TASCAT determined them providing that information to Advocacy Tas was a breach of the Information Act and that they should not have been doing it. They have chosen to no longer routinely provide the information about the details to Advocacy Tasmania. That is a separate issue between TASCAT, the Attorney-General - who is responsible for TASCAT - and Advocacy Tasmania. I do not think it is actually within the auspice of the minister of mental health to be responding to that. There are other processes whereby we provide information to patients about how they can get support from all advocacy agencies. But the issue of it routinely going from TASCAT to Advocacy Tasmania, is an issue for TASCAT and it is clearly about them needing to comply with legislation.

Ms LOVELL - I have some further questions on staffing and workforce and the current workforce and know there is work underway on expanding in various ways. How many staff are there at Roy Fagan Centre in particular at the moment? Is it typically a stable workforce? Is there is a length of service or some data we could be provided with that would indicate whether staff are typically long term or whether there is high turnover?

Mr ROCKLIFF - Thank you, Ms Lovell. The Roy Fagan Centre full time equivalent currently stand at 73.58. In terms of average length of tenure for the staff, we could probably take that on notice. Are we aware of any particular turnover?

Ms MORGAN-WICKS - Apart from speaking during the week to very senior people who have been there for over 20 years who talked about the stability of their own teams, but certainly that is anecdotal. But, we would be happy to provide information specifically. I can comment that obviously the team have had the same COVID-19 impacts we are experiencing and everyone is experiencing across the service. Making sure they are able to continue to fill shifts has been quite a bit of work for them. Supported also by the Royal, in terms of their staffing into the Jasmine Unit.

Ms LOVELL - Premier, if that is to be taken on notice, it might be helpful if we could get a breakdown on average length of service over different categories of staff or different roles within the centre, if that would be possible?

Mr ROCKLIFF - I am sure it would be and I would imagine there will be a correspondence from committee today and we will respond to that.

Ms LOVELL - My next question on staff was in relation to workers compensation over perhaps the last 12 months. And again, I appreciate this may need to be taken on notice. How many staff have made workers compensation claims? Perhaps the length of time people are having to take off work before they are able to return? Also, if there is a breakdown of the category or type of claim, whether that is physical injury or psychosocial claims.

Mr ROCKLIFF - I am happy to provide that detail back to you. I am advised there are currently five workers compensation claims. Three which relate to physical injury. Two which relate to stress.

Ms LOVELL - Is it possible to get over the last 12 months the number of claims?

Mr ROCKLIFF - You ask the question, I will provide the answer.

CHAIR - There could be others of the last 12 months that have been closed and staff returned.

There are questions that we asked you, Premier, and we will write to you and send you the questions we would like you to respond to, thanks.

In terms of the question we asked you about if you had information provided to the Australian Commission on Safety and Quality and Health Care (ASQA), you responded this report highlights the lack of a contemporary care model and insufficient staffing levels across the nursing allied health professionals. Was there any specific feedback from Australian Skills Quality Authority on that or is it just you have responded by seeking to address those issues?

Mr ROCKLIFF - Certainly seeking to address the issues, but particularly, feedback from ASQA themselves. Dale, can you provide some information?

Mr WEBSTER - I do not believe we have had specific feedback. But of course, we have had the snap, since then. They have had a look at Roy Fagan since then.

CHAIR - Is that something you could provide to the committee their report or snap as you call it?

Mr WEBSTER - The snap does not go to individual parts of Statewide Mental Health Services, it generally committed us on consumer and those sorts of things. But specific to this issue there was no direct feedback from the ASQA as I understand it.

CHAIR - This probably includes a little bit from some of the questions from Sarah when she asked you about the nursing hours per patient day model as was agreed to as a binding nursing enterprise agreement in 2007. Yet the review states the process is yet to be applied at the Roy Fagan Centre. We asked what was the rationale for the exemption and you responded, Premier, that there was no exemption sought or provided. The model is now being utilised in mental health in-patient facilities and it is anticipated it will be utilised in a modified form in other mental health facilities, including the Roy Fagan Centre. Can you provide a bit more detail around the nursing hours per patient day model, acknowledging that it is a model used broadly across our health services and the challenges in how it applies in the Roy Fagan Centre?

Mr ROCKLIFF - Certainly, I have the answer to the question in front of me -

UNKNOWN - In terms of the letter I provided to the committee?

Mr ROCKLIFF - Is there anything further to add to that Dale at this stage?

Mr WEBSTER - The complexity of applying the model to a facility like Roy Fagan is you generally probably need more staffing than the model would provide and that is important to emphasise. It is that mix of allied health, nursing, medical staff et cetera on the ward. We do need to be careful in providing a model that is designed for one environment to a very different environment, because Roy Fagan - whilst we emphasis is a hospital-type facility - is

a mix of residential aged care facility, ongoing mental health facility, as well as an acute wing. We do need to be careful in applying a model not designed for it.

As I said, quite often you will find in a facility like this, the staffing is actually higher than what the model would predict.

CHAIR - Why would it be that - this is 2007, I accept that - why would such a model have been accepted for Roy Fagan when it really is not an appropriate staffing model to rely on?

Mr WEBSTER - It provides you with a base to work off, I guess, is what I would say. I think the other thing - to be fair - in those sorts of industrial negotiations it tends to be the bigger units that get focussed on and everything gets whipped up into it.

It is a good model to create a base, but I would emphasise that really - in this context - we would be supplementing the staffing beyond the model because it does need the correct mix of staff for the type of patient you have in there.

CHAIR - As was noted, it is a training facility for psychiatry and the accreditation process has reviews. Has there been a recent review by the Royal Australian and New Zealand College of Psychiatrists.?

Mr WEBSTER - On the accreditation for training?

CHAIR - Yes. On their accreditation for their training.

Dr GROVES - I sit on the branch training committee for RANZCP in Tasmania. Yes, the position remains accredited for a registrar-in-training at that facility.

CHAIR - There is a registrar currently engaged?

Dr GROVES - My understanding is that there is. Yes.

Mr WEBSTER - I can confirm that there is. I met them two days ago.

CHAIR - Okay. There is definitely one there.

When was the last review?

Dr GROVES - The reviews occur regularly. The changeover of trainees is in February and August. There will be a training, as I understand it, allocated in August as well. Each time the director of training makes an allocation, they can only make it to an accredited post and that's done locally - as in Tasmania.

CHAIR - There has been no conditional registration?

Dr GROVES - Not for that position. No.

CHAIR - Thank you. I don't have any further questions. Any other members have any further questions?

Mr ROCKLIFF - I would like to finish with something.

CHAIR - That is fine, I invite you to make some comments minister.

Mr ROCKLIFF - Thank you, Chair. I wanted to take us back to why we are here and I recall very vividly a conversation from Dr Groves around noon on Christmas Day 2020. Putting myself in the shoes of the family who were there to pick up their dear dad and husband at the time and how distressing that was and must have been for them, particularly on a day that should have been a happier day, where families do get together. I phoned a member of the family the following day and offered my apology, and I followed that up in writing again, and also subsequent phone calls. I want to reiterate that today. I made a commitment to the family that as a result of what was a horrific and distressing incident, that there will be considerable improvement in systems and resourcing and continuative care. I am satisfied to date that that is progressing well. I just want to reinforce - responding to Mr Duigan's question as well - the importance of those communications with families of residents, but also the family that is the reason we are here today. I also thank very much the hardworking staff that naturally were very distressed as well, and felt that very deeply, in terms of the public commentary, and also internally. That would have been very distressing for them. I thank them and the families affected, that we've listened to, gained their lived experience, spoken to the staff, and have been invaluable in terms of making these improvements moving forward.

CHAIR - Thank you, Premier, we can never forget what actually brought us here, I agree. Part of the purpose of this inquiry was to acknowledge that very difficult circumstance for many people, particularly the families. It was also to try to reassure the community that the Government is taking that seriously, from what we've heard and received from you today as a team, and that there are mechanisms to enable families to continue to engage. I thank you for that.

Mr ROCKLIFF - We look forward to your correspondence, and we'll write back with detailed answers.

CHAIR - Thanks very much, thanks for your time.

Mr ROCKLIFF - Thank you.

THE WITNESSES WITHDREW.