Forensic Hospital Staffing Profile Review 2020

ACKNOWLEDGEMENT TO COUNTRY

We would like to acknowledge the Traditional Owners of country throughout NSW and recognise their continuing connection to land, waters and culture. We pay our respects to their Elders past, present and emerging. We acknowledge that the high security forensic mental health services, under the guidance of this model of care, will provide care for patients who originate from other traditional lands across all of Australia.

Version Control	Revised by	Amendment Notes:
V1.0	Natalie Ricks, Clinical Integration Manager, Clinical Improvement Unit	Creation
V2.0	Scott Gill, A/Senior Research Officer, Research Unit	Updated information following external reviewer feedback
V3.0	Kevin Brown, Manager Allied Health	Final draft for executive consultation

Version 2.0

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Executive Summary

Overview

The current Forensic Hospital Staffing Profile was created when the Forensic Hospital opened in November 2008, there has been no formal review since this time. When commissioning the Forensic Hospital, the staffing profile was created through a consultation process with both local and international equivalent services. These services formed a reference group to guide the Network in the creation of the profile. Upon completion, the Network began discussions with industrial bodies and an agreement was met in 2008 to create the staffing profile that remains in place. Since opening, the Forensic Hospital has seen a significant change in the patient cohort, creating the need to review the staffing profile and meet our patients changing needs.

The number of Forensic Patients in NSW has increased significantly since the inception of the Forensic Hospital. Comparatively, across the same reporting period New South Wales experiences a 9.18% (7.41 million to 8.09 million; *Australian Bureau of Statistics, 2013 and Australian Bureau of Statistics, 2019*; respectively) increase in population. Yet, New South Wales has experienced a 27% increase in the Forensic patient population (*see Figure One*) since 2013, being a major contributor to this expanding service needs. A comparison between the Forensic patient population and general community populations between June 2013 and June 2019, shows a disproportionate growth has occurred within the Forensic patient population.

Understanding the lived experience of the patient population and understanding their needs is key getting the right staff profile. During consultation, our patients were positive and engaged and identified an overall high degree of satisfaction with the current level of service. Whilst feedback was overall complimentary of the service, the patients highlighted the following five (5) key service growth areas for the Forensic Hospital:

1. Increased access to targeted rehabilitation and therapeutic groups both within and outside the Forensic Hospital;
2. Increased access to clinician time;
3. Increased access to education providers and Non-Government Organisations;
4. Austinmer Women's specific service barriers; and
5. Greater access to Aboriginal and Torres Strait Islander Culturally specific staff and services.

Similarly, consultation with the Forensic Hospital workforce highlighted positive overall feedback in relation to the current staffing profile. In particular, staff articulated a positive approach to patient care, a proactive approach to staff and patient safety, the benefits and availability of training for Forensic Hospital staff and a positive perception of team work across all disciplines. The following areas were identified as key focus areas for review:

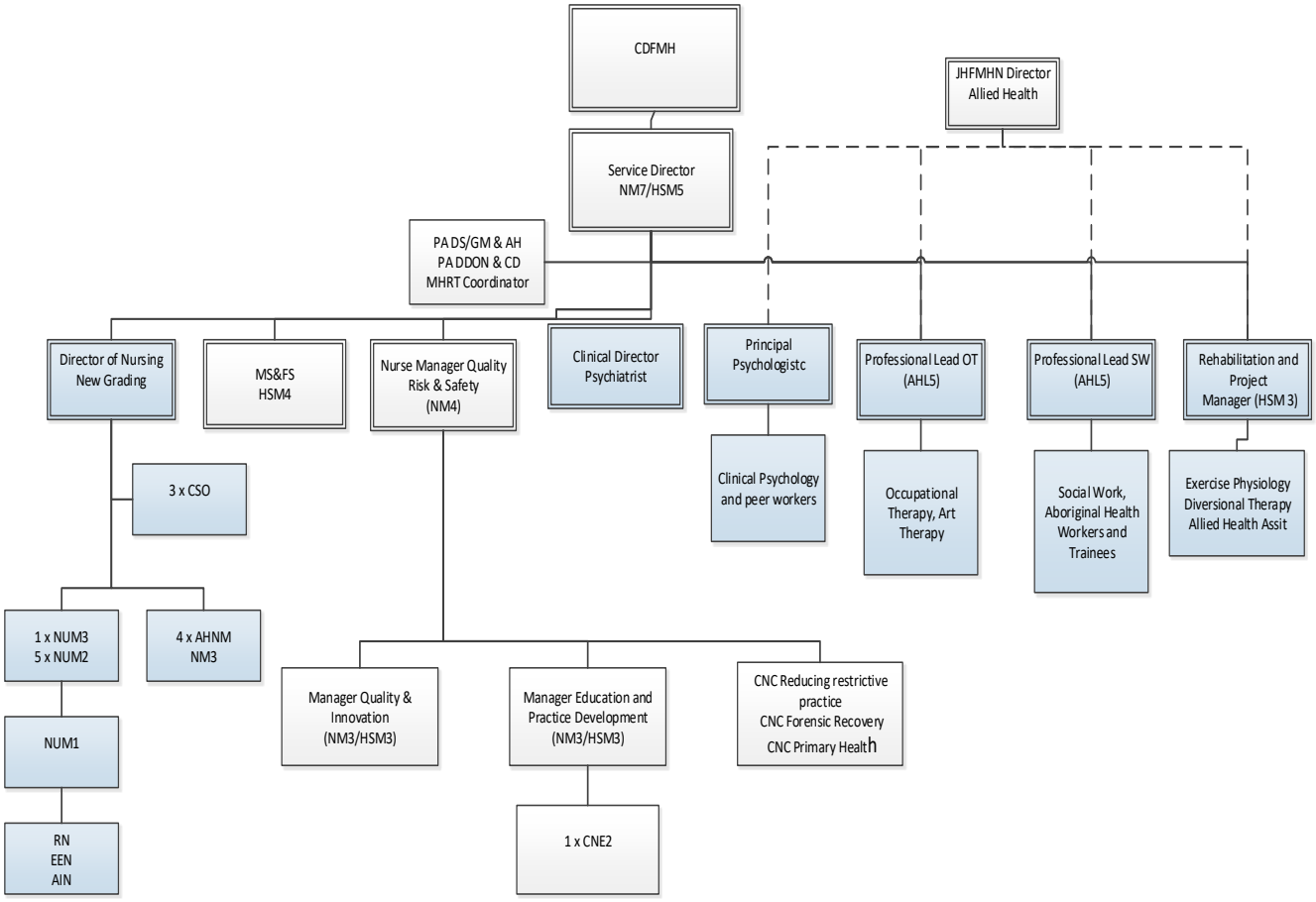
1. The need for a strong leadership structure;
2. Quality, safety and risk;
3. Role clarification;
4. The benefits a balanced MDT approach brings to patient care; and
5. Building a workforce of tomorrow, today.

The 2020 Staffing Profile review will assesses the current staffing structure and provide recommendations that can support patient care, future developments, and sustainability over the next ten (10) years.

The review focuses on Nursing, Allied Health and Administration staffing. Medical officers were excluded from this review.

Recommendation Options Senior Management

Senior Management Option 1 (SM1)



Key changes:

SM1 - Recommendation 1: Director Level (DNS)

Adjust the Director Nursing Services title to Service Director Forensic Hospital. The position could then be dual graded as a Nursing position and/or the equivalent Health Manager level.

SM1 - Recommendation 2: Senior Nurse Level (DDON):

In line with recommendation 1, adjust the Deputy Director Nursing to Director of Nursing Mental Health. This position would require re-grading and provide greater nursing leadership and governance.

SM1 - Recommendation 3: Senior Allied Health Level:

Repurpose the Manager Allied Health (MAH) position and promote current discipline seniors in Occupational Therapy, Social Work, and Clinical Psychology to the FH Senior Management team. The cost savings from repurposing the MAH role could be redirected towards increasing the Network Director of Allied Health position to full time, or providing more frontline clinical Allied Health staffing input. The grading will be set higher with the development of roles able to provide discipline guidance across the entire mental health and potentially network. The higher gradings also take into account the strategic and partnership building currently expected in these roles with key stakeholders such as education, Ministry of Health and Non-Government Organisations (NGOs).

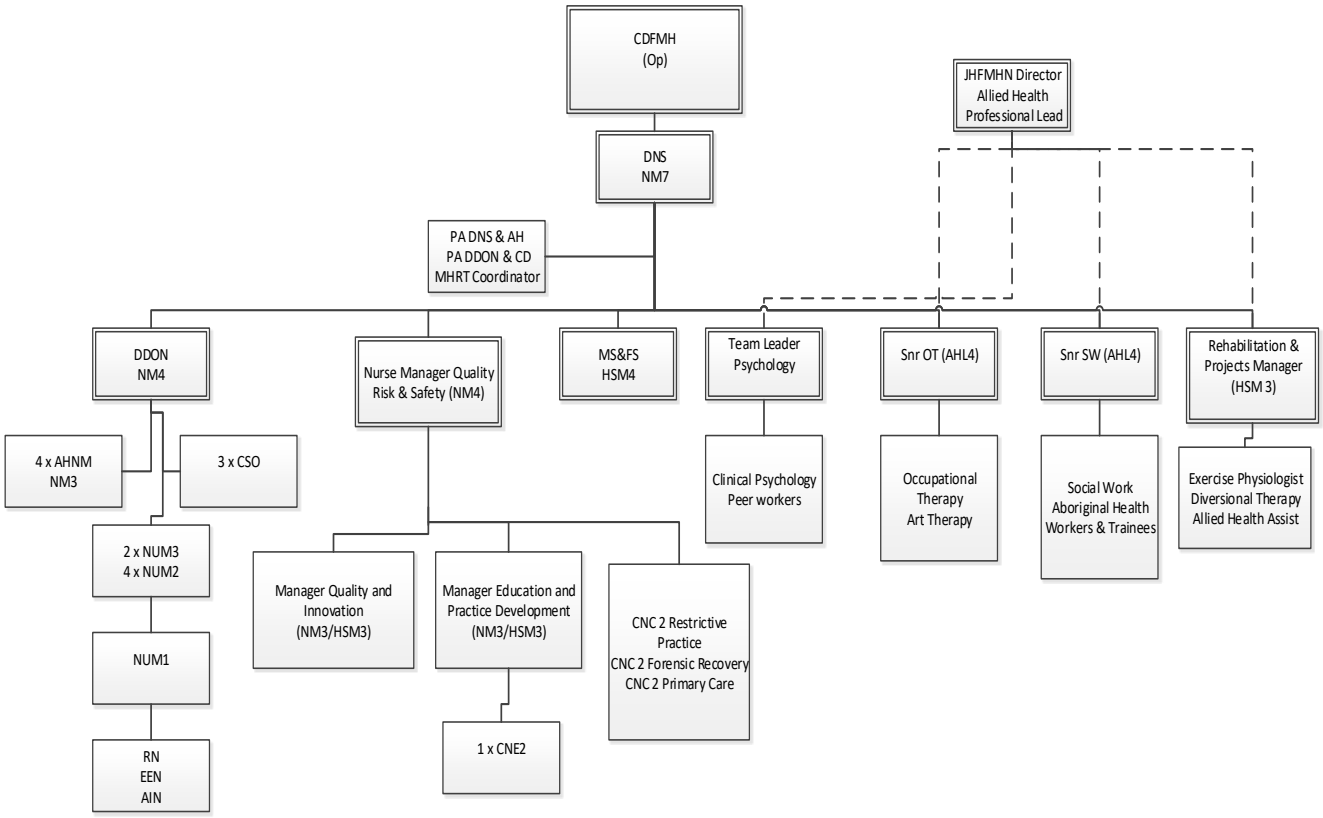
Roles adjusted from the proposed Allied Health Restructure are:

1. **Manager Allied Health**: Repurpose the funding for this position to promote discipline specific Allied Health Leads
2. **Principal Psychologist**: Heightened from Psychology Team Leader, to provide greater recognition and leadership for clinical psychology practice across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.
3. **Professional Lead – Occupational Therapy**: Heightened from Senior Occupational Therapist to provide greater recognition and leadership for Occupational Therapy across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.
4. **Professional Lead – Social Work**: Heightened from Senior Social Worker to provide greater recognition and leadership for Occupational Therapy across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.

SM1 - Recommendation 4: Governance, Quality, Innovation, Safety (NM4/3/CNC):

The Nurse Manager Staff Safety and Restrictive Practices (NMSSR) role be made permanent, with repurposing of the CNC3 role to contribute funding to this position. The NMSSR position can also function as a Deputy Director of Nursing. Adjusting the CNC positions will support the consultation theme of "role clarity" and help offset the costs. Repurpose 1 CNC2 position to create a Manager Safety and Quality, this could be dual graded.

Senior Management Option 2 (SM2)



Key changes:

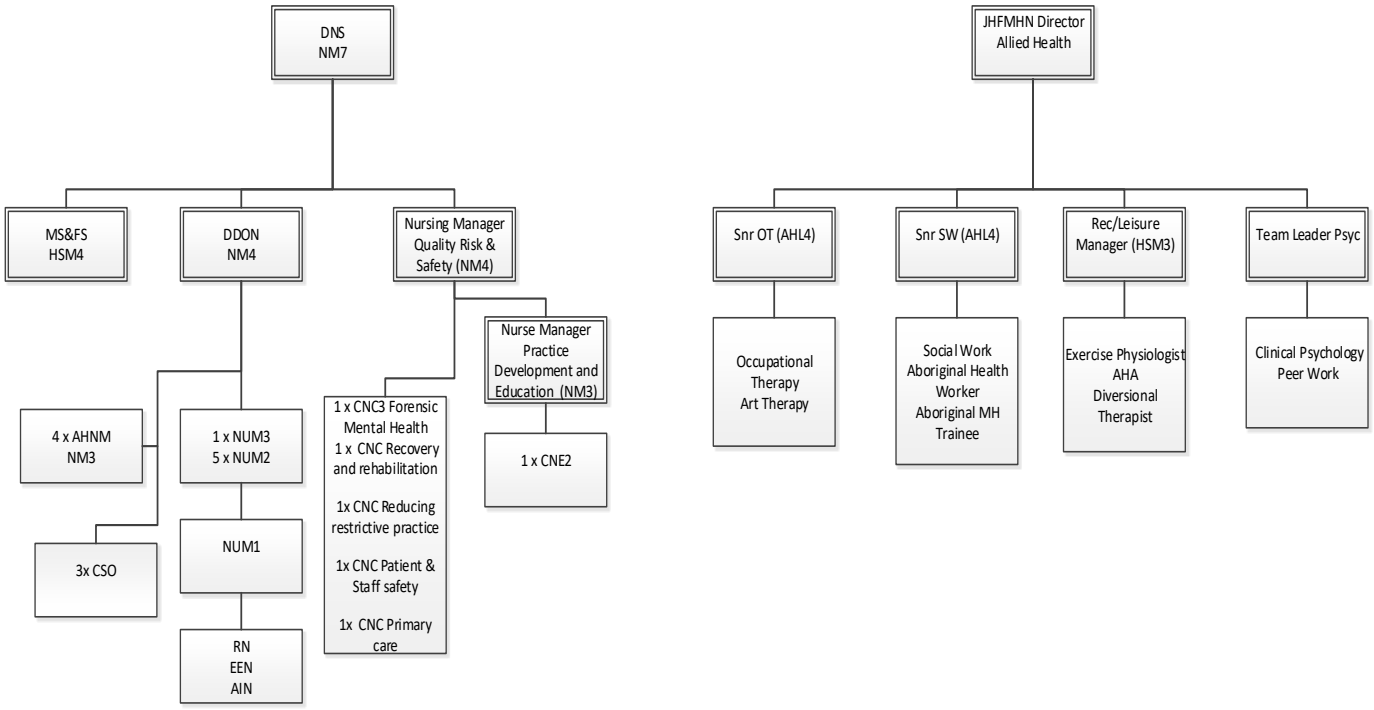
SM2: Allied Health Leadership

Repurpose the Manager Allied Health (MAH) position and promote current discipline seniors in Occupational Therapy, Social Work, and Clinical Psychology to the FH Senior Management team. The cost savings from the MAH should be redirected towards new graduate positions to improve the capacity of the seniors to take on operational duties. Discipline seniors would be specific to the Forensic Hospital.

SM2 - Recommendation 4: Governance, Quality, Innovation, Safety (NM4/3/CNC):

To make the Nurse Manager Staff Safety and Restrictive Practices (NMSSR) permanent, repurpose the CNC3 to contribute funding to this position. The NMSSR position can also function as a Deputy Director of Nursing. Adjusting the CNC positions will support the consultation theme of "role clarity" and help offset the costs. Repurpose 1 CNC2 position to create a Manager Safety and Quality, this could be dual graded.

Senior Management Option 3 (SM3)



Key Changes:

Recommendation 1: JHFMHN Director Allied Health enhancement

This structure would see the repurposing of the MAH position to increase the Director Allied Health role to full time. Operational management of Forensic Hospital Mental Health Allied Health staff would move outside the Forensic Hospital under the Director Allied Health. The four (4) senior disciplines and the Director Allied Health would all be part of the senior management meetings.

Recommendation 2: Forensic Hospital Senior Management Position

The majority of senior management positions would remain Nursing.

Key Considerations for SM3:

For this to be successful a robust model of care and referral criteria would need to be established, including:

- Alignment to future JHFMHN clinical service needs and directions.

- Referral criteria that is focused on patient needs, their journey and targeted at people who will likely require a Forensic Hospital bed.
- Alignment to the specifics of each disciplines scope of practice which would require education to a number of services.
- Specific to mental health initially with an evaluation at twelve (12) months to ensure suitability and value for money.

Recommendations specific to Nursing

Nursing 1: **Role Clarification of Registered Nurses.**

Clarify the roles and responsibilities of a Registered Nurse within the Forensic Hospital. This will drive patient centred care and expectations of staff.

Nursing 2: Grading of Unit Managers is reviewed

The grading of the Unit Manager (NUM2/3) positions to be reviewed from the Grading committee. It is beneficial for positions and grading to reflect the expectations of the role.

Nursing 3: **NUM1 clinical lead for each day shift**

There is a NUM1 clinical lead for each day shift across the site which should be aligned and structured in a way that is consistent and allows for suitable leave coverage. This approach acknowledges the risk carried by clinical leads in this setting.

Nursing 4: Endorsed Enrolled Nursing workforce up to 20% of the total Nursing workforce

Develop systems and structures to grow the Endorsed Enrolled Nursing workforce up to 20% of the total Nursing workforce. This is in line with comparable Forensic Mental Health Hospitals across the Australia and provides cost savings to fund career pathways aimed at increasing the Aboriginal Workforce development.

Nursing 5: Mental Health Care Worker role to be aligned to their Allied Health Assistant Award

The Mental Health Care Worker role to be aligned to their Allied Health Assistant Award, which states they are supervised by Allied Health staff who can oversee competencies and greater supervision and support.

Nursing 6: Introduction of an Assistants in Nursing workforce

The introduction of an Assistants in Nursing (AIN) workforce to support Nursing duties seven days per week. This workforce releases time to care for registered nurses and provides a strategy for increasing the Aboriginal Workforce through apprenticeship style programs designed to “Close the Gap”.

Nursing 7:

A review of the roles and responsibilities of After Hours Nurse Manager team to be undertaken to provide greater engagement in governance and strategic direction.

Nursing 8: Nurse Manager Staff Safety and Restrictive Practices made permanent

The current temporary Nurse Manager Staff Safety and Restrictive Practices made permanent, with line management of the CNC team and Nurse Manager Education and Practice Development positions, and proposed Manager Quality and Patient Safety, by repurposing the CNC3. This position should be strategically focused with practical application driven by the team it manages.

Nursing 9: Refocus two of the CNC2 portfolios

Refocus two (2) of the CNC2 portfolios to Physical health, Restrictive Practices and Forensic Recovery. These positions would work across the hospital and embed the principles and practice across all units.

Nursing 10: **Repurpose a CNC 2 position**

Repurpose a CNC2 position into a dual graded health manager position which focuses on Quality and Patient safety. This is in line with consultation and previous reports recommending greater role delineation and provides a governance structure adaptable for future growth.

Nursing 11: Proposed nursing structure

The proposed clinical nursing structure outlined by this report should be submitted for further consultation with the JHFMHN Workforce and the New South Wales Nurses and Midwives Association. (See page 46 – 49)

Recommendations specific to Allied Health

Allied Health Recommendation 1: Removal of flat structure

A career stepped model from transition year to senior clinician should be considered to help reduce the staffing exodus. The structure should include 2.0 FTE of senior clinicians in the professions of Clinical Psychology, Social Work, and Occupational Therapy representing the core Allied Health professions. There should be 1.0 FTE of senior diversional therapy and art therapy to reflect pathways for these professions. A stepped pathway should be available for Aboriginal and Peer workers.

Allied Health Recommendation 2: Allied Health Unit Profile

Each unit should have an Allied Health 1.0 FTE Build with the following professions: Clinical Psychologist, Occupational Therapist, Social Worker, Diversional Therapist, and a Peer worker. Acute care units Bronte, Adolescents, and Women's should have a designated Art Therapist.

Allied Health Recommendation 3: Allied Health Assistants

As noted above in the Nursing Recommendations the repurposing of Mental Health Care Worker positions in line with their award to Allied Health Assistants and movement of reporting to Allied Health is recommended. This adjustment will enable more tailored program delivery and a workforce capable of delivering activities across 7 days a week. This recommendation in particular relates to a patient who was required to complete the CALM group, but due to staffing issues the group did not proceed and his medium secure referral was delayed.

Allied Health Recommendation 4: Recreation Hall Staff Member

Ensure positions are specific to the required expertise, adjusting the recreation hall staff member from diversional therapist to an exercise physiologist. This recommendation would better support tailored specific exercise programs that can improve the physical health needs of patients in line with current NSW Health guidelines.

Recommendations Administration Staff

Administration Recommendation 1: Ward Clerks:

1. A review of the duties undertaken by Ward Clerks and Clinical Support Officers to ensure clarity of role and alignment with 'The Garling Report'.
2. As per Schedule 1 of the Health Employees Conditions of Employment (State) Award 2019, 'employees working in areas accommodating psychiatric patients shall be paid as set out in

Item 39 of Table 1 per hour whilst so engaged.' The position is required to have direct and indirect contact with Forensic patients throughout each shift as they assist clinical staff in all aspects of support within the FH, therefore the environmental allowance should be added to the award.

Administration Recommendation 2: Personal Assistant to the Director of Nursing and Services (PA DNS):

1. It is recommended that the PA DNS position include the environmental allowance. Due to the position not incorporating the environmental allowance, there is no salary increase for staff on an Administration Officer Level 3 Award. Due to this reason, staff are not inclined to take on such a senior administration role, without a salary increase. Leaving the position without leave cover.

Administration Recommendation 3: Personal Assistant to the Clinical Director Forensic Hospital and Deputy Director of Nursing (PA to CDFH/DDON).

1. It is recommended that the position include the environmental allowance in line with PA DNS recommendation 2.
2. It is recommended that the position be regraded at an AO6. On review of the Administration State Award, it is identified that the position has been inappropriately graded as an AO5. It is recommended that this position be regraded to an AO6.

Administration Recommendation 4: PAS Inpatient Clerk position.

1. It is recommended that the position be regraded from an AO4 to an AO3 and be retitled as a CSO. Additional duties such as patient purchasing, leave relief provision and administration support to Medical Officers to be added to the position description. This role was identified as being inappropriately titled and having scope for additional duties in the Forensic Hospital.

Administration Recommendation 5: The MHRT Liaison and Report Coordinator position

1. It is recommended that the position be renamed to MHRT Liaison and Allied Health Administration Officer, with the position description is to be updated.
2. It is recommended that the position include the environmental allowance in line with PA DNS recommendation 2.

Contents

Introduction

This is a report on the review of the Forensic Hospital Staffing Profile. It should be read in conjunction with specified policies, procedures, position descriptions and relevant State Awards.

The Forensic Hospital Staffing Profile Review (Review) has been conducted to ensure the management of current resources is efficient and effectively providing evidenced based practice to our patients. This Review will ensure that the Forensic Hospital is providing best practice services to all patients and that the staffing of the hospital meets the ever-changing needs of our patient cohort

in line with service provision expansion seen in its first eleven (11) years of operation. An example of the changing needs of the Forensic and High Risk Civil Patient cohort is the proposed Freshwater Mental Health Intensive Care Unit set to be built and opened in late 2021. The Review is supported by senior managers and executive of the Network, placing the organisation as a leader in providing excellence in Forensic Mental Health Services both within Australia and internationally. Since inception of the Forensic Hospital a staffing profile review has not been conducted.

The Review has been conducted to ensure that the Forensic Hospital is providing excellence in Forensic Mental Health in line with comparable services in other Australian jurisdictions. Comparisons have been made with similar services to benchmark and identify possible changes to the services offered to the NSW Forensic Patient cohort.

The recommendations in this Report align with the Strategic Directions of the Justice Health and Forensic Mental Health Network (JHFMHN) Strategic Plan: 2018- 2022

Strategic Direction 1: Provide a values-based, quality model of care

Strategic Direction 2: Engage with community and key stakeholders through strong partnerships

Strategic Direction 3: Attract, grow and retain a talented workforce and foster a safe working environment

Strategic Direction 4: Position the organisation to effectively operate in a changing environment

The focus of the Report is on collating information gathered from a wide range of staffing consultation, development of recommendations and an implementation plan. This Report will also form the basis for the scoping of potential future research. The JHFMHN Research Unit has approval for any information collected throughout this Review to be utilised for potential research projects and publications.

The Forensic Hospital

The Forensic Hospital provides specialist state-wide mental health care for mentally ill patients who have been in contact with the criminal justice system and high risk civil patients. The patient demographic consists of those found not guilty by reason of mental illness, those unfit to plead, mentally disordered offenders or those at risk of offending. The patients of the Forensic Hospital have been ordered into the care of the Network underneath the *Mental Health Act 2007 (NSW)* and *the Mental Health (Forensic Provisions) Act 1990.* The Mental Health Review Tribunal, specialist quasi-judicial body constituted under the Mental Health Act 2007 (Mental Health Review Tribunal - The Tribunal, 2020) having legislative oversight and can make legal orders in relation to the movements of the Forensic Hospital patient cohort.

This is operationalised by the current staffing full time equivalent structure of the Forensic Hospital as of 1 October 2020 is described in table one below.

Table One: Forensic Hospital staffing demographics described by the current year to date total full time equivalent (FTE) average and staff member headcount**.*

*(*FTE – the total number of positions that are funded in the Forensic Hospital budget; ** - the total number of staff members that are employed at the Forensic Hospital, making up the FTE positions.)*

Award Codes	Year to date Average Full Time Equivalent	Year to date Staff Headcount
Award Codes Total	305	300
Medical	27	24

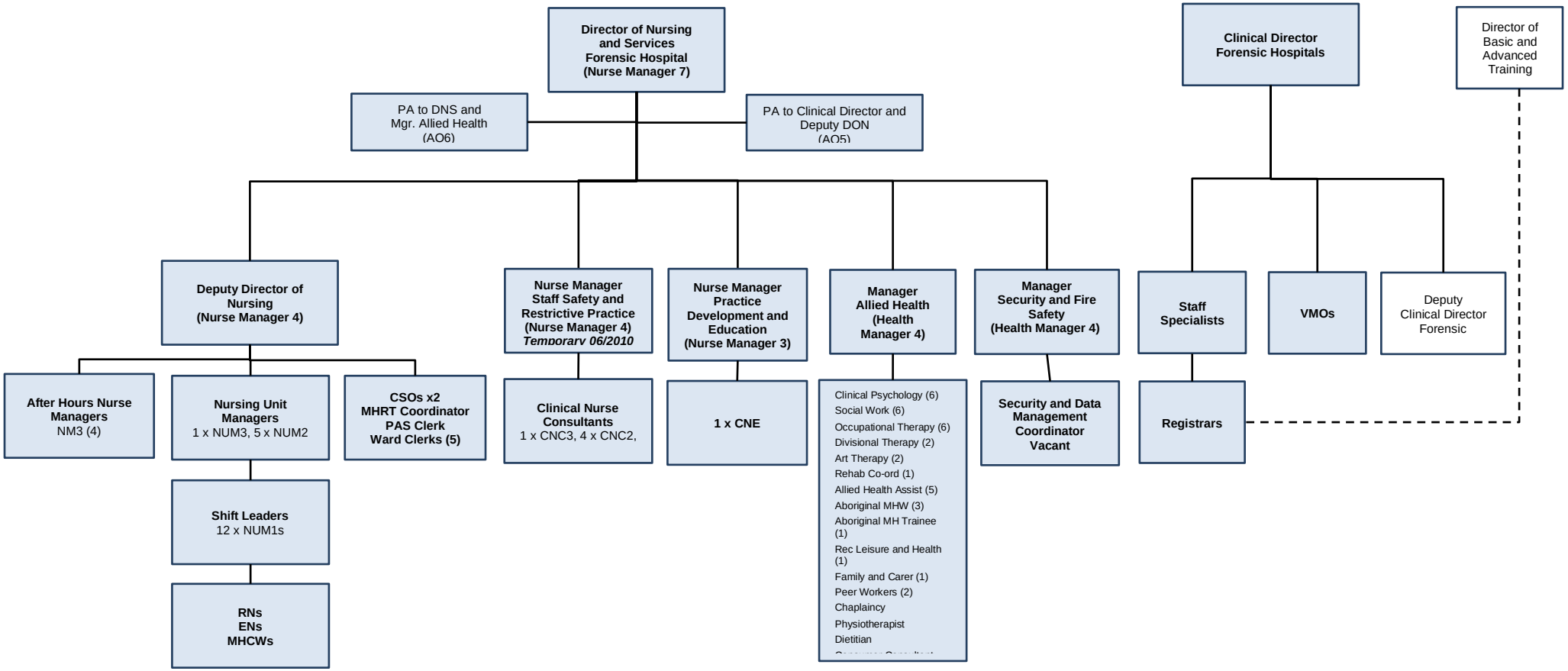
Nursing	226	221
Assistant in Nursing	0	0
Registered Nurse	216	213
Enrolled Nurse	10.0	8.0
Allied Health	23	26
Social Worker	5.9	6.0
Psychologists	6.3	9.0
Art Therapist	2.1	2.0
Diversional Therapist	2.6	3.0
Occupational Therapist	6.0	6.0
Other Professionals, Paraprofessionals and Support Staff	2.3	4.0
Health Education Officers	2.3	3.0
Aboriginal Health	1.0	1.0
Scientific and Technical Clinical Support Staff	12	11
Allied Health Assistants	11	11
Technical Aides/Assistants	0.7	0.0
Corporate Services and Hospital Support	14	14
Ward Clerks and Administration Staff	9.7	10
Health Service Managers	4.2	4.0

The units in the hospital cater for adults and young people. Both male and female patients are admitted across the Forensic Hospital in the following capacity dependent upon their associated risks, current Mental Health presentation, gender, and age:

- Austinmer Women's (17 bed Acute Female unit)
- Austinmer Adolescent (6 bed Acute Adolescent unit)
- Bronte Male Admission (33 bed Acute Male Admission unit, 25 beds currently open)
- Clovelly (27 bed Extended Care unit)
- Dee Why (32 bed Long Stay unit)
- Elouera (20 bed Rehabilitation unit)
- Freshwater (5 bed, state-wide Tier Two Mental Health Intensive Care unit, not yet operational, proposed to open in late 2021)

Organisational Chart

(1 November 2020)



Patient Demographics

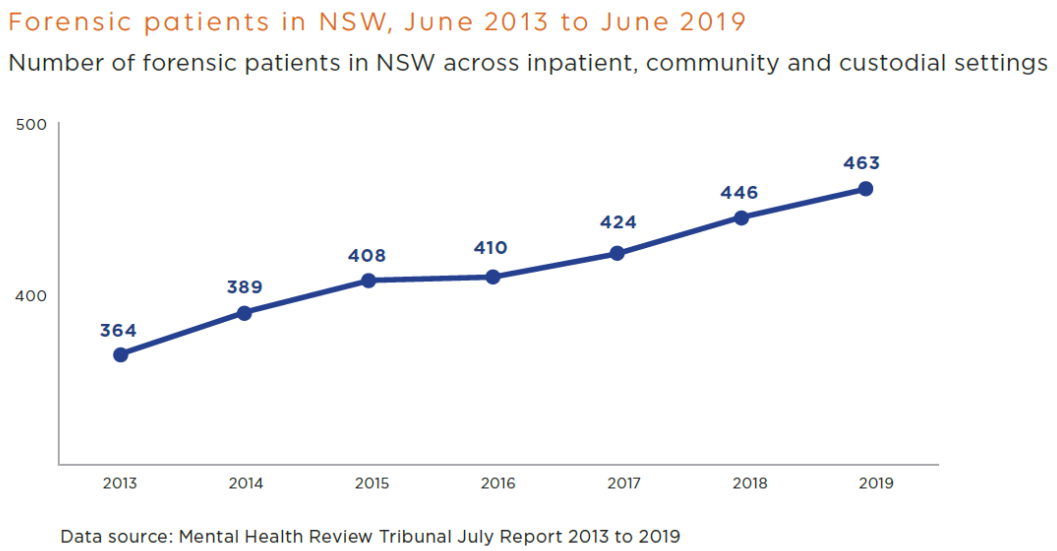


Figure One: Graphic representation of the increased Forensic patient population in New South Wales.

As of the 2019/20 financial year the Forensic Hospital on average provided care across the lifespan of Forensic patients with a wide range of complex needs, with an average bed occupancy rate of the hospital being 95.2% (see table two below). At the time of writing (19 October 2020) the current Forensic Hospital had an average age of 43 years 3 months (Range: 15 years 6 months – 67 years 8 months). Average length of stay for a patients in the Forensic Hospital in the period of 1 July 2015 is 30 June 2020 is described in Table Three below for Adolescents, Adult Female and Adult Male patients.

Table 2: Forensic Hospital occupancy rate for the 2019/2020 financial year.

*(*Austinmer Adolescents occupancy rate for this time period was low due to refurbishment)*

Unit	Occupied Bed Days/Available Bed Days	Bed Occupancy Percentage
Austinmer Adolescents*	1153/2196	52.5%
Austinmer Women's	5794/6222	93.1%
Bronte	8904/9150	97.3%
Clovelly	9620/9882	97.3%

Dee Why	11522/11712	98.4%
Elouera	7271/7320	99.3%
Forensic Hospital	44264/46482	95.2%

Table 3: Forensic Hospital total number of patient discharges, total days spent in the hospital, average length of stay and ALOS range.

Unit	No. Discharges	Total days	Average length of stay (ALOS) (Days)	Range (Days)
Young Persons	70	7 026	100.4	9-830
Adult Females	33	27 804	842.5	15-3402
Adult Males	101	166 928	2058.5	22-4044

A 2016 Forensic Mental Health Patient Survey Report (Justice Health and Forensic Mental Health Network, 2018) reported the following key findings (*see figure two*) in regards to the NSW Forensic patients (n=108):

- 17% of patients are Aboriginal;
- 93% are male;
- The most frequently recorded diagnosis is schizophrenia with 65%, with a strong personality pathology
- 65% have a background of trauma.
- Most common index offences were murder (40.7%), assault resulting in serious injury (15.7%), aggravated assault (14.8%), and aggravated robbery (8.3%);
- 55% have a history of head injury, increasing their treatment complexity and treatment needs;
- 79% of patients self-reported ever using illicit drugs or misusing pharmaceuticals;
- 75% of patients self-reported having experienced or witnessed at least one traumatic event;
- 23% have experienced sexual assault and 21% have been physically attacked across their lifetime;
- 26% of patents have an IQ in the extremely low range and 39% have difficulty reading and/or writing English;
- High Cholesterol is the highest health problem reported at 37%, memory problems at 26%, chronic back, neck or other pain.
- 71% of patients reported having past suicidal thoughts and 52% have attempted suicide in the past.

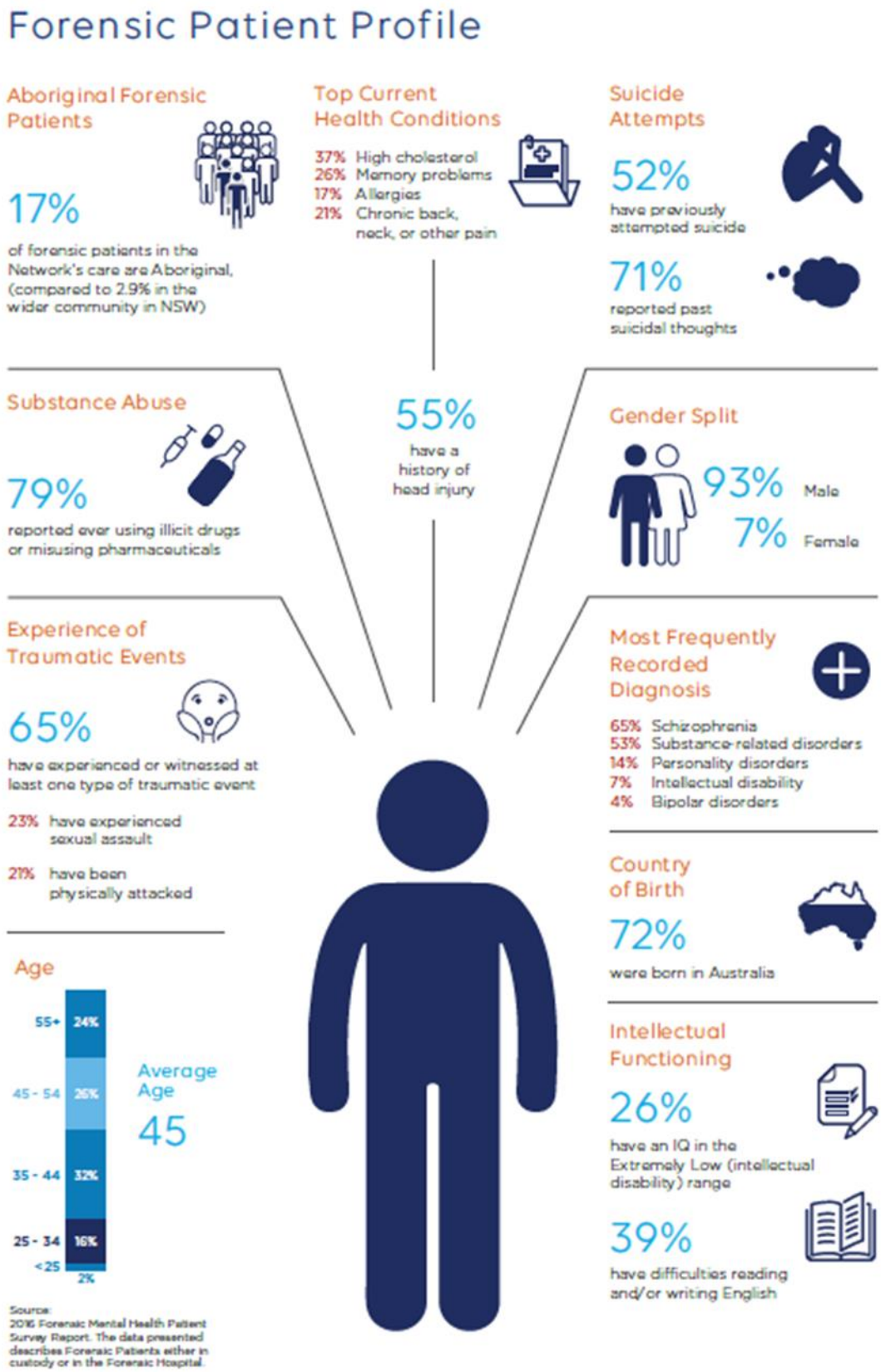


Figure 2: Visual representation of the key patient demographic finding from the 2016 Forensic Mental Health Patient Survey Report (Justice Health and Forensic Mental Health Network, 2019).

In comparison to the general population the Forensic patient population in New South Wales, patients who identify as being Indigenous are disproportionately over represented within this cohort. At the time of writing this report 13% of the Forensic Hospital patient population identified as being of Aboriginal or Torres Strait Islander heritage. Further to this overrepresentation in the Forensic patient population, the Forensic Hospital has a high number of patients who are from a CALD background.

Further complicating the Forensic Hospital meeting the health needs of its patient population is the Network service structure. This structure means that a lot of primary health clinics are provided to the patients dependent on clinically identified referral lists from other specialist teams as part of the Network. Clinic waitlist numbers are consistently high and the number of days a patient waits to see a specialist exceeds the recommended days for the Network to provide sufficient treatment to the patient cohort. Table Four shows the waitlists as of 11 October 2020. Improved physical health care is a priority of NSW Health and included in the Living Well Document and Physical Health care of Mental Health consumers guidelines[1].

Table 4: Data on waitlists for Forensic Hospital patients to gain access to other health care services offered externally.

Clinic	Number of patients on waitlist	Least number of days on waitlist	Most number of days on waitlist	Average days on waitlist
Primary Health	282	0	1607	39
Population Health	34	0	1448	267
Women's Health	19	3	1333	248
Dietician	84	471	1534	101
Optometrist	172	0	557	98
Podiatrist	169	0	424	97
Dentist	2	93	110	102

Data source: Patient Administration System (PAS) Forensic Hospital

Profile Review Team

The review team was appointed by Ms Wendy Hoey, Executive Director of Clinical Operations, JHFMHN, and driven by key internal Forensic Hospital staff members as supports to external reviewers.

The review team members were chosen to provide representation across all staff disciplines within scope of the review (medical staff were excluded) with the external reviewers from similar services in other Australian jurisdictions. The roles of the Forensic Hospital Staffing Profile review are clearly

[1] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_019.pdf

outlined in the Terms of Reference (Appendix 1) for the review. Consultation with a range of key people including the Director of Allied Health Kath Jones, A/Co-Director Forensic Mental Health (Operations) Jason Sevil, and Clinical Director Dr Andrew Ellis all of which have key involvement in the clinical and operational management of this facility.

The reviewers appointed to conduct the Forensic Staffing Profile Review are:

External Reviewers:

Dr Fiona Black, Director of Psychology, West Moreton Health, Queensland Health

Jo Ryan, Executive Director of Nursing, Forensicare, Melbourne, Victoria

Natalie Ricks, Clinical Integration Manager, Clinical Improvement Unit, JHFMHN

Internal Reviewers:

Kevin Baron, A/Director of Nursing and Services, Forensic Hospital, JHFMHN

Kevin Brown, Manager Allied Health, Forensic Hospital, JHFMHN

Scott Gill, A/Rehabilitation Coordinator, Forensic Hospital, JHFMHN

It must be acknowledged that the three (3) internal reviewers of the Forensic Hospital have the potential for their own positions to be impacted by this review or perceived bias as current staff members. The external reviewer(s), have been consulted at every stage of the review process and have final oversight of the document. The external reviewer(s) declare(s) that there is no conflict of interest.

Methodology of Review

The profile review terms of reference scope included Nursing, Allied Health and Administration staff of the Forensic Hospital. Medical staff were out of scope for this review although it is acknowledged that some mentioning of medical staff would be made through exploring the Administration staffing profile.

All positions within scope in the Forensic Hospital have been reviewed in conjunction with position descriptions, and in consultation of current staff members in their respective positions and their direct line manager. Due to COVID-19 restrictions these reviews were conducted via Video Conferencing (PEXIP) and other suitable methods of consultation with all staff in scope of the Review.

Key Stakeholder Consultation:

A consultation plan involving key stakeholders including consumers, staff, and management was developed. Key questions for these stakeholders were designed to target consumer care and safety; staff safety and the working environment; and perspectives on how to position the Forensic Hospital for the future. (See appendix 7 Staff Consultation Plan).

Industrial bodies:

Industrial bodies Health Services Union (HSU), New South Wales Nursing and Midwifes' Association (NSWNMA), and Australian Salaried Medical Officers' Federation (ASMOF) were notified formal notification was sent on Thursday 16 July 2020. This notification provided these industrial bodies with copies of the finalised terms of reference, consultation plan, posed staff consultation questions and the staff notification email sent by the Director of Nursing and Services. Industrial bodies were invited to provide their feedback on the review process (See *Appendix 9* Industrial bodies' communication).

Further consultation with industrial bodies HSU, NSWNMA, Australian Salaried Medical Officers' Federation (ASMOF) will ensue following receipt and acceptance of review recommendations by the Network executives.

Analysis and Recommendations

Forensic Hospital Staffing Background:

Since the Forensic Hospital's inception and opening in 2008, there has been significant expansion in the provision of services and level of care provided to Forensic Hospital patients.

Since the Forensic Hospital opened, the hospitals patient cohort has needed an increased level of interventions and assessments related to their physical health needs. A 2016 *Forensic Mental Health Patient Survey Report* (Justice Health and Forensic Mental Health Network, 2018) highlighted the increasing prevalence of primary health conditions within the Forensic population. The top four conditions reported were; (1) high cholesterol (37.1%); (2) memory problems (25.7%); (3) chronic back, neck or other pain (21.0%) and; (4) other conditions including hyperthyroidism and obesity (29.5%). Forensic consumers surveyed (n = 105) 69.6% had one to two primary health diagnoses with 32.4% having three to four compared to the other patient groups (n=20) having 45% and 5% respectively. Other key Physical Health findings from this study include: 18.7% of participants reported difficulties keeping up with their daily activities and 48.8% of participants had a body mass index (BMI) above 30 (obese), with an additional 29.5% in the overweight range. This has resulted in an increase on the Forensic Hospital nursing teams' responsibilities to match the needs of the patients. These responsibilities include but are not limited to patient escorts and bed sits at other hospitals to provide the appropriate care for the patients. Forensic Hospital policy states that a minimum of two staff members (usually RN's and dependent on the patients scale) need to provide these ad-hoc escorts, therefore contributing to a significant to the hospital in staffing over-time costs.

An example of the increased service expansion can be shown through the development of the Centralised Group Program. The Forensic Hospital has seen an exponential increase in the delivery of therapeutic programs in the hospital since the inception of the program in 2013. The Centralised Group Program currently provides 36 different groups to the patients, with groups being facilitated on a hospital-wide, clinically identified referral basis. The Centralised Group Program is predominantly facilitated by the allied health staff across the hospital. Groups address six out of seven DUNDRUM-3 programme completion items and all of the DUNDRUM-4 recovery items. This particular program has organically grown in size and now offers 2317 occasions of service to the hospital's patients each year. A 2019 review of the Centralised Group Program highlighted a number of areas for improvement. As of the 9 October 2020 367 individual waiting lists entries, representing Forensic Hospital patients referred to the Centralised Group Program were on the waiting list to access the program. The current average waiting time for a patients to access a program as part of the Centralised Group Program is 217* days (least number = 0 days, greatest number = 700 days, *it

must be noted that waiting times were not recorded prior to October 2018. It is also important to highlight that the greatest number of days being 700 is a combination of the clinical need being unmet, staffing changes occurring resulting in the cessation of programs and inappropriate referrals being made). This number helps the review team to illustrate some of the problems being experienced in meeting the clinically identified needs of the patients. Currently an established working party is working through the recommendations raised in the 2018 review, inclusive of improving internal Forensic Hospital processes to address waiting times.

Service provision growth can also be seen in the change of the Forensic Hospitals leave policy. This change has now seen an increase in the number of therapeutic leaves facilitated for patients and the implementation of compassionate leave for patients in the hospital. These sessions are individually designed for the patient, to expose them to activities of daily living in the community, allow clinical staff to access these patients in the community and to enable the patient to build the necessary skills for a successful reintegration into society. Further to this, over the past two years the Forensic Hospital facilitated 10 episodes of compassionate leave for patients. These episodes of leave involved a minimum number of three staff to facilitate each leave and afforded patients the opportunity to see a close member of family in a time of need. Even though the number of compassionate leave sessions is relatively low, it is a key indicator of the Forensic Hospital evolving to meet the needs of the patients, whilst also displaying the principals of the Human Rights Acts currently legislated in other Australian jurisdictions (ACT, Victoria and Queensland).

Substantial effort and commitment to improving work place safety through the development of systems of support to reduce risk are paramount to ensuring the work health and safety of our staff. For the purpose of this review, risk will be defined as any potential incident that may lead to the potential for an individual to cause harm to their self or others and staff members who may experience occupational violence. The types of risks prevalent within a Forensic patient populations are inherent with these risks being multi-model and complex in nature. To minimise these risks a sophisticated management strategy was implemented, needing to be continually improved and at the forefront of new emerging technologies. Examples of ways to minimise these potential risks are evident through the increased staffing numbers in the Forensic Hospital in line with the Therapeutic security model, violence prevention and management and environmental security measures implemented in the hospital.

In 2017, it was highlighted that a high staffing vacancy rate and overtime costs were impacting on work place safety and a consistent Forensic Hospital budget overspend. Chaplow, D.G., et al. (2017), highlighted that the Forensic Hospital nursing staff were being utilised to focus on security within the hospital and not completing nursing specific tasks. The combination of a high staffing vacancy rate coupled with a focus on providing security had the potential to cause increased staff burn out, turnover and exposure to distressing situations leading to vicarious trauma. To mitigate these issues the Forensic Hospital conducted a two year trial of an Allied Health Assistant and Mental Health Care Worker workforce in the hospital. Throughout the trial eight new staff members were recruited to the Forensic Hospital to help address the following identified service deficits:

1. Inadequate time out of seclusion for two long term seclusion patients
2. High cancellation rates of the Centralised Group Program (CGP)
3. Clinicians' time being diverted from core clinical tasks to facilitate therapeutic groups

Following the initial two year period a discussion paper (Ananin, D, et al., 2019) was prepared for the Network Executive. This paper highlighted the success of the trial in reducing seclusion rates, increased Centralised Group Program facilitation rates and redirection of clinical staff time to

discipline specific tasks. A recommendation of the discussion paper was to conduct a Forensic Hospital staffing profile review.

It must be noted that irrespective of the previous staffing recruitment issues, it is vital to the Forensic Hospital to focus upon the long term retention of its staff members. The Forensic Hospital staff are speciality trained Forensic mental health professionals, who are subject matter experts. Each discipline within the Forensic Hospital staffing profile have a specialist skill set enabling our patients to continue upon their rehabilitation pathways. This has been shown through the low recidivism rates of Forensic patients in NSW.

It is vital that the Forensic Hospital senior management and the Network executive focus upon the workforce, as NSW Health is currently facing an aging workforce along with a young transient workforce. This document addresses the needs to create and build pathways for new and potential future staff members through emerging workforces (i.e. assistants in nursing, endorsed enrolled nurses, allied health assistants and allied health discipline specific new graduate positions), creation of clear pathways for current staff to move into leaderships roles and create a sustainable structure for the current workforce.

Consumer Perspective

Feedback from the FH patients is invaluable. The reviewers gathered patient feedback through a group interview with the unit patient representative and the Consumer Consultant. It is acknowledged the important of having the patient voice in co-designing service delivery and pleasing to note the FH have a Consumer Advisory Committee (CAC).

The purpose of the Forensic Hospital CAC, is to provide patients the opportunity to authentically connect with the management team to raise concerns, ideas for innovation and provide feedback. Each unit has an elected representative who attends the monthly meeting bringing forward feedback or concerns from their respective unit. This committee was pivotal to acquiring the patient voice and their perceived needs for a future focused service.

The external reviewers posing two overall questions to the members of the committee, these being:

1. What will help you whilst you are here in the Forensic Hospital?
2. What can we do better to help you move on from the Forensic Hospital?

The patients were positive and engaged throughout this process and identified an overall high level of satisfaction with the current structure. Key positives included; high staffing numbers, the positive and caring nature of the Forensic Hospital staff, the number and variety therapeutic programs on offer and the step down model which adult male patients have as they move through the Forensic Hospital. The patients were very positive regarding the noted increase in patient access to activities and specifically highlighted the diversional input that Mental Health Care Workers and Allied Health Assistants have played in this. The Forensic Hospital patients unanimously articulated the value of being engaged in a robust therapeutic program, and particularly valued diversional and skill/knowledge development to aid mental health recovery and ready them for discharge.

Whilst the feedback was overall complimentary of the service, the patients highlighted five key service growth areas for the Forensic Hospital, these being:

1. Increased Access to targeted rehabilitation and therapeutic groups both within and outside the Forensic Hospital;
2. Increased access to clinician time;
3. Increased access to education providers and Non-Government Organisations;

4. Austinmer Women's specific service barriers; and
5. Greater access to Aboriginal and Torres Strait Islander Culturally specific staff and services.

Patient Identified Service Growth Areas

The five key service growth priority from the Consumer Advisory Committee consultation will be discussed in greater detail below.

Key Growth Area 1: Increased Access to targeted rehabilitation and therapeutic groups both within and outside the Forensic Hospital.

Patients from across the FH identified the need and value of having a seven day therapeutic program to support their recovery. The patients highlighted that currently on weekends, the staffing profile is nursing dominant with nil other disciplines available to facilitate structured therapeutic programs. It was also identified that there is very limited capacity to engage patients in meaningful work or "unit jobs" to distract them from positive symptoms and build a sense of purpose whilst in the hospital.

The patients also raised issues with current wait times to access leave into the community. The Forensic Hospital offers therapeutic leave to patients who have been accepted to a medium secure unit. However, due to significant bed wait lists to MSU's, many patients may be ready to move onto a less secure setting but cannot. Therefore, having completed programs within the Forensic Hospital, their rehabilitation from a patient perspective stalls, as there is limited capacity to facilitate therapeutic leave, due to limited availability of staff and capacity of the hospital. Therapeutic leave is critical to exposing patients to evolving community services and technologies outside of the hospital, to ready them for the future. Patients also voiced their desire to access day leave, access work and community projects which in hand would enhance their rehabilitation and build their occupational capacity.

Key Growth Area 2: Increased access to clinician time

Our patients believe they would benefit from greater direct feedback from the care team regarding progress and barriers to their progress, as well as clarification of expectations, which would allow them to improve their insight and focus on key development areas. In doing so they could consolidate their understanding and direction of care, and cultivate personalised relapse prevention strategies.

Key Growth Area 3: Greater access to Non-Government Organisations and formalised education.

Forensic Hospital patients reported they really enjoyed access to TAFE programs such as OTEN (online) and face-to face courses provided by TAFE facility staff. The patients reported these programs assisted in meaningfully fulfilling their days, whilst allowing them to build vocational skills to ready them for the future. Adult patients in particular raised concerns that currently they are unable to access face-to-face TAFE courses.

The Adolescent patients in particular were concerned that there is currently no formal education available for them. Furthermore, Adolescents who have completed their Year 10 Cert- have no access to TAFE or courses to assist in gaining life skills e.g. obtaining a white card, their learner drivers licence etc.

The patients praised the hospital with the engagement of local NGOs to provide structured therapeutic programs in the hospital. For example the engagement of First Hand Solutions, a local Aboriginal Corporation to facilitate a Native Gardening and Bush Tucker group. The patients would like to see an expansion of the FH engagement with NGOs to provide a range of programs as they see the benefits that programs like this can provide.

Key Growth Area 4: Austinmer Women's specific service barriers

FH Patient consultation discussed the limitations of Austinmer Women's unit are compounded by all female patients being in one unit. The female patients have a sense of reduced access to services compared to the male patients. For example, patients on the Elouera unit have access to a structured cooking program, allowing them to build necessary skills to cook essential meals each day, increasing their ability to become self-sufficient whilst concurrently increasing their functionality for activities of daily living.

Key Growth Area 5: Greater access to Aboriginal and Torres Strait Islander Culturally specific staff and services.

A common theme that our Aboriginal and Torres Strait Islander patients identified as being important, was connection to culture and the maintenance, development and nurturing of their cultural identity. There has been some growth in the Forensic Hospitals Aboriginal and Torres Strait Islander workforce and this has been extremely beneficial to our patient cohort. Consequently, there continues to be an unmet need with limited cultural activities and the ability to access these activities. Suggestions included yarning groups, didgeridoo groups, and access to Aboriginal Elders, Koori music, dance and native gardening. Furthermore, it is also felt that external therapeutic leave opportunities could be expanded to consider participation in cultural activities and opportunity to participate and give back to the local community and Aboriginal cultural community initiatives.

Workforce Perspective

Extensive consultation across all Forensic Hospital disciplines took place over a two week period. Throughout these consultation session's benefits of the current Forensic Hospital staffing profile were highlighted through the total number of staffing resources that are currently available, the proactive approach to staff and patient safety, training on offer to Forensic Hospital staff and invaluable team work seen between disciplines to enhance patient care. It is important to note that these listed benefits have allowed the Forensic Hospital to substantially grow its service provision since is opening in 2009. A multitude of changes have occurred, improving the services offered along with innovation to further expand these services. In particular, Forensic Hospital staff have been resilient with the changing acuity of Forensic patients and actively engaging with both patients and carers to provide patient focused care. Being the sole high secure Forensic facility in the state, there is pressure on the hospital staff to go above and beyond to provide this excellence in forensic mental health care.

The workforce consultation highlighted a number of key themes which include:

1. The need for a strong leadership structure
2. Quality, safety and risk
3. Role Clarification
4. The benefits a balanced MDT approach brings to patient care.
5. Building a workforce of tomorrow, today.

The need for a strong leadership structure (1)

Across the hospital it was noted that the Forensic Hospital needs to ensure that it has a strong leadership structure across all areas. Allowing a strong leadership structure to be continued in the Forensic Hospital creates improved clinical excellence along with a strong culture. Continuing to provide, establish and engrain a positive, safe and innovative culture in the Forensic Hospital has been the focus, as the unique environment can be a high stress environment. Strong leadership allows staff to seek and receive necessary help to improve their clinical interactions. Further, this creates an environment where staff are able to have a rewarding career in NSW Health.

Consultation with staff members was highlighted as a clear need across the hospital. The current structure provides staff with opportunities to develop leadership skills and move into leadership roles within the Forensic Hospital. However, the current structure also has barriers to providing clear leadership to staff and in some streams a lack of leadership positions exist. Exacerbating these barriers, is the lack of role clarification, job creep and appropriately graded positions.

Discussions with the Allied Health seniors highlighted the lack of discipline representation in the Forensic Hospital. Bench marking with other NSW mental health services and forensic services in other jurisdictions, shows the need for a stronger Allied Health senior structure to be implemented in the Forensic Hospital. This can be achieved through the repurposing of the Manager Allied Health role to fund an increase in the three main Allied Health streams and the creation of a Leisure and Recreation stream creating a greater voice for each discipline at the senior management level, and diversifying the senior leadership team.

Quality, safety and risk (2)

The Forensic Hospital is committed to ensuring that patients receive reliable, safe, quality care, every time. In the years proceeding this review, the Forensic Hospital had undergone a rapid period of change driven and focused on staff and patient safety. The goal being to create a culture of safety; thus preventing patient harm, preventing staff harm, ensuring reliability and improving the quality of outcomes. Cultures of safety don't merely encourage people to work towards change, they take action when needed and commitment to change. Throughout the consultation there was broad recognition of the Forensic Hospital's investment to foster this change.

Changing and maintaining positive workplace culture is one of the hardest leadership challenges. In order to be successful, it requires investment and the right people with the right skills leading. Feedback throughout the consultation process was consistent with this, particularly in relation to the need to retain the Nurse Manager Staff Safety and Reducing Restrictive Practice role. There was unanimous feedback that this role has been instrumental in bringing positive cultural change to staff safety and patient care. However, the feedback also articulated the necessity to ensure safety and quality systems receive equal focus, as although there are strong governance processes in place, investing in dedicated quality, safety and risk positions would sow excellence in Forensic Mental Health care. It was acknowledged that there is a Quality and Risk team within Nursing, however their scope and focus needs clearer definition.

Role clarification: (3)

Staff consultations highlighted confusion about a number of positions in the Forensic Hospital across all administration, nursing and allied health streams. It further highlighted the need for current position descriptions across all streams to be updated to reflect the positions role in the hospital.

A relevant example is the confusion for all staff between the role of a Mental Health Care Workers and Allied Health Assistants. There is no clarity about how Mental Health Care Workers should work,

and why Allied Health Assistants work differently. The requirement to establish a clear role of the Hospital's Mental Health Care Workers has been highlighted through nursing consultation. Mental Health Care Workers are currently line managed by the Nursing Unit Managers of each unit, however, Allied Health Assistants are managed under the Allied Health Assistant award. It is important for the Forensic Hospital to ensure that all current and new positions have a strong position description.

Allied Health is considered an umbrella term for health professionals, with the Forensic Hospital currently having up to 10 different disciplines within the Allied Health team. The current Allied Health team consists of 35 FTE and 44 staff members across these disciplines. Their invaluable add to the service is shown through their commitment to consumer centred care. A barrier highlighted within the current Allied Health team profile is the staff to consumer ratio. Forensic Hospital Allied Health staff currently work usual business hours (Mon-Fri), creating a service gap outside of these hours and particularly on weekends. Further to this, all disciplines highlighted the critical need to increase the Allied Health staff presence in the hospital. It is important that the disciplines present on each unit are tailored for the needs of that particular consumer group, enhancing the rehabilitation offered to the consumers.

Forensic Hospital Allied Health staff make up on average approximately 50 percent of the current MDT meetings each week. However, these staff have a significantly reduced staffing number when compared to other disciplines in the hospital. This reduced number is also reflected by the working hours of these staff members, as they do not staff the hospital on a 24/7 hour basis. Consultation also highlighted the lack of career progression and senior roles for Allied Health professionals within the current staffing profile. This will be discussed in greater detail below.

The Forensic Hospital incident data and feedback during consultation identified that increased Allied Health services, particularly Diversional Therapy, would positively impact rates of aggression and therapeutic milieu. It was noted that the Allied Health staffing profile on each unit is reduced towards the rehabilitation end of the hospital. These units are arguably where a greater Allied Health discipline focus should be made, to enable the consumer to engage in their individual rehabilitation. For example, the Forensic Hospital has 2.0 FTE of Diversional Therapy, which has been placed at the acute end of the hospital. An increase in the number of Diversional Therapy services across the Forensic Hospital would see a continuity of care for the consumer, enabling them to build skills in leisure activities, ultimately allowing consumers to spend their free time in a meaningful way. The need for greater Diversional Therapy services will be discussed in greater detail below.

The two year trial of a multi-disciplinary Allied Health Assistant workforce in the Forensic Hospital has had a significant positive impact on service provision. This temporary workforce operate under the supervision of an Allied Health professional, becoming an extension of these professionals in providing therapeutic engagement to consumers and releasing clinicians to complete discipline specific tasks. A review of this trial highlighted the need to continue the employment of this workforce to maintain the current service provision in the Forensic Hospital, in particularly within the Allied Health team and Centralised Group Program.

The benefits a balanced MDT approach brings to patient care (4).

The Forensic Hospital have Allied Health staff on duty Monday to Friday, with each Allied Health staff member allocated to a unit specifically including seniors. These staff provide the majority of therapeutic activities. Seniors do not have operational management responsibilities. The structure is flat with no stepped progression. In comparison with other services the senior Allied Health staff carry a higher level of clinical load than their counterparts in other jurisdictions. The role of the seniors in the Forensic Hospital is siloed specifically to the Hospital, where in other services they have a professional oversight across all mental health. Service 1-3 have a stepped career progression

system, and new graduate programs to transition recent graduates into their first clinical role, however this is absent within the Forensic Hospital. The average patient to Allied Health staff member allocation is maximum 1 staff member -15 patient. One service reported Allied Health staff rostered on rotating shifts 7 days per week in their acute units in line with the NSW Seclusion and Restraint reduction strategy.

Building our emerging workforce (5)

A recurrent theme across all disciplines was the current lack of junior health professionals in the Forensic Hospital. The creation of a junior stream, targeting current university students in all disciplines would allow the Forensic Hospital to build an emerging forensic mental health workforce for tomorrow, today. The current staffing profile has 16 FTE allocated to registered nurse year one who complete a rotating transition to practise program. In addition, the hospital has endorsed enrolled nurse positions delivering nursing care to the consumers in the hospital. At the date of this report, the Forensic Hospital does not have an Assistant in Nursing workforce, which would fill the service gap from realignment of mental health care workers. Assistant in Nursing roles can be specifically targeted to second year nursing students, who through support can be upskilled to transition to nursing employees upon completion of their degree.

There is a fine balance between ensuring enough nurses on a shift have the right skills for the positions. The registered nursing workforce are a key component of any functioning hospital environment providing the essential care required to support patient care. Consideration of an Assistant in Nursing and Enrolled Nursing workforce has merits in developing the Hospital's workforce for tomorrow, today.

In targeting university students and creating a transition to practise program for graduate Allied Health disciplines, the Forensic Hospital can foster a specialised Forensic Mental Health workforce. It will make the Forensic Hospital the first Australian forensic service to create a specific forensic transition to practise and psychology intern program. It would also allow Allied Health students to gain invaluable experience in the forensic mental health field, aligning allied health disciplines with a similar structure to those already in place within other staffing streams.

Through the Network investing in this emerging workforce we can have a positive impact on the development of service delivery by diversifying the workforce. This diversity of talent means a broader range of skills among employees, as well as a diversity of experiences and perspectives which increases the potential for further improved patient outcomes. This approach to building the Forensic Hospital workforce will allow the Network to position itself as a leader in Forensic Mental Health in Australia.

Profile Analysis

Senior Management

The current Forensic Hospital senior leadership team has a strong presence in the hospital, with a clear vision to enhance the services in the hospital. The senior leadership team has a clear focus on ensuring the quality, safety and risk in the Forensic Hospital environment. A barrier to the structure is that it is predominately graded to nursing specific positions and in some roles and absence of clarity re the specific focus of the manager.

Nursing

As a proportion of its total workforce, Nursing is the largest discipline in the Forensic Hospital accounting for approximately 94% of FTE. The Hospital's Model of Care is multi-disciplinary. The

units are largely nursing led with the majority of direct day to day care, assessment of risk and supporting patient recovery across the site managed by nursing.

The Hospital's Nursing Structure has two distinct streams. The first is Nursing Operations, managed by the Deputy Director of Nursing, who reports to the Director of Nursing and Services. Nursing Operations facilitates the day to day implementation and management of mental health nursing services within the Hospital. The second stream is Nursing Quality and Risk and Education. This stream enables the development and maintenance of clinical practice standards, and leads the implementation of evidence based practice across the Hospital. This stream is led by the Director of Nursing and Services.

There are increasing national shortages in mental health and in particular the registered mental health nursing workforce. Reviews of relevant literature identify the challenges in recruitment and retention of nurses particularly in the early part of their careers. Initiatives that improve the transition from education to the workplace, provide workplace support, build workplace capacity, keep nurses in their jobs and make the most of valuable clinical skills can significantly mitigate against future workforce shortages.

Nursing Operations

In terms of overall structure, the Hospital's nursing operations has remained relatively unchanged since it's opening in 2008. The reviewers and staff who engaged in the consultation shared the opinion the Hospital is well-resourced from a Nursing perspective. However, there were clear themes which can be summarised as; challenges with local unit based culture, inconsistent Nurse Unit Management leadership and structure, a perception of poor levels of accountability and a necessity to increase access to primary care nursing skills.

Nurse Unit Managers

Historically, when the Hospital opened it mirrored Victoria's Thomas Embling Hospital with a Nurse Unit Manager (NUM) level 2 or 3 equivalent as the unit manager, and a clinical lead on each shift. Within the Hospital these clinical leads are NUM 1 positions.

A number of years ago, the Hospital attempted, unsuccessfully, to move away from the NUM1 model, to a Nurse in Charge (NIC) model across the site. Any remaining NUM1's were reclassified as 'Shift leaders' with a plan to remove this band of nursing via natural attrition. Arguably, this resulted in a significant deterioration in clinical leadership, inconsistent and blurred expectations, poor team cohesion, which led to a negative impact on patient care though a loss of clinical expertise. This has left the Hospital with an inconsistent unit based Nursing leadership structure with a differing understanding of roles and responsibilities with many believing governance, resource and performance management duties are not their responsibility. This perception does not align with the position description. There is a need to define the role and responsibilities of the NUM1 positions across the Hospital.

At the NUM 2 and 3 level, it was apparent that each unit had different leadership needs. Austinmer Women's Unit presented with the same complexities and workload as the Bronte Unit. However the NUM grading was not similar among these units. This was also articulated during the profile review, noting the fragmented NUM structure across the site and inconsistent balance of both clinical workload and managerial duties.

After Hours Nurse Managers

A further example of a poor clarity of role was with the Hospital's Afterhours Nurse Manager team. This team is responsible for managing operational service within the Hospital for up to 70% of the time. Whilst their management of direct clinical incidents and care is well defined, clear operational

responsibilities remain elusive, with the challenges of a rotating roster often cited as the key inhibitor to engagement and connectivity to the governance of the Hospital. As a result there is a level of disconnectedness from the remainder of the senior nursing leadership team. As a group they are frequently absent from working parties and key meetings. Working a rotating roster will pose a challenge to shift this perception. However, the value they could bring needs to be reviewed as they are a significantly underutilised resource and frequently given tasks which do not align to their grade or position. Whilst a review of the Award notes that their After-hours facility management responsibilities are appropriately graded, their active engagement in governance and strategic direction requires greater empowerment and responsibility.

Registered Nurses

Forensic Mental Health nursing focuses on the intersection between criminal justice and mental health. Forensic Mental Health Nurses (FMHN) practice involves the management and treatment of patients with mental health issues who have a history of criminally offending or who present a serious risk of such behaviour. Central to this is the assessment and management of risk in particular the risk to others. At the Hospital this takes place within a secure yet therapeutic environment and in consideration of the environmental, procedural and relational needs of the service and its patients. Whilst there are varying levels of engagement and exemplary practice, it is apparent that many nurses within the Hospital were unable to clearly define the expectations and responsibilities of their role. In the absence of consistent clinical leadership, the propensity for risk aversion has favoured a culture whereby taking positive therapeutic risks is less common.

Relational Security is regarded as one of the most important elements for nurses to improve quality of patient care in a secure service. However, nursing care can become overshadowed by a focus on physical and procedural security, with patient centred care displaced by less individualised care to ensure minimal risk, and the completion of all expected duties and allocated tasks during their shift. As the discipline with the greatest patient contact hours, clarity of the role is essential to ignite broad engagement, professional integrity and advance the Forensic Mental Health Nursing Specialty. To achieve this, there is also a need to be specific about what are FMHN specialist duties in order to increase nursing time dedicated to providing therapeutic care. This is exemplified by the security needs of the patient cohort requiring nurses to often work in pairs to undertake tasks and provide direct care.

Endorsed Enrolled Nurses

Endorsed Enrolled Nurses (EENs) play a key role within the health system, providing care and treatment in a range of settings and under the supervision of a Registered Nurse. The number of EEN's within the Hospital is currently very low in comparison with other FMH services in Australia. Since the opening of the Hospital and the initial development of the nursing profile, EEN training and scope of practice has expanded. There still remains though, a lack of experience in mental health and this remains a barrier to recruitment. To overcome this, Victoria and the Thomas Embling Hospital, has initiated a transition to practice and an on-boarding program to grow the workforce within their service that has been identified as very successful. Should the Hospital embrace a similar approach, it would lower barriers to growing this area of the workforce, and assist enrolled nurses with the knowledge and skills, and support required to effectively transition into mental health nursing.

Mental Health Care Workers

Most striking throughout the consultation process was the value Mental Health Care Workers (MHCWs) brought to each of the units. The position is varied on each unit though is generally not a seven (7) day service and duties, expectations and services provided varies significantly across the

site. This position description describes the role's primary purpose as '*providing practical support services to aid clinical staff within the MDT and in coordination with the team, initiate general service delivery*'. During consultation a stand out theme was the value the position brings to enabling diversional activity, and supporting the facilitation of groups for patients.

However, recent changes to the positions industrial award now requires this position to come under the supervision of an Allied Health professional. The position is currently managed by nursing, though their duties, and noted benefits it brings are more aligned with Allied Health support. If this position was repurposed as Allied Health Assistants in name, as well as the Award, it would create greater opportunity for role development. By aligning the positions with Allied Health, it would facilitate greater supervision, support and collaboration.

Nursing Support

Following on from the recommendation that MHCWs become more aligned with Allied Health. It is apparent that nursing specific support duties would be better aligned with the development of Assistant in Nursing (AIN) positions within the staff profile. AINs can be an addition to the nursing team by assisting in the provision of basic nursing care, whilst working within a plan of care under the supervision and direction of a registered nurse.

Nursing - Quality, Risk and Education

The Nursing Quality Risk and Education stream are central to the Hospital's practice improvement processes using quality, research and education frameworks. The feedback during consultation and observations from this review, identified a lack of clarity regarding nursing, and indeed the broader hospitals quality, risk and education framework, with a differing understanding of its purpose across the service. The richness of a multidisciplinary approach to quality, risk and education is essential in the delivery of recovered focused care, yet the current structure within the hospital suggests this is only the domain of nursing, as there are only Nursing positions which are dedicated to Quality Risk and Education. The currently budgeted positions are a Clinical Nurse Consultant team, Nurse Manager Education and Practice Development, Clinical Nurse Educator. There is also a Nurse Manager Staff Safety and Restrictive Practice which is a temporary full time position. These positions report directly to the Director of Nursing and Services.

The Hospital had a restructure to the leadership team in 2018, with the amalgamation of the Service Director and Director of Nursing roles. This amalgamation resulted in the creation of the Director of Nursing and Services position. There is a perception that the amalgamation of these roles impacted the direction of nursing quality, risk and education stream. It is believed the focus of the Director of Nursing and Services as the position became too stretched as it covered all clinical and support services, with the exception of Medical services. This perception was arguably exacerbated by challenges in recruiting to positions across this stream for a protracted period of time. This led to a high level of cross cover of positions which blurred the roles and responsibilities of Nursing Quality, Risk and Education positions.

This blurring of roles was particularly evident with the Hospital's Clinical Nurse Consultants (CNCs). Over the past two (2) years, the roles have been challenged by a lack of clarity and clear direction, and in some instances a belief that they "*just do education, policy and procedure*". This was reaffirmed by the CNCs during consultation, with a view put forward that they are becoming less involved at a strategic level. The team described this as scope creep, picking up operational duties outside the boundaries of a CNC role. The CNCs identified their work has become progressively more reactive, with less time to deliver proactive clinical consultancy for patient care.

A contributing factor to this perception was the inability to recruit to the Nurse Manager of Education and Practice Development to cover a twelve (12) month period of leave. The

consequence of this was the CNC team took on the majority of the education and training for the Hospital, which went on to account for an estimated 30-40% of their workload. As a result, clinical input to patient treatment was significantly impacted, and fostered a perception from the operations stream, that the CNCs were not available for clinical work. In essence this was true as their availability had been consumed by a focus on education, training, policy review and development. Yet in the absence of other positions with capacity to complete the work, there was a necessity to complete it.

During consultation the CNC team identified that with the recruitment of the Nurse Manager Education and Practice Development, their roles have reverted back to subject matter experts, as the facilitation, management and compliance aspects of education have been taken back over by this manager. This has allowed the team to refocus and realign themselves with CNC duties. However, a challenge is maintaining focus, as the current titles of the position exacerbate ambiguity regarding clarity of the roles. Despite a lack of presence with direct patient care, the review consultation process demonstrated a necessity for units within the Hospital to have access to CNC input.

Collaboration among health professionals is the key to positive patient outcomes. Yet, Nursing, Allied Health and Medical disciplines currently all run their own education programs and Nursing is the only discipline which has a dedicated education position. This means many programs may be repeated or run concurrently which is an inefficient use of resources. Nursing has the largest workforce within the hospital with a dedicated education and practice development position. There is an opportunity to reconsider the Hospital's approach to education by broadening the scope of this position across disciplines.

In 2019, largely driven by the safety journey of the Hospital, a temporary full time Nurse Manager Staff Safety and Restrictive Practices position was developed as part of the Hospital's senior management team. The focus of the position was to provide leadership and direction on contemporary strategies to improve workplace safety culture, whilst reducing restrictive practices such as seclusion and restraint. This position has a demonstrable positive impact in navigating what appear to be incompatible necessities in contemporary forensic mental health care. There was consistent feedback for the necessity to embed this position and focus within the leadership team. This position has provided strong and consistent leadership, ensuring a focus was placed on clinical practice and safety for all. A collaborative approach to safety, quality, risk and education has spearheaded the Hospital's safety culture ensuring a focus on practice review and development to improve patient and staff safety.

This position, whilst not obviously aligned, also took on the line management of the Hospital's CNCs to relieve work load from the Director of Nursing and Services. The position also provides direct support to the Nurse Manager Education and Practice Development. These positions officially report to the Director of Nursing and Services, however, this temporary and supportive structure has proven effective to achieving rapid culture change and practice development.

Service Provision

The reviewers observed that within the Hospital's acute units there is a high nursing staff to patient ratio, allowing nursing teams to safely manage patient risk and provide acute rehabilitative care within a therapeutic security model. This high nursing ratio allows staff to build therapeutic relationships with their patients, whilst safely providing a therapeutic program. Conversely, the Hospital's Rehabilitation Units are not staffed with high numbers of nurses. During consultation, the collective understanding for this was these patients present a reduced risk, requiring less input to 'manage' them based on their security needs, as opposed to individual patient rehabilitation needs. Subsequently there are less nurses available to undertake meaningful rehabilitation with patients.

Model of Care review 2017

A 2017 review of the Hospital's model of care found similar findings to the staffing profile review. The points raised in that review that resonate and align with this current review are identified below. Whilst a body of work was undertaken to address these issues following the review, these similarities likely remain as they require adjustments to the staffing profile to fully address them.

- Balance of risk versus therapy - the reviewers identified that '*there was a sense that the hospital security always prevailed over therapy*'. Consequently, with a propensity for risk aversion, a skewed balance of risk and therapy has resulted in rehabilitation sometimes taking a back step.
- Nurses are more often undertaking security related tasks rather than therapeutic activity. Over the years with the high ratio of nurses within these units, duties have crept into nurse workload that are not necessarily nursing related tasks.
- Nursing unit management, described as lacking "*linear responsibilities and accountabilities relating to resource management, the support of clinicians and ultimately of patient care" and "There appeared to be little cohesion in nursing leadership and often a reluctance to 'performance-manage'.* A recommendation from the 2017 Model of Care Review was the '*protocols and procedure for NUM1s be standardised in order to maintain consistency among the NUM1s*'.
- Whilst improved, the reviewers and consultation process would echo that challenges within the operational and clinical nursing structures and clarity of roles remains today.

References

Haines, A., Perkins, E., Evans, E. A, McCabe, R. (2018) Mental Health Revs Multidisciplinary team functioning and decision making within forensic mental health; 23(3): 185–196.

Allied Health

The Allied Health structure has been reviewed and a proposal developed. The Allied Health team is comprised of 32.0 FTE (44 headcount) across fourteen (14) different disciplines. The Manager Allied Health provides direct line management for all clinicians in the team (current organisational chart). The Manager Allied Health reports to the Director Nursing and Services and is a member of the Senior Management Team of the Forensic Hospital.

When the Hospital opened in 2008 the management and governance structure of the Allied Health team was organised by professional disciplines, with Team Leaders (who had line management responsibilities) of the core disciplines - Psychology, Social Work (SW) and Occupational Therapy (OT). This resulted in strong governance and effective employee line management. However, due to financial reasons and recruitment difficulties some time thereafter, the Allied Health team was re-organised where the Team Leader positions were changed to Senior Clinician positions, removing discipline specific line management. As a consequence, line management was absorbed by the Manager Allied Health position for all Allied Health positions within the facility. A flat structure was put in place which does not acknowledge the qualifications and expertise of clinicians has evolved.

Since the implementation of the flat structure, the Allied Health team has continued to increase in size, scope and responsibility. Allied Health have developed and operationalised the Centralised Group Program (36 hospital-wide therapeutic groups), implemented therapeutic leave, facilitated TAFE vocational programs and organised a range of Hospital wide events and initiatives including the design and opening of Golden Wattle, Close The Gap, NAIDOC Day and the Forensic Hospital Celebration Day. More recently, the Allied Health team has been responsible for the introduction, implementation and management of new clinical teams such as the cross–disciplinary Allied Health Assistants (AHA's), Peer Workers, Consumer Consultants and Aboriginal Mental Health Workers; as well as the expansion of the student placement program and the addition of the Aboriginal Mental Health Trainee and Family and Carer Consultant positions.

Proposed Allied Health Restructure

In 2019 a proposed restructure of the Allied Health was proposed and endorsed. The design of this restructure was based on a formula of cost efficiency, and not what is required for consumer care, or appropriate workloads. It did however provide a stepped carer progression model. Consultation with disciplines and the staffing profile review has identified the sustainability of this structure does not support growth, and would be unreasonable to enhance Allied Health service above what the current structure is due to the impact on workload. The current senior positions under the proposed structure would inherit operational management duties on top of their sole discipline role on a unit. The current seniors all have responsibility to provide services to at least seventeen (17) people on their respective units; and/or drive health promotion, project work and other therapeutic activities which is unsustainable. This structure does not benchmark well against like for like services, and therefore a seven (7) day Allied Health staffing roster would not be sustainable. The reviewers have considered the alignment from the perspective of career development, patient/consumer care and future sustainability. They have based their recommendations on sustainable structures that will provide scope for seven (7) day coverage, improved efficiencies, and in line with patient/consumer consultation.

Consultation Themes

Staff from the various Allied Health professions highlighted many keys themes through consultation lack of discipline identity in the Forensic Hospital, limited career progression, workload issues, staffing ratios, disconnect between the acute and rehabilitation units, education as well as staff to run therapeutic groups and lack of focus on a true bio/psycho/social model in the hospital.

Discipline Identity

All disciplines under the "umbrella" term Allied Health strongly discussed how they lose their discipline specific identity. The current structure in the Forensic Hospital sees the team split into four (4) teams, a psychology, social work, rehabilitation and therapy team. Due to the increased expansion of the Forensic Hospitals Allied Health teams since the opening of the hospital, these teams have experienced creep, with different teams absorbing further disciplines, along with new and emerging workforces in the hospital. Further to this, with having a "Manager Allied Health" this limits the individual identities of each discipline in the hospital and the voice of this discipline in key hospital wide discussions and decision making. For example, it is important for Social Workers to be seen as Social Workers and for them to have their own stream. As mentioned previously, it was noted in other services there are discipline seniors and not a generalist Allied Health Manager. This was reinforced by the Manager Allied Health who noted historically favouritism is shown to the discipline of the Manager Allied Health if they are represented in the hospital build. In order to build a strong Forensic Hospital leadership structure for each discipline, the repurposing of the Manager Allied Health will allow for the creation of distinct streams to occur.

Limitations with Career Progression

Allied Health staff across all disciplines raised concerns with the current limitations with career progression in the Forensic Hospital. The current team structure plays a role in this, coupled with the low number of senior professional positions despite the Forensic Hospital being a unique service in NSW Health. Each team has one "senior level" position, who is expected to provide operational management in the new proposed structure while maintaining a 60% clinical load. Many of these seniors pointed out they are allocated to a unit so it is approximately a 90% clinical load to meet clinically identified patient needs. The flat un-stepped Allied Health career pathway has also been linked to high volumes of staff turnover, with staff moving outside the hospital with a high level of specialist corporate knowledge. Occupational Therapists, Social Workers, and Clinical Psychologist are well represented, however there is an absence of an Exercise Physiologist in the Recreation Hall, and only two (2) diversional therapists which seems to be insufficient when meeting the needs of patients is noted in both patient and staff feedback. The lack of career pathway for new graduates and the absence of a transition to practice program for Allied Health staff, similar to that offered to registered nurses is of noted concern.

Workload and Staffing Ratios

It is evident that the current workload pressure sustained by Allied Health clinicians is challenging, with a variation in the number of patients on each individual staff member's case load across the site. Allied Health disciplines in the Forensic Hospital are currently unevenly distributed, with some staff having a case load of up to thirty two (32) patients. Historically the clinicians have been allocated per unit, with each unit except for adolescents having 1.0 FTE of Social work, Psychology and Occupational Therapy. Acute units also receive the services of 2.0 FTE Diversional Therapy split across the three (3) units. On average, an Allied Health clinician has a staff to patient ratio in the Forensic Hospital of 1:23 patients, which when compared to best practise and academic journals is 2.15 times higher than the recommended average. Therefore, patients are either unable to be engage to due to the workload, or time constraints of the clinicians on each unit. Mutli-disciplinary teams need to use clinical rationale to ensure they're meeting the demands of their patient cohort. Further to this, Allied Health clinicians do not receive leave cover, therefore any patients on their current caseload are left without access to clinicians throughout this period of leave.

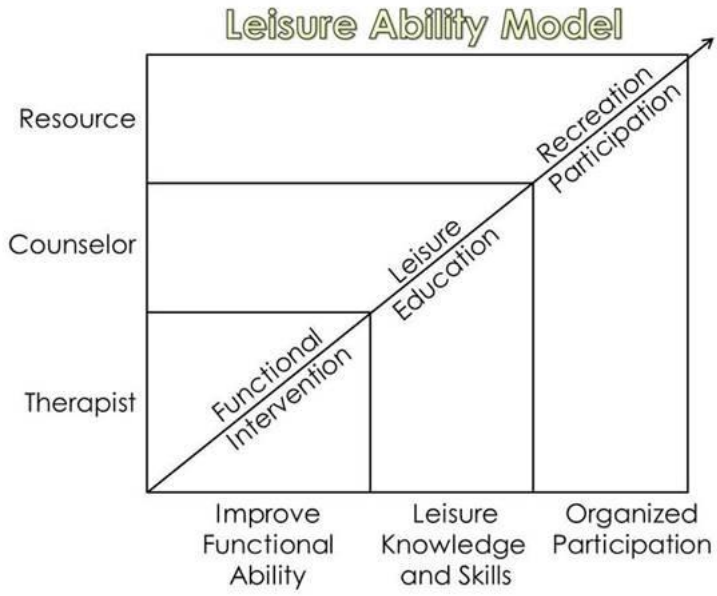
Disconnect between Acute and Rehabilitation

Consultation indicated that within the Allied Health disciplines there is disconnect between the Acute and Rehabilitation units of the Hospital with the acute end usually benefitting from a greater number of disciplines and total numbers of Allied Health staff. This uneven distribution of workload and lack of linking between both ends of the Hospital sees a reduction in the continuum of care for Forensic Hospital patients.

The disconnect between units is exemplified by a lack of patient access to a Diversional Therapist after progressing from the acute units. If Diversional Therapists were to be embedded within each multidisciplinary team throughout the hospital, patients would have an increased opportunity to become independent in planning, initiating and participating in meaningful leisure activities, as illustrated in the leisure ability model below (See Figure 1). Diversional Therapists will be able to target the areas of need for each patient allowing patients to begin to develop their skills to initiate their leisure and spend free time meaningfully, leading to a greater chance of reintegration into the community. Further, clinicians could see a reduction in their problem behaviours and giving them opportunity to connect and participate in the community which can be a protective factor.

Figure 1:

The leisure ability model reflects the three (3) main components of Diversional Therapy service provision; treatment, leisure education, and recreation participation.



Therapeutic Programs (Groups, Education, Psychosocial Care)

A common theme from patients and staff is the need for more programs and activities for patients, which are primarily offered by the Allied Health professionals. These activities are offered both on and off unit, as either part of the Centralised Group Program (CGP), unit based therapeutic groups or in the Recreation Hall. Allied Health disciplines predominantly facilitate these activities and groups in the Forensic Hospital, with these groups complemented by individual sessions create the psycho/social section of the hospitals "Bio/Psycho/Social" model. The CGP is comprised of thirty six (36) groups/programs which address DUNDRUM items, providing patients with clinically indicated rehabilitation. Currently this program, apart from operational oversight, does not have any allocated staff and is facilitated by staff from each unit, increasing their workload but also reducing their input on each unit. The Allied Health Assistant workforce trial has been proven successful in achieving

some great outcomes, yet is only temporary and will ultimately result in a loss of staff. Creating a program workforce would enable our patients to have access to all necessary programs, reducing current extensive waiting times and relieve workload pressures of the already over worked staff. Further, through engaging and providing occupational opportunities for the patients it would address the current occupational deprivation patients are faced with due to lack of access to what individuals have in the community.

Allied Health Assistants

A two (2) year trial of an Allied Health Assistant workforce in the Hospital was undertaken with remarkable results. This was the driving force behind a 30% increase in access for patients to the Centralised Therapeutic Groups Program (CGP). However, as the positions have been temporary, with extensions granted for short periods, this has impacted on the retention of FTE to these positions, with job security cited as the primary driver for the attrition of staff. Consequently, due to the high clinical workload of staff there has been limited availability to supplement FTE to support both 1:1 sessions and the program.

As a result, the team have reduced some individualised patient clinical time as they team strive to service the broadest possible number of patients. A 2018 internal review of the CGP highlighted limited staffing was impacting waitlists to provide clinically indicated programs. It also identified that in limited instances patients were waiting extended periods of time to gain access to rehabilitation groups, prolonging their length of stay within the service.

Incidents occur generally during evenings, and weekends with patients reporting boredom as a challenge in the hospital. Engaging patients in meaningful activities and programs is not only a therapeutic necessity, but a harm minimisation strategy to ensure a safe environment for all. In line with NSW Health Seclusion and Restraint reduction guidelines expanding allied health staffing to extended hours would be beneficial for the patients, staff and service.

Administration

The Forensic Hospital (FH) Administration Review has been conducted to ensure the management of current administration resources is efficient and ethical.

The FH administration positions were created when the FH commenced operations in November 2008. There has been no formal review of these positions to date.

Leave relief was not considered on the commencement of the administration positions and this ongoing issue has been managed ever since.

Administration position descriptions within the FH were created prior to the publication of the administration support standards specified within the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals, otherwise known as The Garling Report (TGR), published in November 2008.

All administrative positions within the FH have been reviewed in conjunction with the administration officers. Each administration officer was interviewed, with the exception of the PAS Inpatient Clerk who declined on more than one (1) occasion to be interviewed. During these interviews all position descriptions were examined for accuracy. This report recommends that all inaccurate position descriptions be updated and signed off immediately, and prior to the next scheduled performance review date.

The NSW Health Administration Officer (State) Award was also used to determine the accuracy of each position description in terms of the rate of salary and wages appropriate to each work load.

TGR was used to determine the recommendations for supporting the clinical workforce.

It is identified that administrative support is lacking in the provision of patient shopping services in the FH. There is currently no funding within the FMHD specifically to provide administrative support for patient shopping. It has been identified that patient shopping duties are currently being conducted by Ward Clerks, which does not strongly align with the TGR.

In addition, support to Medical Officers has historically not been sufficiently provided within the FH. This has been reported through the JHFMHN Medical Staff Council and the project on Administration Support to Senior Medical Staff completed in January 2016.

In January 2016, the JHFMHN Medical Staff Council reported their concerns to the Chief Executive regarding the provision of administrative support to senior medical staff across the Network. The report noted that the highest number of complaints regarding administrative support to senior medical staff came from the FH.

The report found administration support provided to senior medical staff within the FH requires supplementation with consideration be given to provision of additional administrative support with the appropriate level of training and expertise to better support senior medical staff. Based on the number of consultant staff working within the Forensic Hospital (10 Staff Specialists = 6.2 FTE, and 1 VMO), it was estimated an additional 2.0 FTE of appropriately trained administrative support is required. This would provide approximately 0.2FTE of administrative support per 1.0 FTE staff specialist/VMO. The additional administrative support should be available to all senior medical staff within the Forensic Hospital and be primarily dedicated to support the preparation and typing of psychiatric reports and other clinical correspondence. One of the two (2) CSO positions has been funded since the time of this report.

The report included concerns for the administrative support provided to clinicians throughout the Network and stated inadequate provision of administrative support results in inefficient use of clinicians' time. Ultimately, this is likely to be associated with poor clinical outcomes, which is ultimately likely to have a detrimental effect on patient care.

Other Considerations

Bed Sits/Escorts:

Patients transported outside the hospital are accompanied by multiple staff, and during their hospital stay require supervision. Exploring more cost effective methods of providing this service or new care structures should be considered.

Model of Care:

There is no well-developed model of care to guide practice within the hospital, because of this interpretations and expectations can vary from staff members and leaders. With increasing expectation to deliver care which aligns with a medium secure level of care, clarifying service delivery with an updated model of care may assist the progression of 20% of patients whom are waiting on medium secure acceptance. Being classed as high secure does not prevent the Forensic Hospital from providing least restrictive care and being aligned to the patient centred care.

Care Hours:

Consideration should be given to developing a formula for the required staffing to patient care contact. Currently the most common form of this is Nurse Hours per Patient Day, however a more multi-disciplinary inclusion would be beneficial especially when expanding beds.

Family and Carer Consultant:

There is no clear understanding with who is the lead for carer consultation within the Forensic Hospital as it does not align with social work services. The reviewers believe it might be more

beneficial to move this role of Family and Carer consultant outside of the hospital into a more network wide focused role, and clarify expectations of the social work department taking the lead with care support.

Key Partnerships:

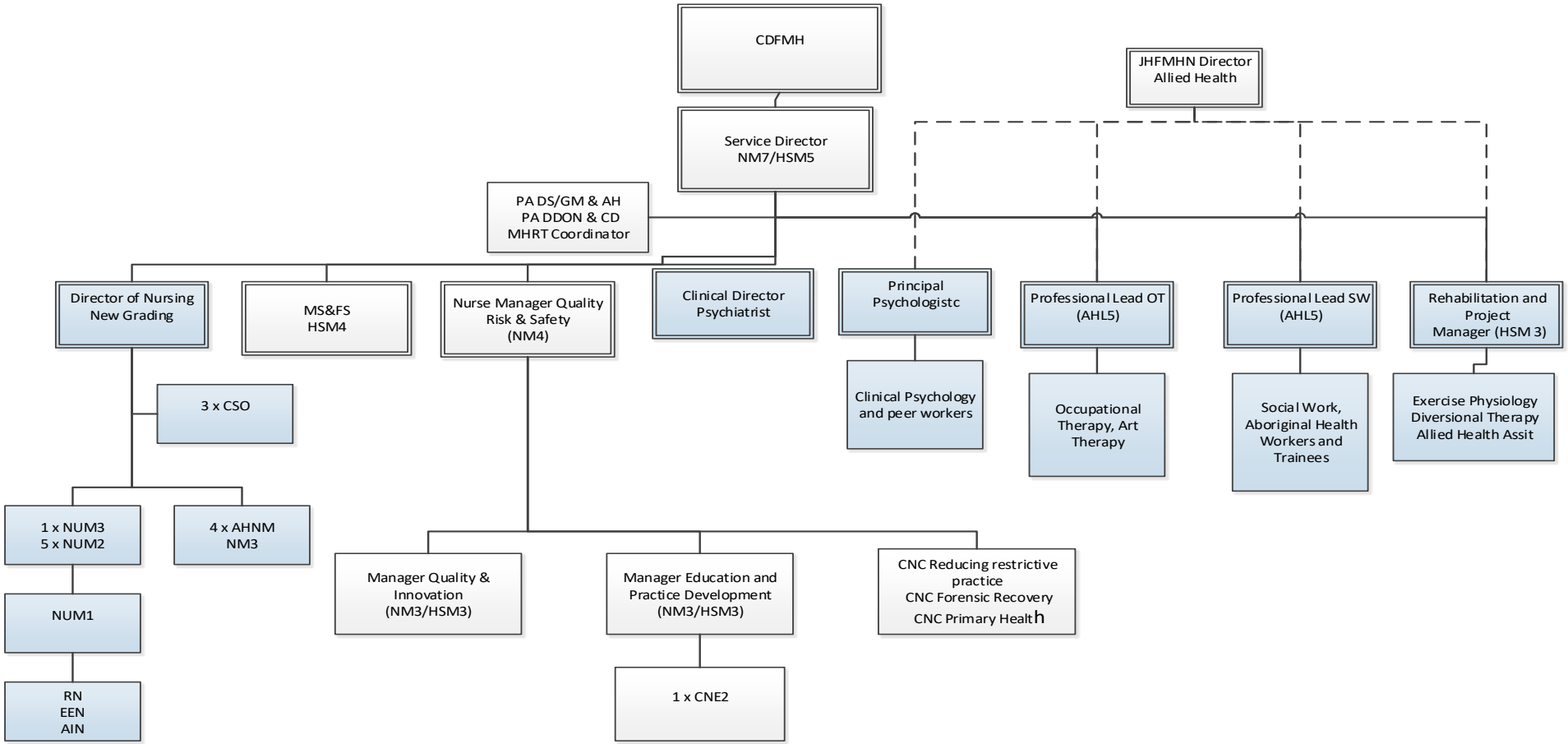
The Forensic Hospital engages with a number of NGOs and has limited input from education providers for patients. These partnerships have allowed the hospital access to culturally specific services, therapeutic programs, education and enable patients to course a meaningful recovery journey and increase their future vocational opportunities. An example of this is the distance education opportunities provided by OTEN. This allows patients to complete tertiary education whilst at the hospital. Though this services remains challenging, in 2019 the Forensic Hospital lost its partnership with TAFE NSW, who were previously contracted as part of a CSNSW partnership. This partnership was not renewed and despite many attempts the Forensic hospital has been unable to forge a new relationship with TAFE NSW, this in part was also inhibited by the absence of technology infrastructure. The program was providing education across a range of key fundamental life skills including literacy and numeracy, with the programs tailored to the needs of the Forensic Hospital patients.

Key providers which were highlighted include:

- NDIS – The Forensic Hospital currently has only been able to access the NDIS on a limited basis for individual consumers. This is a key growth area the hospital needs to develop so they can provide individualised plans for patients tailored to their needs.
- NGOs – these organisations can bring new services into the Forensic Hospital, for example First Hand Solutions, a local Aboriginal NGO has previously provided culturally appropriate groups to the Aboriginal Consumers in the Forensic Hospital. Due to financial limitations the Forensic Hospital has limited capacity to maintain external access, though meeting the Cultural needs of the patient cohort is paramount.
- TAFE –provides vocational education and training to build occupational skills for reintegration into the workforce. When benchmarked against Thomas Embling Hospital, it is demonstrated that the delivery of these services is feasible within secure Forensic Services.
- The Department of Education and Training – Education is the social institution through which society provides its members with important knowledge, including basic facts, job skills, and cultural norms values. It is intrinsic to successful recovery, and to not further disadvantaging our patients.

Despite the number of barriers in engaging the above providers, the Forensic Hospital is committed to engaging and thinking outside the box to forging positive working relationships.

Recommendations: Senior Management 1 (Chart)



Recommendations: Senior Management 1 (Narrative)

Findings:

The core role of this position is the strategic and operational management of the Forensic Hospital. Due to the current discipline specific grading, there are a number of cross discipline healthcare leaders who would not meet the selection criteria of this position. Dual grading this position with the equivalent Health Manager level will expand the role to other disciplines and not limit recruitment persons from a Nursing background only.

Recommendation 1: Director Level (DNS)

Adjust the Director Nursing Services to Service Director Forensic Hospital to be dual graded with the equivalent Health Manager level.

Findings:

In line with recommendation one, the title of the Deputy Director of Nursing would require alteration to Director of Nursing Forensic Mental Health. This position would provide discipline specific, strategic and operational guidance for Forensic Mental health nursing, and benchmarks well with other services external of JHFMHN.

Recommendation 2: Senior Nurse Level (DDoN):

Adjust the Deputy Director Nursing to Director of Nursing Forensic Mental Health to provide mental health nursing oversight. This position would require re-grading and provide greater nursing leadership and governance.

Findings:

Referenced in the Chaplow reports, staff consultation (including the current incumbent), and benchmarking consultation, this role does not represent various Allied Health disciplines as required. Greater influence would be provided at a senior management level, and reflect the importance of a Multi-Disciplinary approach.

Recommendation 3: Senior Allied Health Level (MAH):

Repurpose the Manager Allied Health position and promote current discipline seniors in Occupational Therapy, Social Work, and Clinical Psychology to the FH Senior Management team. The cost savings from the MAH could be redirected towards increasing the Network Director of Allied Health position to full time, or providing more frontline clinical Allied Health staffing input. The gradings will be set higher with the development of roles able to provide discipline guidance across the entire mental health and potentially network. The higher grading also take into account the strategic and partnership building currently expected in these roles with key stakeholders such as education, ministry of health and NGOs.

Roles adjusted from proposed Allied Health Restructure are:

1. **Principal Psychologist**: Enhanced from Psychology Team Leader, to provide greater recognition and leadership for clinical psychology practice across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.
2. **Professional Lead – Occupational Therapy**: Enhanced from Senior Occupational Therapist to provide greater recognition and leadership for Occupational Therapy across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.

3. **Professional Lead – Social Work**: Enhanced from Senior Social Worker to provide greater recognition and leadership for Occupational Therapy across the network. This position will maintain current attendance at Ministry of Health discipline specific meetings.

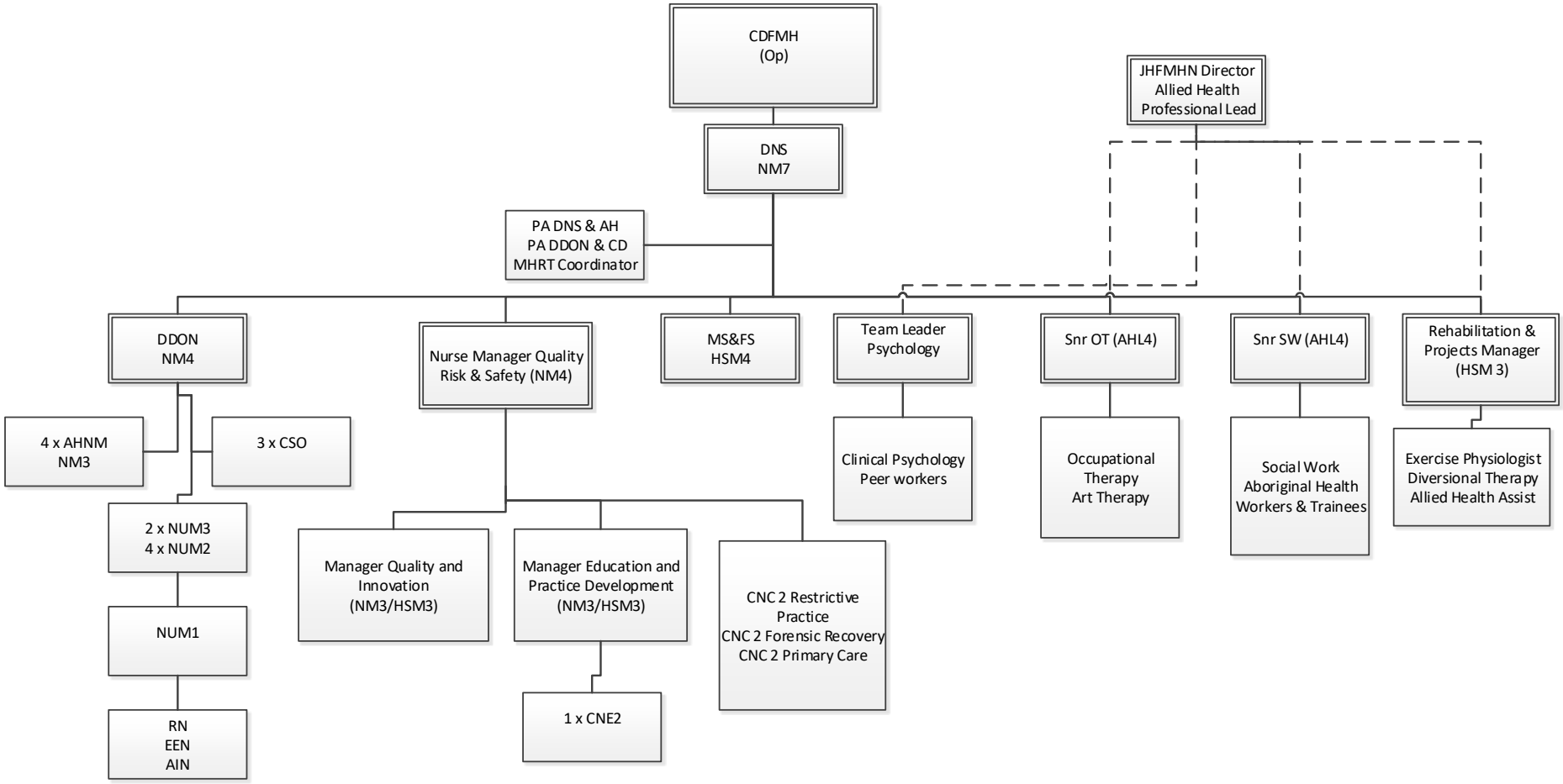
Findings:

The Chaplow Report identified the need to clearly articulate roles. The staff consultation remains consistent with this report, with the continued need for role clarification and a clear understanding of what senior managers do. This structure will be more supportive for growth and provide targeted support in key operational management areas. Ensuring nurses appointed to these positions can remain on the NSW Nursing Award is imperative, therefore there is scope of one of the positions to be dual graded.

Recommendation 4: Governance, Quality, Innovation, Safety (NM4/3/CNC):

To make the Nurse Manager Staff Safety and Restrictive Practices (NMSSandR) permanent, repurpose the CNC3 to contribute funding to this position. The NMSSandR position can also function as a Deputy Director of Nursing. Adjusting the CNC positions will support the consultation theme of "role clarity" and help offset the costs. Repurpose 1 CNC2 position to create a Manager Safety and Quality, this could be dual graded

Recommendations: Senior Management 2



Recommendations: Senior Management 2 (Narrative)

Findings:

There is scope to repurpose the Manager Allied Health position and promote current discipline seniors in Occupational Therapy, Social Work, and Clinical Psychology to the FH Senior Management team. The cost savings from the MAH should be redirected towards new graduate positions to improve the capacity of the seniors to take on operational duties. Discipline seniors would be specific to the Forensic Hospital. This adjustment to the original proposed Allied Health restructure will enable strong discipline representation at a senior level, and improve patient access to these disciplines. The structure also brings in scope to introduce a transition to practice Allied Health program.

Recommendation 1: Senior Allied Health:

Repurpose the Manager Allied Health position and promote current discipline seniors in Occupational Therapy, Social Work, and Clinical Psychology to the FH Senior Management team. The cost savings from the MAH should be redirected towards new graduate positions to improve the capacity of the seniors to take on operational duties. Discipline seniors would be specific to the Forensic Hospital

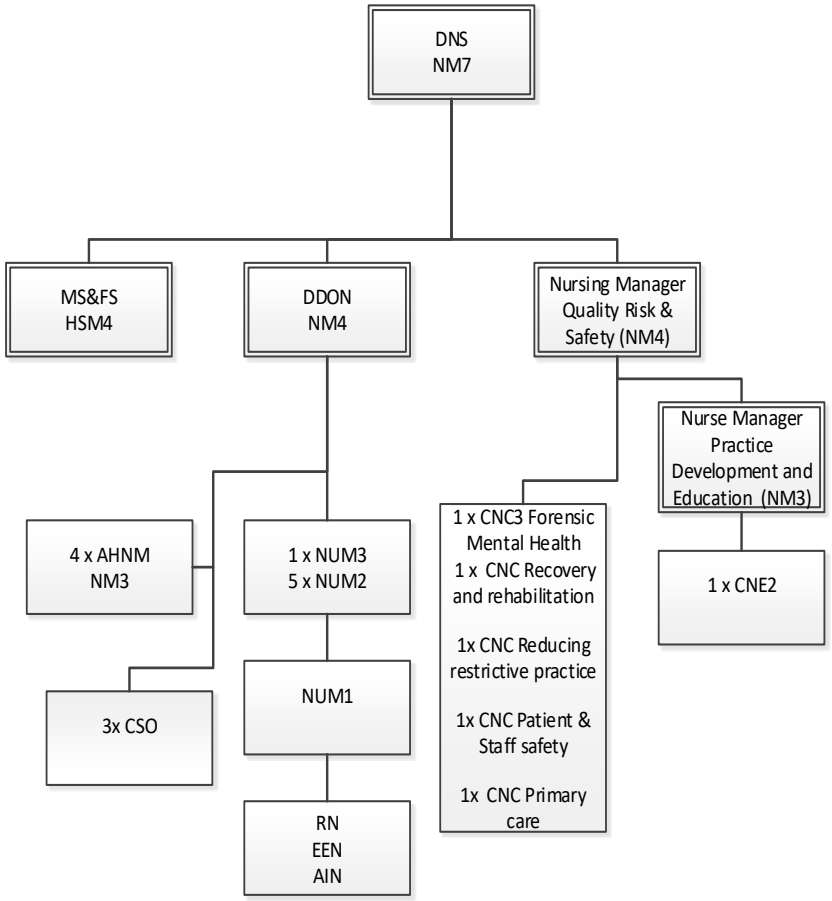
Findings:

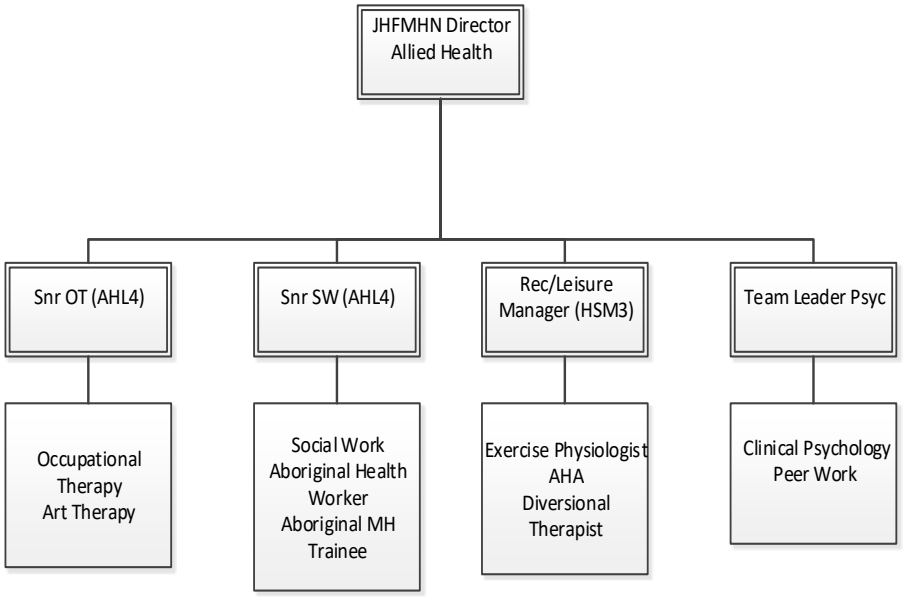
The Chaplow Report identified the need to clearly articulate roles. The staff consultation remains consistent with this report, with the continued need for role clarification and a clear understanding of what senior managers do. This structure will be more supportive for growth and provide targeted support in key operational management areas. Ensuring nurses appointed to these positions can remain on the NSW Nursing Award is imperative, therefore there is scope of one of the positions to be dual graded.

Recommendation 4: Governance, Quality, Innovation, Safety (NM4/3/CNC):

To make the Nurse Manager Staff Safety and Restrictive Practices (NMSSR) permanent, repurpose the CNC3 to contribute funding to this position. The NMSSR position can also function as a Deputy Director of Nursing. Adjusting the CNC positions will support the consultation theme of “role clarity” and help offset the costs. Repurpose 1 CNC2 position to create a Manager Safety and Quality, this could be dual graded

Recommendations: Senior Management 3





Recommendations: Senior Management 3 (Narrative)

Findings:

This restructure would align with the consultation and an adjustment of reporting lines would be the most significant change, providing growth for all allied health grouped positions in the future.

Scope to provide dynamic transition to practice programs for allied health new graduates would align well under this structure and match the current nursing transition program. Reducing new graduate allied health staff being sole practitioners on the units, and improve their understanding of the patient/consumer journey.

These resources are rarely accessible outside the Forensic Hospital. A new way of working would need to occur and the development of new pathway models for referral to Allied Health staff would be required. However, the benefit of Allied Health engaging with complex patients/consumers earlier in their custodial journey has great potential. Involved earlier on could support improved transition and release planning; access to NDIS, HASI and support services, reducing either time spent in the Forensic Hospital or potentially avoiding Forensic Hospital placement.

The Allied Health cost centre as a whole averaged $240,000 favourability over the past 5 years based on staffing vacancies, unspent education funds all of which have been redirected to offset the overall Forensic Hospital budget position. In particular the barriers to professional development activities were noted in consultation by Allied Health Staff who have been advised the hospital overall budget position impedes the Allied Health budget spending on these activities. It is noted that when fully staffed this cost centre would have far less favourability with approximately only $40,000 favourability when fully staffed. However, this does reinforce issues with the current structure, which may promote an alternative lensed approach.

Recommendation 1: JHFMHN Director Allied Health enhancement

This structure would see the repurposing of the Manager Allied Health position to increase the Director Allied Health role to full time, and move operational management of Forensic Hospital Allied Health staff outside the Forensic Hospital under the Director Allied Health. The four (4) senior disciplines and the Director Allied Health would all be part of the senior management meetings.

Recommendation 2: Forensic Hospital Senior Management Position

The majority of senior managers' positions would remain Nursing specific.

Key considerations with this approach**:**

For this to be successful, a robust model of care and referral criteria would need to be established, including:

- Alignment to future JHFMHN clinical service needs and directions;
- Referral criteria that is focused on patient needs, their journey and targeted at people who will likely require a Forensic Hospital bed;
- Alignment to the specifics of each disciplines scope of practice which would require education to a number of services; and
- Specific to mental health initially with an evaluation at twelve (12) months to ensure suitability and value for money.

Recommendations: Nursing

Findings:

Nurses within the Hospital were unable to clearly define the expectations and responsibilities of their role.

Nursing 1:

Clarify the roles and responsibilities of a Registered Nurse within the Forensic Hospital. This will drive patient centred care and expectations of staff.

Findings:

It is unclear what the differing accountabilities and responsibilities are for the differing Unit Managers across the site graded at NUM level 2 or 3.

Nursing 2:

The grading of the Unit Manager (NUM2/3) positions to be reviewed from the Grading Committee. It is beneficial for positions and grading's to reflect the expectations of the role.

Findings:

There is an inconsistent NUM1 allocation across the site with differing perceptions of the role. The NUM1 positions carry a high level of risk and responsibility when coordinating a shift. Clarity must be provided to define the duties and accountabilities that promote and enable clinical leadership and safe, quality patient care.

Nursing 3:

There is a NUM1 clinical lead for each day shift across the site and should be aligned and structured in a way which is consistent and allows for suitable leave coverage. This approach acknowledges the risk carried by clinical leads in this setting.

Findings:

Since the opening of the Hospital and the initial development of the nursing profile, EEN training and scope of practice has expanded. The number of EEN's within the Hospital is currently very low in comparison with other FMH services in Australia. The development of an EEN program would promote a pathway for future nursing growth and development.

Nursing 4:

Develop systems and structures to grow the Endorsed Enrolled Nursing workforce up to 20% of the total Nursing workforce. This is in line with comparable Forensic Mental Health Hospitals across the Australia and provides cost savings to fund career pathways aimed at increasing the Aboriginal Workforce.

Findings:

Aligning the positions with Allied Health will ensure workforce governance and Award compliance. The Allied Health Assistant role also has tertiary education programs available to support and equip this workforce with knowledge and skills to support their practice. This alignment would promote a pathway for Allied Health professional growth and development.

Nursing 5:

The Mental Health Care Worker role to be aligned to their Allied Health Assistant Award, which states they are supervised by Allied Health staff who can oversee competencies and greater supervision and support.

Findings:

The realignment of the Mental Health Care Worker position with Allied Health services will create a necessity to introduce nursing specific support staff. AINs can be an addition to the nursing team by assisting in the provision of basic nursing care. There could be scope for this position to support hospital processes that are not nursing specific. E.g. hospital bed sits and therapeutic leave.

Nursing 6:

The introduction of an Assistants-in-Nursing workforce to support Nursing duties seven (7) days per week. This workforce releases time to care for registered nurses and provides a strategy for increasing the Aboriginal Workforce through apprenticeship style programs designed to "Close the Gap".

Findings:

To enable full engagement as part of the senior nursing leadership team. This will promote the seamless facilitation of strategic direction, clinical leadership and operational governance.

Nursing 7:

A review of the roles and responsibilities of After Hours Nurse Manager team to be undertaken to provide greater engagement in governance and strategic direction.

Findings:

Staff and patient safety and the reduction of restrictive practices is a priority for the Hospital. This temporary structure has had a demonstrable positive impact in navigating what appear to be incompatible necessities in contemporary forensic mental health care. The permanency of this structure would facilitate a coordinated response to developing safe, quality, reliable care. The repurposing of the CNC3 would reduce any ambiguity of the clinical lead.

Nursing 8:

The current temporary Nurse Manager Staff Safety and Restrictive Practices made permanent, with line management of the CNC team and Nurse Manager Education and Practice Development positions, and proposed Manager Quality and Patient Safety, by repurposing the CNC3. This position should be strategically focused with practical application driven by the team it manages.

Findings:

Focusing the positions scope of practice in line with NSW Health Mental Health Focus areas. Defining the positions focus will reduce scope creep and blurring of the positions boundaries. This will release time to provide proactive clinical consultancy for patient care.

Nursing 9:

Refocus three of the CNC2 portfolios to Physical health, Restrictive practices and Forensic Recovery. These positions would work across the hospital and embed the principles and practice across all units.

Findings:

Quality and safety does not belong solely to the discipline of Nursing. Opening this position to dual grading allows for broader expertise within the team. This will reduce the dependency upon the CNC team to carrying a high proportion of the Hospitals Quality and patient safety portfolio.

Nursing 10:

Repurpose a CNC2 position into a dual graded health manager position which focuses on Quality and Patient safety. This is in line with consultation and previous reports recommending greater role delineation and provides a governance structure adaptable for future growth.

Nursing 11:

The proposed clinical nursing structure outlined by this report should be submitted for further consultation with the JHFMHN Workforce and the New South Wales Nurses and Midwives Association. (See page 46 – 49)

Proposed Shift Structure for each unit

Austinmer Adolescents

Shift Pattern			
	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	2	2	2
EEN	0	0	0
AIN	2 (10hrs) – Shift times determined by unit		1
AHA	1 (10hrs) – Managed by Allied Health		0

Base FTE Comparison		
	Current FTE	Proposed FTE
NUM1	2	3.22
RN	17.57	10.68
EEN	0	0
AIN	0	6.36
MHCW/AHA	1	2.12
Total	20.57	22.38

Austinmer Women's

Shift Pattern			
	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	5	5	2

Base FTE Comparison		
	Current FTE	Proposed FTE
NUM1	3	3.22
RN	36.24	20.34

EEN	2	2	2
AIN	2	2	1
AHA	1 (10hrs) – Managed by Allied Health		0

EEN	2	10.68
AIN	0	8.56
MHCW/AHA	1	2.12
Total	42.24	44.92

Bronte

Shift Pattern			
	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	6	6	3
EEN	2	2	2
AIN	2	2	1
AHA	1 (10hrs) – Managed by Allied Health		1

Base FTE Comparison		
	Current FTE	Proposed FTE
NUM1	2	3.22
RN	41.84	25.68
EEN	3	10.68
AIN	0	7.73
MHCW/AHA	2	2.12
Total	48.84	49.43

Clovelly

Shift Pattern

Base FTE Comparison

	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	4	4	2
EEN	1	1	1
AIN	2	2	1
AHA	1 (10hrs) – Managed by Allied Health		0

	Current FTE	Proposed FTE
NUM1	2	3.22
RN	26.77	17.12
EEN	0	5.34
AIN	0	7.73
MHCW/AHA	1	2.12
Total	29.57	35.53

Dee Why

Shift Pattern			
	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	4	4	2
EEN	1	1	1
AIN	2	2	1
AHA	1 (10hrs) –Managed by Allied Health		0

Base FTE Comparison		
	Current FTE	Proposed FTE
NUM1	2	3.22
RN	25.21	17.12
EEN	1	5.34
AIN	0	7.73
MHCW/AHA	1	2.12
Total	29.21	35.53

Elouera

Shift Pattern			
	AM Shift (0700-1530hrs)	PM Shift (1330-2200hrs)	Night Shift (2130-0730hrs)
NUM 1	1	1	0
RN	2	2	2
EEN	1	1	1
AIN	1 (10hrs)		0
AHA	1 (10hrs) – Managed by Allied Health		0

Base FTE Comparison		
	Current FTE	Proposed FTE
NUM1	1.6	3.22
RN	16.08	10.68
EEN	0	5.34
AIN	0	2.12
MHCA/AHA	1	2.12
Total	18.68	23.48

Recommendations: Allied Health

Findings:

Aligns with all Senior Management recommendations, consultation feedback, comparable services and Chaplow report. Provides greater career development and retains staff in line with JHFMHN Strategic Directions and Forensic Hospital Goals.

Allied Health Recommendation 1:

A career stepped model from transition year to senior clinician should be considered to help reduce the staffing exodus. The structure should include 2 FTE of senior clinicians in the professions of Clinical Psychology, Social Work, and Occupational Therapy representing the core Allied Health professions. There should be 1 FTE of senior diversional therapy and art therapy to reflect pathways for these professions. A stepped pathway should be available for Aboriginal and Peer workers.

Findings:

In alignment with recommendations 1, the Forensic Hospital patients should have equitable access to allied health resources. Seclusion and Restraint reduction initiatives, and international literature on seclusion and restraint note the value Allied Health input can provide to patient care and seclusion reduction, which has been evident through some patient stories provided to the reviewers. This proposed structure provides a fair and reasonable workload for Allied Health staff, and in line with Allied Health Recommendation 1 improves leadership, clinical knowledge, governance and supervision for Allied Health staff and Allied Health Assistants working 7 days.

Allied Health Recommendation 2:

Each unit should have an Allied Health FTE Build with the following professions: Clinical Psychologist, Occupational Therapist, Social Worker, Diversional Therapist, and a Peer worker. Acute units (Bronte, Adolescents, and Women's) should have a designated Art Therapist.

Findings:

This subjective feedback from the patient group has also been substantiated by Forensic Hospital data which showed on average patients across the Forensic Hospital have access to 219 structured therapeutic groups each month. An Allied Health Assistant Workforce should be considered to ensure group programs can be facilitated as these link directly into patient care and their ability to be referred to Medium Secure Units.

Allied Health Recommendation 3:

As noted above in the nursing recommendations the repurposing of Mental Health Care Worker positions in line with their award to Allied Health Assistants and movement of reporting to Allied Health is recommended. This adjustment will enable more tailored program delivery and a workforce capable of delivering activities across 7 days a week.

Findings:

Positions within the Forensic Hospital should be targeted to required expertise and not generic positions to maintain staffing numbers. This would include ensuring the recreational hall is staffed by a qualified exercise physiologist who has the skill set to provide exercise plans tailored to the individual patient's needs.

Allied Health Recommendation 4:

Ensure positions are specific to the required expertise, adjusting the recreation hall staff member from Diversional Therapist to an Exercise Physiologist. This recommendation would better support

tailored specific exercise programs that can improve the physical health needs of patients in line with current NSW Health guidelines.

Recommendations: Administrative Support

Findings: Ward Clerks

Ward Clerks have no leave relief and therefore rely on other Ward Clerks to cover their unit during times of leave. This can mean that one (1) Ward Clerk can be looking after three (3) units at one time.

FH Ward Clerks are currently conducting duties that are not in line with the recommendations outlined in The Garling Report (TGR). As per TGR it is more appropriate for a CSO to provide support for Managers and Doctors ensuring that their time is dedicated to clinical tasks rather than non-clinical workload.

As per TGR Ward Clerk duties should only include the maintenance of patient notes, tracking and maintaining medical records, processing admission and discharges and answering patient enquiries. Ward Clerks provide support in the general running of the unit.

Recommendations:

1. **Undertake a review of the current ward clerk and CSO's to clarify duties and ensure alignment with the TGR**
2. **A review of leave cover provision to be undertaken**

Findings: Personal Assistant to the Director of Nursing and Services

The position of Personal Assistant to the Director of Nursing and Services (PA DNS) was reported by the position holder to be sufficiently and appropriately operated.

The position has in the past been offered as HGD to administration staff, during times of leave, however, due to the position not incorporating the environmental allowance, there is no salary increase for staff on an Administration Officer Level 3 Award. Due to this reason, staff are not inclined to take on such a senior administration role, without a salary increase, leaving the position without leave cover.

The position is required to work within the Forensic Hospital and encounters daily face to face interaction with patients, within the units and in common areas.

Recommendations:

1. **It is recommended that the PA DNS position include the environmental allowance.**

Findings: Personal Assistant to the Clinical Director Forensic Hospital and Deputy Director of Nursing

The position of Personal Assistant to the Clinical Director Forensic Hospital and Deputy Director of Nursing (PA to CDFH/DDON) was reported by the position holder to be sufficiently and appropriately operated.

On review of the Administration State Award, it is identified that the position has been inappropriately graded as an AO5. It is recommended that this position be regraded to an AO6.

The position has in the past been offered as HGD to administration staff during times of leave, however, due to the position not incorporating the environmental allowance, there is no salary increase for staff on an Administration Officer Level 3 Award. Due to this reason, staff are not inclined to take on such a senior administration role without a salary increase, leaving the position without leave cover.

The position is required to work within the Forensic Hospital and encounters daily face to face interaction with patients, within the units and in common areas.

Recommendations:

3. **It is recommended that the PA CDFH /DDON position include the environmental allowance.**
4. **It is recommended that the position be regraded at an AO6.**

Findings: PAS Inpatient Clerk

The PAS Inpatient Clerk position was identified as being inappropriately titled and having scope for additional duties, such as providing leave relief to administration staff within the FH, conducting patient purchasing duties and providing administrative support to Medical Officers within the FH. To ensure a broad scope of duties, the position should also be regraded to an AO3 and renamed as a CSO.

It is important to note that multiple attempts were made to interview the incumbent, however these were declined.

Recommendations:

1. **It is recommended that the position be regraded from an AO4 to an AO3 and be retitled as a CSO.**
2. **Additional duties such as patient purchasing, leave relief provision and administration support to Medical Officers to be added to the position description.**

Findings: MHRT Liaison and Report Coordinator

The MHRT Liaison and Report Coordinator position was identified as undertaking additional duties that are not included in the current position description, however are noted as being appropriately aligned to the position. The duties include administrative support to the Manager Allied Health. To ensure a broad scope of duties, the position should be renamed to MHRT Liaison and Allied Health Administration Officer.

The position has in the past been offered as HGD to administration staff, during times of leave, however, due to the position not incorporating the environmental allowance, there is no salary increase for staff on an Administration Officer Level 3 Award. Due to this reason, staff are not inclined to take on such a senior administration role, without a salary increase. Leaving the position without leave cover.

The position is required to work within the Forensic Hospital and encounters daily face to face interaction with patients, within the units and in common areas.

Recommendations:

3. **It is recommended that the position be renamed to MHRT Liaison and Allied Health Administration Officer.**
4. **The position description is to be updated as per additional duties undertaken.**
5. **It is recommended that the position include the environmental allowance.**

Budget Impact of Administration Recommendations

Current Administration Budget

Position	No of Staff on rate	Total FTE	Salary Cost per FTE per Year	Current Total cost per year	Notes
Admin Officer Lvl 3 - 2nd Year	8	8	68,500	547,998.98	
Admin Officer Lvl 4 - 2nd Year	1	1	73,736	73,735.70	
Admin Officer Lvl 5 - 2nd Year	1	1	75,685	75,684.58	No allowances
Admin Officer Lvl 6 - 2nd Year	2	2	82,112	164,224.60	No allowances
Total	**12**	**12**		**$ 861,643.87**	

Proposed Administration budget

Position	No of Staff on rate	Total FTE	Salary Cost per FTE per Year	Current Total cost per year	Notes
Admin Officer Lvl 3 - 2nd Year	9	9	68,500	616,498.85	
Admin Officer Lvl 6 - 2nd Year	3	3	85,197	255,591.00	Environmental Allowance included
Total	**12**	**12**		**$ 872,089.85**	

Efficiency Savings

Based on consultation and analysis, efficiency savings have been calculated based on the amount of time each medical position devotes to simple administrative duties that should be conducted by administration staff. It is acknowledged this estimated releasing time to care efficiency saving will step outside the administration specific budget and touches on a staff profile outside the scope of this review. However, due to costs being a significant driver the review team felt it was important to acknowledge an important highly valuable potential efficiency savings. Although medical staff are not in scope for this review, the efficiency saving of $200,000 in salaries and wages for medical staff will support patient care, and in scope staffing provide care and is worth consideration.

Position	No of Staff on rate	Total FTE	Salary Cost per FTE per Year	Hrs spent per week on admin tasks	Admin Duties Cost per year	Notes
Senior Staff Specialist - Level 1	6	3.3	$ 364,456.49	13	91,114	
Staff Specialist - Level 1, Year 5	2	1	$ 330,269.75	4	25,405	
Staff Specialist - Level 1, Year 3	2	1.6	$ 304,073.96	6.5	38,009	
Staff Specialist - Level 1, Year 2	1	0.6	$ 286,172.41	2.5	13,758	
Staff Specialist - Level 1, Year 1	2	1	$ 268,888.53	4	20,684	
VMO	1	0.4	$ 306,257.00	2	11,779	Equivalent 16 hrs/week or 834.86 hours per year
Total	**14**	**7.9**		**32**	**200,750**	

Abbreviations

Acronym	Meaning
AH	Allied Health
AO	Administration Officer
CDFH's	Clinical Director Forensic Hospitals
CSO	Clinical Support Officer
DDON	Deputy Director of Nursing
DNS	Director of Nursing and Services
FH	Forensic Hospital
JHFMHN	Justice Health and Forensic Mental Health Network
MAH	Manager Allied Health
MAS	Manager Administrative Services
MDT	Multi-Disciplinary Team
NUM	Nursing Unit Manager
PA	Personal Assistant
PAS	Patient Administration System
PD	Position Description
PIC	PAS Inpatient Coordinator
WC	ward Clerk

Appendices

Appendix 1: Term of Reference

Health
Justice Health &
Forensic Mental Health Network

DG14032/20

Terms of Reference

Forensic Hospital Staffing Profile Review

Contact Officer

Jason Sevil

A/Co-Director Forensic Mental Health

Justice Health and Forensic Mental Health Network

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The Forensic Hospital provides specialist mental health care through a step down model for adults and young people, both male and female. The patient demographic includes; forensic, correctional and high risk civil patients. Patients are primarily found not guilty by reason of mental illness and a small contingent of patients found unfit to plead.

The current staff profile which includes Nursing, Allied Health, Administration and Medical staff, has remained largely unchanged since the Forensic Hospital commenced operation in 2008. Since then the Forensic Hospital has been confronted by a number of challenges, including but not limited to:

a. Significant expansion in the provision of service and level of care provided to Forensic Hospital patients
b. Substantial effort and commitment to improving work place safety through the development of systems of support which reduce incidents of aggression towards staff.
c. High staffing vacancy rates and overtime costs.

Given the current restriction on traveling and social distancing associated with COVID 19, suitable "virtual" methods such as via Audio visual links will be considered.

Positions not in scope

Medical staff are not within scope of this review.

Review Objective

The Staffing Profile review will determine whether the current; Nursing, Allied Health and Administration staffing profile meets the clinical and operational needs of the hospital; ensuring care delivery is high quality and expenditure is efficient. The preference is for and expenditure to be held within existing Forensic Hospital budget, however this should not be a barrier. The Review must incorporate the following:

a. Consumer perspectives.
b. An environmental scan of literature on Forensic Hospital staffing profiles and interstate benchmarking of Forensic Hospital staffing profiles.
c. Consider if there are gaps or limitations within the current staff profile which may be mitigated or reduced through alternative modelling. Any proposed changes to the model must continue to uphold least restrictive care principles and maintain a safe environment for all.
d. Alignment with the approved allied health restructure whilst considering the feasibility of 7 day AH provision.

Methodology

Desktop, "virtual" via audio visual technology, or other suitable methods of consultation with all staff in scope of the review.

Desktop review of relevant Hospital policies, procedures, included the following:

- The Health Professionals Workforce Plan 2012-2022
- Forensic Hospital Operational budget 2019-2020
- JHFMHN Strategic Plan 2018-2022
- Forensic Hospital Operational Plan 2018-2022
- Brief to CE re Forensic Hospital Staff Profile Review (DG88631/19)
- Review of the trial Allied Health Assistance and Mental Health Care Workers (DG46770/19)
- Relevant industrial awards
- Forensic Hospital Daily rosters and establishment data
- IIMS data
- VPM and CRAM Training Frameworks
- Management of Emergency Procedure
- Psychiatric Emergency Management Procedure
- Staff Safety Reports October, November and December 2019
- Seclusion and restraint Data
- KPMG Report on Hospital Escorts
- Allied Health Proposed Restructure – Discussion Paper

Consultation

Consultation will occur with staff in scope of the review and/or in clinical/operational/discipline leadership roles.

Consultation with industrial bodies (HSU and NSWNMA) will occur during the review process, and/or if receipt and acceptance of review recommendations impacts staffing.

Reviewers

Suitable external nursing and allied health reviewers will be appointed by the Executive Director.

Suitable internal nursing, allied health and administrative support staff will be appointed by the Executive Director.

Reporting

A written report on the findings in relation to the scope of the review for dissemination to parties approved by the Executive Director.

Completion Date

The report is to be provided to the contact officer no later than eight weeks from commencement staff consultation.

Confidentiality

- The reviewer(s) will ensure that any material used, copied, supplied or reproduced will be solely for the purposes of performing this review and will be returned to JHFMHN.
- This report is solely for the use of Justice Health and Forensic Mental Health Network and any reliance on this report by third parties shall be at such party's sole risk and may not contain sufficient information for purposes of other parties or for other uses.
- Information collected from staff maybe used for future research, this will be communicated to involved parties, and dependant on ethics approval.

Appendix 2: Operational Plans

Operational Goal	Link to JHFMHN Strategic Plan	Action Required	Outcomes	Action Officer	Timeframe	Performance
1 . To provide the Forensic Hospital with best practice, allied heath care whilst improving participation and empowerment of patients.	Strategic Direction 1 - 1.1 (a) - 1.1 (c) - 1.1 (f) - 1.1 (g) - 1.2 (a) - 1.3	-Review the delivery of Allied health care under the Hospital Model of Care and implement -Conduct a gap analysis on service needs and allocation of resources and address through service planning -Focus on collaborating with patients and partnering with them on their care journey -Improve the physical health of forensic mental health patients	Improved and equitable access to timely therapeutic interventions Measurable improvements in physical and mental health outcomes Greater consumer involvement and participation	Manager Allied Health	August 2019	Service gaps are acknowledged and addressed through service planning Demonstrated improvements in the physical and mental health of patients Patient empowerment and co-design in the delivery of therapeutic interventions
2 . To develop valuable partnerships with our local communities and key stakeholders	Strategic Direction 2 - 2.1 (c) - 2.2 (a) - 2.2 (d) - 2.2 (e)	-Develop partnerships with local organisations and stakeholders - AHC, DET -Strengthen relationships with health facilities and providers -Implement successful NDIS strategy -Foster relationships with local communities and groups – Elders, First Hand Solutions	Improved access to NDIS services for eligible patients Greater engagement and with local Elders and cultural groups Collaboration and partnership within JHFMHN and with key organisations and service providers	Manager Allied Health	June 2019	Increased choice of disability providers for our patients Healthy relationships with local communities and increased cultural connectedness Collaborate with key stakeholders and organisations to provide a seamless service
3. Develop and retain a talented Allied Health workforce that is adaptable and responsive to clinical need	Strategic Direction 3 - 3.1 (b) - 3.2 (a) - 3.3 (b) - 3.3 (c) - 3.3 (e)	-Develop leadership skills and capacity building opportunities -Develop effective management structure -Foster a strengths based approach -Develop a Peer Workforce -Develop Aboriginal workforce	Pathways for career development and building workforce capacity A sustainable workforce that is able to meet service needs in a proactive manner Community of Practice - SAPROF	Manager Allied Health	June 2020	A workforce culture that retains and promotes talented and valued staff A sustainable workforce that grows and develops talent from within A safe workplace for all staff
4. Position Allied Health to operate in a changing environment	Strategic Direction 4 - 4.1 (a) - 4.4 (a) - 4.3	-Investigate potential therapeutic applications of advances in technology -Continuous improvement of individual, group and family based therapeutic interventions -Develop discipline specific performance indicators -Record health outcomes and activity data	Technology and internet based therapeutic solutions for patients An established community Informed decision making in regards to resource allocation and service delivery Deliver an effective and efficient service based on evidence	Manager Allied Health	March 2020	Data driving change in the Hospital and used to demonstrate performance and health outcomes for our patients Secure PC integration in Forensic Hospital Evidence informed redesign of Allied Health programs

Operational Goal	Link to JHFMHN Strategic Plan	Action Required	Outcomes	Action Officer	Timeframe	Performance
Attract grow and retain a talented workforce	SD 3 – Outcome 3.2, 3.3	- Development of a recruitment strategy -Support and build capacity of existing staff; through education, professional development and support services -Review of staffing resources is undertaken Including Nursing, Allied Health Aboriginal and Peer workforce	Implementation of the recruitment strategy which reduces vacancies The Hospital has a designated pathways for career development and a system which supports / enhances staff wellbeing The Hospital has a staff profile which enriches the whole person and complements our the divers patient cohort	Director Of Nursing and Services	June 2019	Reduction in staff vacancies and the cost of overtime Retain our talented and valued staff Introduction of a Peer and Aboriginal workforce and clinical staff who ad to diversity and clinical need of the patient population
Strive to position the service as a leader in Forensic Mental Health care and a centre of excellences based on evidence best practice	SD1 and 4 – outcome 1.2 (a)	-Review the vision and model of care of the Hospital -Conduct a service gap analysis of ; the recovery framework, six core strategies, Trauma informed Care and Practice toolkit and develop recommendations	Staff are aware of aspiration of the model of care and vision statement. Research and, analysis is utilised by the hospital to inform practice , service delivery and planning, Which includes development of Key performance indicators And working to reduce Cohesive practices	Director Of Nursing and Services and senior leadership/ Clinical team	Aug 2019	The vision and model of care is embedded into orientation and the culture of the Forensic Hospital Analysis of gaps in service are acknowledged and addressed through a plan and be marking occur with similar facilities Recommendations are embedded into training
Develop and improve Patient participation and empowerment	SD1 1.2	The Hospital will review the patients journey and explore avenues for support and choice and better health	Review IT access Secure PC, Skype Development of Peer workforce Strength assessments, review of existing pathways to better physical health and community care	Director Of Nursing and Services, and Senior leadership/ Clinical team	Aug 2019	Choice of Disability providers Introduction of the Peer workforce Introduction of whole of person measures such as Saprof Risk tool, The physical health space
Develop a service and infrastructure which is responsive to clinical need	SD4 Outcome 1.3 (d)	Develop a governance and support process for project identification management in the hospital.	The Hospital will have a framework for the identification and implementation of projects and support for project leads which will build capacity in the Hospital for innovation and effective change management	Director Of Nursing and Services and Senior leadership	October 2019	There is an established process and meeting to manage Change management

Appendix 3 Brief for Chief Executive Approval Allied Health Assistants/Mental Health Care Workers

Brief for Chief Executive

Clinical Operations

Forensic Hospital Staff Profile Review

Topic To provide the evaluation of the Allied Health Assistants and Mental Health Care Workers (AHA/MHCWs) trial and seek approval to proceed with staff profile review (excluding medical).

Analysis The Forensic Hospital trialled eight temporary of AHA/MHCWs for 24 months. The trial of the AHA/MHCWs has demonstrated a substantial increase of service provision to the long-term seclusion patients, Centralised Group Program and Allied Health services. A staff profile review of the Forensic Hospital would have other benefits. The review would be conducted by a suitable team including Forensic Hospital staff and independents preferably from a forensic mental health in another jurisdiction.

1. Approve an independent staff profile review of the Forensic Hospital (excluding medical)

Rajiv Anand
A/Chief Executive

Rajiv Anand **Date** 25/11/19
Linked with DG 18515/19
To next ERC

The Forensic Hospital trialled eight temporary of AHA/MHCWs for 24 months

In 2017, the Forensic Hospital identified service deficits in relation to two long-term seclusion patients' access to therapeutic programs. Three key service deficits were identified by Forensic Hospital senior management in 2017; (1) inadequate time out of seclusion for two long-term seclusion patients which may be in violation of human rights, Mental Health Review Tribunal recommendations and family/carer concerns; (2) High cancellation rates of Centralised Group Program (CGP) groups and reduced access to therapeutic programs; and (3) Clinicians' time being diverted from core clinical tasks and Allied Health services.

Eight positions were created; four AHA and four MHCW positions for the two year trial (recruitment, development, 12 month implementation and evaluation) **(TAB A).** An evaluation of the trial has now been completed with the eight contracts currently due to expire on 8 April 2020.

These positions were approved on the basis of redesign of current nursing FTE and remain unfunded at this time.

The trial of the AHA/MHCWs has demonstrated a substantial increase of service provision to the long-term seclusion patients, Centralised Group Program and Allied Health services

The effectiveness of the AHA/MHCWs is demonstrated in a Review of the Trial **(TAB B).** Option 3 in the Review report is recommended.

Continued employment of the AHAs and MHCWs is considered essential to ensuring continuity of care and to maintain the level of service provision in the Forensic Hospital.

The trial has seen an exponential increase in the time out of seclusion for the long term seclusion patients, exposing them to therapeutic activities and programs. Furthermore these positions have provided additional support to nursing staff, through reducing levels of exposure to events which can cause vicarious trauma and compassion fatigue. KPI data for AHA positions demonstrates the effectiveness of the trial in the Forensic Hospital between March 2018 and March 2019 **(TAB C).** The

positions also have the potential to be added to the Emergency Response Team, further increasing staffing safety in the Forensic Hospital

The eight temporary AHA/MHCWs are unfunded; however loss of the positions would be detrimental

The failure to implement on FTE redesign has resulted in eight positions posing a cost pressure to the Forensic Hospital of $448,424 per annum.

The temporary AHA/MHCWs were originally intended to be funded during the trial using eight vacant nursing positions, however the hospital has continued to roster premium nursing labour (either overtime or agency staff) against those eight vacant positions, so the current arrangement is not financially viable.

The evaluation demonstrates the effectiveness of trial and significant improvement in care delivery.

A staff profile review of the Forensic Hospital would have other benefits

The staff profile of the hospital has not been reviewed since its opening 10 years ago.

A review would also determine whether the current nursing, allied health, corporate and administrative staff meet the current clinical and operational needs of the hospital. Medical staff would not be included in the staff profile review.

Changes to the staff profile would also be intended to reduce the chronic nursing vacancy in the hospital, reduce the need for nursing staff to do escorts and bed-sits, reduce the hospital's nursing overtime, and reduce use of premium cost nursing agency staff.

The review would be conducted by a suitable independent from forensic mental health in another jurisdiction

If proceeding to a staff profile review is approved, a terms of reference will be drafted. A suitable person from Health in another jurisdiction would be engaged to conduct the review.

The review will require consultation with staff and industrial associations, and may be controversial.

Consultation

Allied Health and Austinmer Women's, Forensic Hospital David Ananin, A/Manager Allied Health, Forensic Hospital

Kevin Baron, Deputy Director of Nursing and Services, Forensic Hospital Jason Sevil, Director of Nursing and Services, Forensic Hospital Katherine Jones, Director of Allied Health, JHFMHN

Appendix 4: Review of AHA/MHCW Two Year Trial.

REVIEW OF TWO YEAR TRIAL

ALLIED HEALTH ASSISTANTS AND MENTAL HEALTH CARE WORKERS

FORENSIC HOSPITAL 2019

Author: Jason Sevil in consultation with Scott Gill, Kevin Baron and David Ananin

1. Executive Summary

This paper will outline the effectiveness and significant improvement in care delivery during a two year trial of multidisciplinary Allied Health Assistants (AHAs) and Mental Health Care Workers (MHCWs) within the Forensic Hospital.

The trial was initiated to improve the care of two high risk and complex forensic mental health patients who were housed in seclusion for a significant period of time. The paper will cover the background to initiation of the trial and outline the specific roles and differences in both workforces and the current progress on the identified service deficits.

Furthermore, the paper will outline the achievements and benefits of the trial and the challenges the Justice Health and Forensic Mental Health Network (the Network) faces to continue to provide this level of service provision.

In conclusion the paper will outline three options available to the Network that best protect its employees, care for its patients, and is cost effective.

2. Background

The Forensic Hospital provides specialist mental health care through a step down model for adults and young people, both male and female. The patient demographic includes forensic, correctional and high risk civil patients. The forensic patient demographic consists primarily of patients found not guilty by reason of mental illness and a smaller contingent of patients found unfit to plead.

Since 2008 there has been significant growth in the provision of service and level of care provided to the Forensic Hospital patient cohort. In recent years, the Forensic Hospital has also struggled with a high staffing vacancy rate and turnover, in part due to vicarious trauma.

Three key deficits were identified by senior management within the Forensic Hospital service provision:

1. Inadequate time out of seclusion for two long term seclusion patients
2. High cancellation rates of the Centralised Group Program (CGP)
3. Clinicians' time being diverted from core clinical tasks to facilitate therapeutic groups

In 2017 the Forensic Hospital recruited four AHAs and four MHCWs on a two year temporary basis until 8 April 2020. These positions were employed to provide direct patient care and support the operational functionality of nursing and allied health (AH) staff by:

- Facilitating time out of seclusion for two complex high-risk patients in line with legislative requirements and Mental Health Review Tribunal (MHRT) recommendations
- Assist with patient medical escorts and therapeutic leave
- Conducting diversional activities
- Assisting with the expansion and facilitation of the CGP
- Providing increased supervision and staffing of the Recreation Hall
- Allowing nursing and AH staff to redirect their time to other core clinical activities

3. Role of Allied Health Assistants and Mental Health Care Workers

AHAs and MHCWs work within the multidisciplinary teams (MDT) to actively reduce the hours spent in seclusion for two complex patients. Both patients require a team of five VPM trained staff to safely allow the exit from seclusion. Beyond this similarity, both roles have quite different day to day functions and purpose within the Forensic Hospital.

AHAs

The AHAs provide assistance and support to the AH professionals in the delivery of AH services to patients of the Forensic Hospital. AH professionals in the Forensic Hospital currently work Monday – Friday between 0800 – 1630 hours.

Each AHA devotes on average two hours/day, equating to 10 hours per week, facilitating time out for the two long term seclusion patients in partnership with the Austinmer Women's team. This limit of 10 hours per week (25% of their contracted hours) per staff member is a management strategy implemented to limit vicarious trauma, burnout and to encourage the retention of staff. This strategy has been highly successful with no staff resigning due to working with these two complex patients.

In addition to their role in facilitating time out of seclusion, the AHAs engage in other therapeutic or administrative activities under the direction and/or supervision of an AH professional, allowing clinicians to redirect their time to discipline-specific activities.

AHAs have been heavily utilised as co-facilitators of therapeutic groups as part of the CGP. AHAs currently co-facilitate half of the 26 CGPs being facilitated in the Forensic Hospital each week. AHA activities include:

- Adolescent education sessions
- Alcoholics Anonymous
- 5 x Bike Riding Groups
- 4 x Chapel services
- Consumer led Barista Group
- Consumer led Horticulture Group
- 2 x Computer groups
- 2 x Music groups
- 2 x Psychology clinics
- Study Skills
- 5 x Swimming groups
- Women's Art Therapy
- Psychological groups
- Therapeutic Leave events
- Op Shops – monthly
- Field Days – monthly

Additionally AHAs help to cover periods of leave, ensuring consistency and continuity of care to our patients.

Key Performance Indicators - Allied Health Assistants

To evaluate how effective the two year trial of the four multidisciplinary AHAs in the Forensic Hospital, three Key Performance Indicators (KPIs) were established (*please see figure 7.1).* These were developed in line with the three deficits highlighted on page one of this document. The KPIs are as follows:

- KPI 1: Amount of time out of seclusion facilitated
- KPI 2: Improvement in the facilitation of the Centralised Group Program
- KPI 3: Hours reinvested for Allied Health professionals

A summary for each of the three KPIs is discussed below whilst addressing the three key deficits.

MHCWs

The MHCW position provides practical support services to aid clinical nursing staff within the MDT. In coordination with the MDT, MHCWs are involved in the initiation of appropriate general service delivery and provision of mental health care; while maintaining the safety and security of the patients and staff in the Forensic Hospital.

MHCWs currently support the nursing team by completing the following tasks:

- Assisting with seclusion exits for two long term patients
- External escorts for medical appointments
- Meal provision
- Facilitation of diversional and other therapeutic activities
- Supervising visits
- Facilitating unit morning meetings
- Facilitating walks for patients
- Administration support – completing IIMS and Restraint Register
- Facilitating kiosk access
- Facilitating patient buy-ups and access to patient property
- Dentist and hairdresser support
- Recreational Hall access
- Room searches
- Facilitating therapeutic leave
- Assist with new admissions to the unit.

MHCWs also complete other tasks as delegated by the Nurse in Charge (NiC) or Nursing Unit Manager (NUM).

4. Service Deficits

4.1 Inadequate time out of seclusion for two long term seclusion patients

As discussed previously the Forensic Hospital has two patients who are in long-term seclusion due to their ongoing high risk of violence. Patient 1 has been in seclusion since August 2013 and Patient 2 since April 2014.

These patients represent only 1.6% of the Forensic Hospital's population. However they are significantly over represented in the Forensic Hospital IIMS reports from June 2018 to June 2019 as shown below:

- 64% of total Forensic Hospital aggression death threats
- 40% of total Forensic Hospital discrimination, prejudice, harassment
- 29% of total Forensic Hospital aggression bullying and intimidation
- 28% of total Forensic Hospital aggression against an inanimate object
- 27% of total Forensic Hospital verbal aggression
- 14% of total Forensic Hospital aggression throwing objects
- 13% of total Forensic Hospital physical aggression
- 11% of total Forensic Hospital aggression other

In line with international best practice the Forensic Hospital is striving to reduce the total amount of seclusion hours for both patients. Whilst this approach has been commended by the Mental Health Review Tribunal (MHRT), the MHRT has issued further strong recommendations to continue to increase this time out of seclusion. This challenge is further complicated by the Network's duty of care and the legislative requirements under the Mental Health (Forensic Provisions) Act 1990. Furthermore, Integrated Service Response (ISR) is undertaking a project to explore possible short, medium and longer term improvements in the care and support of Patient 1.

Clinicians within the Forensic Hospital have been working collaboratively across all disciplines to increase the quantity and quality of seclusion time out for both patients. The Forensic Hospital has adopted a distinctive approach to staffing, utilising the AHAs and MHCWs to support clinical staff in reducing seclusion hours for the two high risk patients; whilst simultaneously working towards resolving complex placement issues to create sustainable access to less restrictive care.

Patient 1

Patient 1 is a 36 year old Aboriginal woman, who is a civil involuntary patient under the Mental Health Act 2007. Patient 1 is currently placed in a secure and highly restrictive environment to contain her risk of aggression.

Triggers for aggression include perceived rejection/abandonment, loss of or removal of property, physical health issues, requests being denied, references to paedophilia or crimes against children, television programs with violent or gory content, boredom, high risk periods (e.g. Tribunal dates, Christmas, significant anniversaries), casual/agency/new staff or staff she does not like, inconsistent management or routine and being denied her time out of seclusion.

A significant amount of effort has been put into engaging Patient 1 in a less restrictive environment. Since 2017 some of the key achievements have been:

- changing practices to be less restrictive with a more patient-centred approach
- reviewing practice to reduce the risk of traumatisation when administering medications
- facilitating a significantly increased amount of time out of seclusion

Another significant outcome has been implementation of a timetable (*see figure 7.2*) which was developed to have structured times and activities for the patient. At present staff currently facilitate time out of seclusion twice a day, for two hours total. This timetable was developed through collaboration between the patient and treating team. It is flexible and adaptable, offering a range of interchangeable therapeutic activities of the patient's interest.

Patient 2

Patient 2 is a 44 year old woman; diagnosed with severe treatment resistant schizophrenia with persecutory delusions, perceptual disturbances and disorganised behaviour. The specific content of her delusions and perceptual disturbances are complex and frequently changing, resulting in aggressive behaviour.

Patient 2 displays two main patterns of aggression. The first is an unpredictable, sudden attack on someone in close proximity. Psychotic phenomena have been associated with these incidents, including paranoid ideation, passivity phenomena and auditory hallucinations. The second pattern is an impulsive and reactive aggression with overt anger. Typical acts of aggression are kicking, hitting or scratching. Given the ongoing incidents of aggression during seclusion exits, Patient 2's risk for assault is very high. The use of mechanical restraints allows some modulation of this risk.

Whilst the trajectory for improvement is slow, the AHAs and MHCWs are playing a pivotal role in both building team rapport with Patient 2 and allowing her to engage in diversional activities outside of seclusion. These staff members are involved in her twice daily exits, engaging her in meaningful therapeutic activities. For example, AHAs facilitating occupational and diversional therapy directed activities with consistent staffing. If these positions did not exist Patient 2 would not be able to safely exit seclusion regularly and/or other patients from the unit would be unable to complete other therapeutic activities.

Due to the imminent risk posed by both patients discussed above and from implementing various strategies it can be said that the greatest achievements with these patients are shown through consistent staffing and regular time out of seclusion. Increased time out of seclusion creates a less restrictive and more soothing environment to enhance each patient's ability to self-regulate thus

decreasing aggressive behaviours. Additionally, exits from seclusion increase meaningful engagement in diversional activities, rapport building, enhanced social skills, and increased exposure to high stimulus environments and reintegration onto to the unit and the Forensic Hospital.

KPI 1: Amount of time out of seclusion facilitated

Since February 2018 multidisciplinary AHAs in the Forensic Hospital have been able to:

- Deliver 1,438 occasions of service;
  - 834 hours facilitating time out of seclusion, engaging in therapeutic activities.

**Note: This data only reflects the times in which an AHA was present.*

Without the support of AHAs and MHCWs seclusion exits could not be facilitated daily thus causing further deterioration in both of these patients and the reduction of service provision to the other 15 patients on the women's unit.

4.2 High cancellations rates of the CGP

KPI 2: Improvement in the facilitation of the Centralised Group Program

The CGP is a hospital wide therapeutic group program with a bio-psycho-social model, which is a major component of the patient's rehabilitation and recovery journey. This program was formally implemented in the Forensic Hospital in January 2013, with the program developing based on the clinical need of the Forensic Hospital's patient cohort.

Since February 2018 the four multidisciplinary AHAs have:

- facilitated 640 CGP groups averaging 36 groups per month
- facilitated 760 hours of CGP groups

Since implementation of AHAs the CGP has significantly decreased the cancellation rate of groups. Prior to AHAs, approximately 60% of booked groups were successfully facilitated. This has now increased to a monthly completion of rate of 91%. There has also been a significant increase in the number of therapeutic groups that are now on offer to patients in the CGP; with an increase of approximately 30% more groups (*see figures 7.3 and 7.4)*. These two factors alone demonstrate how valuable the AHAs have been in increasing patient access to therapeutic groups that meet their clinical identified needs and facilitating their recovery journey. It also enables AH professionals to devote a greater percentage of their time to clinical tasks that require advanced clinical reasoning such as assessment, diagnosis and treatment planning.

4.3 Clinicians' time being diverted from core clinical tasks to facilitate therapeutic groups

KPI 3: Clinical hours reinvested for Allied Health Professionals

The Forensic Hospital's AH team is comprised of 15 different disciplines. A total of 872 hours of Allied Health Professional's time has been reinvested across Allied Health disciplines.

- Occupational Therapy 254 hours
- Diversional Therapy 188 hours
- Recreation Hall 149 hours
- Other 134 hours
- Psychology 81 hours
- Social Work 66 hours

Since the implementation of the multidisciplinary AHAs, an increase of over 870 hours of diversional, psychological and therapeutic care and activities have been delivered to the patients within the Forensic Hospital.

In summary, since implementation of the AHAs in the Forensic Hospital they have redirected and saved the Network a total of 2466 hours of clinician time (all KPI's combined). This is a saving of $11.46 per hour. This time saved has been redirected to core clinical tasks, providing a further saving of $28,260 to the Network. It must be noted that this amount does not include any time saved for clinicians in administration tasks also completed by AHAs.

5. Budget impact

AHA/MHCWs are paid under the *Allied Health Assistants (State) Award 2019*. These positions are currently unfunded.

Median cost per annum of 1.0 FTE:

- AHA/MHCW $56,053 per annum
  - x8 $448,424 per annum
- AH professional $78,692 per annum
- Registered Nurse $76,887 per annum before allowances

Analysis

Over the past 10 years there have been significant changes in the needs and patient cohort of the Forensic Hospital. The initiation of this trial was in direct response to these changing needs and the requirement to provide safe and reliable care to complex and challenging high risk patients.

The Forensic Hospital now faces a significant challenge whereby without the continuation of the current increased profile it is not possible to facilitate further increases in time out of seclusion nor maintain the level of Allied Health services across the service. In order to maintain the current therapeutic engagement timetables for the two long term seclusion patients alone, it has been estimated that 6.58 FTE staff are required. This total is not inclusive of the contribution to the maintenance of the Centralised Group Program and Allied Health service provision.

Whilst the Forensic Hospital has been commended by the MHRT for the progress made with the two seclusion patients, they both expect and recommend we continue to increase and extend the level of care provided, in particular hours out of seclusion. Consequently terminating the positions and attempting to provide the same level of service provision within the originally budgeted FTE, would pose a significant safety and unreasonable work load issue.

At a State-wide level it is recognised that the Forensic Hospital manages particularly challenging patients which is demonstrated by the involvement of Integrated Service Response (ISR). ISR assists services to coordinate wraparound support for a person who has a disability and complex support needs, when their wellbeing is threatened by a crisis. They achieve this through facilitating collaboration and assisting in the development of a comprehensive plan to achieve the outcomes required. ISR are currently undertaking a project to explore possible short, medium and longer term improvements in the care and support of Patient 1. The need for additional staffing has been clearly identified through this process, although nil additionally funding has been offered.

Recently, the mental health intensive care unit, 'Freshwater' has been approved for full capital funding. Discussions regarding the proposed staffing profile have commenced. The success of this trial has highlighted the need for AHA/MHCWs in the proposed staffing profile. AHA/MHCWs have proven to be an effective and valuable addition to the team, and particularly cost effective.

Should AHA/MHCW contracts be extended temporarily there is potential that they could be absorbed into the staffing profile of Freshwater once it comes online. This would be conducive with the model of care, as it is likely foreseeable that our long term seclusion patients would be eligible for care in the Freshwater Unit for periods of intensive care.

At a service level, the loss of the eight positions would result in a decrease of CGP group facilitation, diversional activities and care provided to all patients. Furthermore, there is a direct correlation

between patient engagement and adverse incidents. It is anticipated that terminating these positions would contribute to a significant decrease in staff and patient safety.

Ultimately, this may leave the Network exposed to an increased risk of litigation in relation to potential breaches of human rights and relevant legislation such the *Mental Health Act 2007, Mental Health (Forensic Provisions) Act 1990* and the *Work Health and Safety Act 2011*.

6. Conclusion

There is no simple solution to this complex problem and it is acknowledged that to provide an adequate level of care to these patients and to minimise risk of exposure to litigation, something needs to change. The AHA/MHCW trial has demonstrated an effective model to address this complex problem, along with many other collateral benefits to patient care across the service.

However, the described increase in care comes with considerable cost implications not currently budgeted within the Forensic Hospital FTE. Therefore it is recommended that the Hospital pursues the option that will best protect its employees, care for its patients, is cost effective and will best position the Hospital for the future.

The authors endorse option 3 as the best solution available.

Recommendations

The options outlined below are presented for consideration:

- **Option 1:** Cease trial
    - Terminate the eight employees
    - Significant increase of seclusion hours
    - Exposes the Network to litigation and potential breaches of human rights
    - Non – adherence to MHRT current recommendations
    - Increased cancellation rate of Centralised Group Program
    - Reduced access and number of therapeutic group programs
    - Significant increased risk to staff safety and WHS concerns

- **Option 2:** Temporary extension
    - Extend the eight temporary employee contracts
    - Continuity of care and level of service provision in the Forensic Hospital
    - Reduced risk of litigation and breaches of legislation
    - Continue to foster a safe working environment for both staff and patients
    - Financial impact is an additional cost to the Hospital of $448,424 per annum

- **Option 3:** Full review of Forensic Hospital staffing profile
    - Extend the eight temporary employee contracts
    - Continuity of care and level of service provision in the Forensic Hospital
    - Engage an independent consultant to conduct a full review of the Forensic Hospital's staffing profile and implement recommendations
    - Utilise the existing budget to decrease premium labour, overtime and the vacancy rate whilst increasing FTE through the incorporation of AHA/MHCWs
    - Strategically position the Forensic Hospital for the introduction of the Freshwater unit
    - Position the Network to effectively operate in a changing environment

Figure 7.1: Allied Health Assistants - Mid Term Report - March 2018

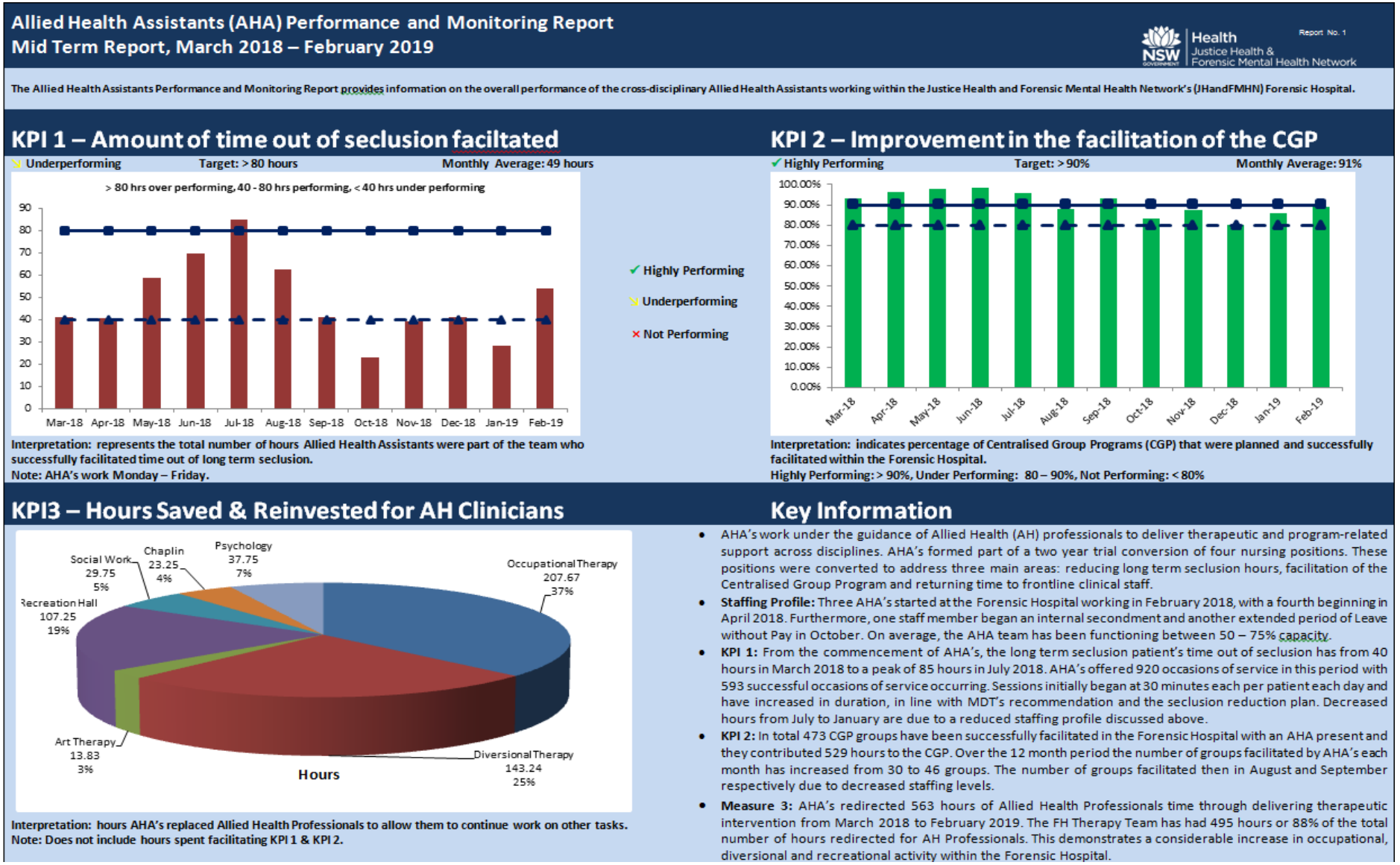

Figure 7.2: 2019 Patient 1's weekly timetable, showing planned exits and diversional activities.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
0830	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.	Self-Administered Medication, Breakfast And Personal Care.
0900 - 0930	Handball/ WALK AHA: Heather Kiosk – 15 mins Buy drink only	Wii Games AHA: Bianca & Heather		30 min Rec hall – Volleyball AHA: Bianca *1st Thursday of the month OpShop*	Walk 30 min (Full Lap) AHA: Heather	WALK – 30 MINS	WALK – 30 MINS
0930 - 1000			Psychology session Andrew Family room 1 AHA: Heather & Bianca	Walk	Alternative weeks: Leisure Time or Katrina From Sal Consultancy Family Room		
1000 - 1030	Nursing activity	Nursing activity		Nursing activity	Nursing activity		
1030 - 1100	Coffee Time	Coffee Time	Coffee Time	Coffee Time	Coffee Time	Coffee Time	Coffee Time
1100							
1200	LUNCH WATCH TV	LUNCH WATCH TV	LUNCH WATCH TV	KIOSK LUNCH WATCH TV	LUNCH WATCH TV	LUNCH WATCH TV	LUNCH WATCH TV
12:15 - 13:15	QUIET TIME – DS1	QUIET TIME – DS1	QUIET TIME – DS1	QUIET TIME – DS1	QUIET TIME – DS1	QUIET TIME – DS1	QUIET TIME – DS1
1400 - 1500	Around the World	Meal prep & Cooking (Monthly) Options: 1.Karaoke, 2.Drumbeat and 3.Gardening AHA: Heather/Bianca OT: Mariam	Bike (if raining Puzzles). AHA: Bianca & DT Pete PG call Amanda Smith) *first Wednesday of each month for 30 mins*	Animal Antics AHA: Heather & Bianca	Beauty Group		

Figure 7.3: Centralised Group Program Calendar - December 2017

Centralised Groups Program- Sept-December

LOCATION	Monday	Tuesday	Wednesday	Thursday	Friday
MORNING GROUPS					
Family Room			**YARNING GROUP** Adam & Alex 10-12pm Fortnightly		
Chapel		**CHAPEL SERVICE** 10:30-11:30am Don	**CHAPEL SERVICE** 10:30-11:30am Don		
Music Room					**MUSIC THERAPY** Kim & Laura 5 week program 10:30-11:30am
Recreation Hall	**FUNCTIONAL FITNESS** 10am Laura & Melissa		**FUNCTIONAL FITNESS** 10am Laura & Melissa	**OPPORTUNITY SHOP & SMOOTH TALKIN CAFÉ** 9-12PM 1st Thursday of the month	
AFTERNOON GROUPS					
Arts and craft room		**FREE RANGE ART** Margie & Oleen 1-3pm	**CONSUMER ADVISORY COMMITTEE** Last Wednesday of the month 2:30-4pm		
Education Room		**HORTICULTURE** 1-4pm Gavin & Michelle			**ME & MY EMOTIONS** Kim, Adam 1:30-2:30pm
Computer Room			**STUDY SKILLS** Laura & Gavin 2-3:30pm	**LITERACY & NUMERACY** Time TBC Norma & Cassie	
Family Room			**DRAMA THERAPY** Nickie & Patricia 2:30-3:30pm		
NHRT 3				**LEISURE BITES** Rachel & Laura 2:30-3:30pm	**CBT for Psychosis Module 2** Fortnightly Tatyana & Andrew 1-2pm
Clovelly Activities Room					**SOCIAL SKILLS** 2:30-3:30pm Kerri & Nickie
Dee Why Activities Room		**SCIT** Xerox & Heather 1-3:30pm			
Recreation Hall			**AGED FOR ACTION** Laura & Melissa 1pm		

Figure 7.4: Centralised Group Program Calendar - September 2019

Centralised Group Program
September - December 2019

Monday	Tuesday	Wednesday	Thursday	Friday
		Bike Riding 9 - 10am Perimeter Bianca & Heather	Op Shop & Smooth Talkin' Café 1st Thursday of the month 8:45-11:45am	
Consumer Led Barista Training 9.30-12noon Arts & Crafts Room Bianca & Gavin	1:1 PT Sessions 10-10:30am Rec Hall Mel	Functional Fitness 10-10:30am Rec Hall John & Mel	Swimming 10-11am Rec Hall John	Functional Fitness 10-10:30am Rec Hall John & Mel
Functional Fitness 10-10:30am Rec Hall John & Mel	Chapel Service 10:30-11:30am Chapel Don & June	Chapel Service 10:30-11:30am Chapel Don & Ali	Swim Assessments 11-11:30am Rec Hall Bianca & John	Swim Fun 10-11am Rec Hall Bianca & John
SUTP Group 4 1-3pm Art Room Cortney & Tara	Life Skills 1-2pm Chapel Ali & Leanne	Consumer Led Horticulture 1-2pm Arts & Crafts Room Danielle & Heather	CBT for Psychosis M1 1-2pm MHRT 3 Tatyana, Natalia, Liz, Aileen, Emily	
Swim Fun 1-2pm Rec Hall Bianca & John	Free Range Art Therapy 1-3:30pm Arts & Craft Room Margie & Robbi	Healthy Lifestyles 2-3pm Rec Hall Mel & John	Yarning Group 2-3:30pm, Alternating Family Visits & Art Room Lelia & Sue	Muslim Support Group 1-2pm Chapel Don & Mohammed
Alcohol Anonymous 2:30 - 3:30 pm Family Visits Room Nickie, Bianca & June	SUTP Group 1 1:30-3:30pm MHRT Room 3 Heather & Tatyana	SUTP Group 3 1-3pm Chapel Alex & Sarah		Study Skills Computer room 1:30-3pm Ali & June
	SUTP Group 2 2-4pm Chapel Gabrielle & Jerome	Consumer Advisory Committee 2:30-4pm 4th Wednesday of every month		SMART RECOVERY 2 - 3:30pm Arts & Crafts Room Trevor, David & Tatyana
	CBT for Psychosis M1 2-3pm Education Room Laura & Kris			
	Yang Xin Tang 2-3pm (Last Tuesday/Month) Dee Why Activity Room Andrew & Natalia			FH Sports Comp 3-4pm Rec Hall John & Mel

REFERENCES

- Australian Institute of Health and Welfare, 2018, *Mental Health Services—in brief 2018*, Cat. no. HSE 211. Canberra: AIHW.
- Mental Health Act 2007 No. 8, Section 68 (f), New South Wales, page 36.
- National Mental Health Consumer and Carer Forum, 2009, *Ending Seclusion and Restraint in Australian Mental Health Services,* page 9 - 10.
- Industrial Relations Commission of New South Wales, 2019, *NSW Health Service Allied Health Assistants (State) Award 2019*, page 5 – 6.
- Industrial Relations Commission of New South Wales, 2019, *NSW Health Service Health Professionals (State) Award 2019*, page 16.

Appendix 5: Incident Management System (IIMS)

Incident Information Management System (IIMS)

All Incidents By Time Band (February - April)

Adolescents		Women's		Bronte		Clovelly		Dee Why	
Time Band	Number of incidents	Time Band	Number of incidents	Time Band	Number of incidents	Time Band	Number of incidents	Time Band	Number of incidents
00:00 to 00:59	0	00:00 to 00:59	12	00:00 to 00:59	0	00:00 to 00:59	0	00:00 to 00:59	0
01:00 to 01:59	0	01:00 to 01:59	8	01:00 to 01:59	0	01:00 to 01:59	0	01:00 to 01:59	0
02:00 to 02:59	1	02:00 to 02:59	4	02:00 to 02:59	0	02:00 to 02:59	0	02:00 to 02:59	0
03:00 to 03:59	0	03:00 to 03:59	8	03:00 to 03:59	1	03:00 to 03:59	0	03:00 to 03:59	0
04:00 to 04:59	0	04:00 to 04:59	7	04:00 to 04:59	0	04:00 to 04:59	0	04:00 to 04:59	0
05:00 to 05:59	0	05:00 to 05:59	13	05:00 to 05:59	0	05:00 to 05:59	0	05:00 to 05:59	0
06:00 to 06:59	0	06:00 to 06:59	12	06:00 to 06:59	0	06:00 to 06:59	0	06:00 to 06:59	0
07:00 to 07:59	2	07:00 to 07:59	16	07:00 to 07:59	1	07:00 to 07:59	1	07:00 to 07:59	0
08:00 to 08:59	6	08:00 to 08:59	30	08:00 to 08:59	6	08:00 to 08:59	4	08:00 to 08:59	2
09:00 to 09:59	9	09:00 to 09:59	67	09:00 to 09:59	8	09:00 to 09:59	2	09:00 to 09:59	3
10:00 to 10:59	3	10:00 to 10:59	75	10:00 to 10:59	18	10:00 to 10:59	4	10:00 to 10:59	4
11:00 to 11:59	2	11:00 to 11:59	26	11:00 to 11:59	14	11:00 to 11:59	2	11:00 to 11:59	4
12:00 to 12:59	2	12:00 to 12:59	41	12:00 to 12:59	4	12:00 to 12:59	2	12:00 to 12:59	0
13:00 to 13:59	9	13:00 to 13:59	26	13:00 to 13:59	8	13:00 to 13:59	0	13:00 to 13:59	2
14:00 to 14:59	10	14:00 to 14:59	72	14:00 to 14:59	19	14:00 to 14:59	1	14:00 to 14:59	2
15:00 to 15:59	10	15:00 to 15:59	79	15:00 to 15:59	11	15:00 to 15:59	5	15:00 to 15:59	1
16:00 to 16:59	5	16:00 to 16:59	41	16:00 to 16:59	10	16:00 to 16:59	4	16:00 to 16:59	1
17:00 to 17:59	6	17:00 to 17:59	25	17:00 to 17:59	3	17:00 to 17:59	2	17:00 to 17:59	3
18:00 to 18:59	8	18:00 to 18:59	24	18:00 to 18:59	4	18:00 to 18:59	1	18:00 to 18:59	0
19:00 to 19:59	9	19:00 to 19:59	31	19:00 to 19:59	11	19:00 to 19:59	1	19:00 to 19:59	1
20:00 to 20:59	6	20:00 to 20:59	12	20:00 to 20:59	6	20:00 to 20:59	1	20:00 to 20:59	2
21:00 to 21:59	4	21:00 to 21:59	13	21:00 to 21:59	0	21:00 to 21:59	1	21:00 to 21:59	0
22:00 to 22:59	3	22:00 to 22:59	13	22:00 to 22:59	0	22:00 to 22:59	1	22:00 to 22:59	0
23:00 to 23:59	1	23:00 to 23:59	13	23:00 to 23:59	1	23:00 to 23:59	0	23:00 to 23:59	0
Unknown time	1	Unknown time	0	Unknown time	0	Unknown time	0	Unknown time	0
Not recorded	4	Not recorded	3	Not recorded	1	Not recorded	3	Not recorded	1
Total	101	Total	671	Total	126	Total	35	Total	26

Hospital Total

	Adolescents	Women's	Bronte	Clovelly	Dee Why	Total
Time Band	**Number of incidents**	**Number of incidents**	**Number of incidents**	**Number of incidents**	**Number of incidents**	
00:00 to 00:59	0	12	0	0	0	12
01:00 to 01:59	0	8	0	0	0	8
02:00 to 02:59	1	4	0	0	0	5
03:00 to 03:59	0	8	1	0	0	9
04:00 to 04:59	0	7	0	0	0	7
05:00 to 05:59	0	13	0	0	0	13
06:00 to 06:59	0	12	0	0	0	12
07:00 to 07:59	2	16	1	1	0	20
08:00 to 08:59	6	30	6	4	2	48
09:00 to 09:59	9	67	8	2	3	89
10:00 to 10:59	3	75	18	4	4	104
11:00 to 11:59	2	26	14	2	4	48
12:00 to 12:59	2	41	4	2	0	49
13:00 to 13:59	9	26	8	0	2	45
14:00 to 14:59	10	72	19	1	2	104
15:00 to 15:59	10	79	11	5	1	106
16:00 to 16:59	5	41	10	4	1	61
17:00 to 17:59	6	25	3	2	3	39
18:00 to 18:59	8	24	4	1	0	37
19:00 to 19:59	9	31	11	1	1	53
20:00 to 20:59	6	12	6	1	2	27
21:00 to 21:59	4	13	0	1	0	18
22:00 to 22:59	3	13	0	1	0	17
23:00 to 23:59	1	13	1	0	0	15
Unknown time	1	0	0	0	0	1
Not recorded	4	3	1	3	1	12
Total	101	671	126	35	26	959

Appendix 6: Forensic Hospital Training Framework Clinical Risk Assessment and Management (CRAM)

Introduction

Risk assessment forms an integral part of care coordination, risk assessment, planning and review processes within the Forensic Hospital (FH). A structured approach to risk assessment improves the validity of decisions regarding risk management. There are a number of approaches to risk assessment and the Network has adopted the Structured Professional Judgement (SPJ) approach endorsed in the Clinical Risk Assessment and Management (CRAM) framework.

The CRAM Program is CE mandated (blue flag) for all FH Clinical staff.

Aims

The aim is:

- To have 100% of clinical staff be compliant with CRAM mandatory requirements
- To provide increased knowledge of the CRAM theory and FH framework when completing risk assessment processes

Proposed Outcome

Participants will be able to:

- Explain the theory relating to clinical risk assessment and management
- Explain the relationship between mental illness and violence
- Explain how the CRAM Framework is implemented in the Forensic Hospital
- Explain where you would gain your information for a clinical review, documentation review and corroborating information
- Explain how to complete an Anamnestic Assessment
- Describe how to use the HCR-20
- Describe the formulation of a static/dynamic summary
- Describe the formulation of an Anamnestic summary
- Describe how to develop a TPRIM

2020 Plan to Address Aims

Four (4) CRAM Workshops will be provided in 2020:

- 25th March
- 10th June
- 18th August
- 27th November

Targeted staff must enrol self to a CRAM Workshop or a line manager can enrol them to a CRAM Workshop via My Health Learning.

New staff completing the FH Orientation Program will be enrolled to a CRAM Workshop by the Nurse Educator FMH

Coordinator, Trainers and Administration

Position	Name	E-mail	Phone
CNC and Coordinator	Jane Jackson	Jane.jackson@health.nsw.gov.au	3171
CNC	Shona MacLeod	Shona.Macleod@health.nsw.gov.au	3198
CNC	Linzi Stark	Linzi.Stark@health.nsw.gov.au	3109
Clinical Director	Andrew Ellis	Andrew.Ellis@health.nsw.gov.au	3083

Procedure

1. Training Requirements

1.1 The CRAM Program is CE mandated (blue flag) for all FH clinical staff

1.2 The CRAM Program consists of a 1 day (8 hour) Workshop

1.3 The Workshop requires two trainers (preferably 1 MO and 1 other)

1.4 Participant numbers, minimum = 10 and maximum = 30

2. CRAM Coordinator Responsibilities

2.1 Jane Jackson is the CRAM Coordinator and can be contacted via Jane.Jackson@health.nsw.gov.au or 9700 3171.

2.2 The CRAM Coordinator is responsible for:

- The administrative and organisational requirements necessary for the successful implementation of CRAM Workshops
- The annual training schedule
- Arranging availability of trainers and venues
- Local governance of the CRAM training within the FH, including reporting to the relevant manager/department
- Offering guidance to trainers and ensuring they are proficient in providing training under the relevant guidance and documentation of the CRAM Program
- Oversight of participant attendance and compliance via My Health Learning

- Collating evaluations and program reports
- Scheduling Train the Trainer Workshops as necessary
- Ordering any necessary equipment/resources
- Forwarding the My Health Learning sign on sheet to the allocated trainers at least 2 days before training
- Completing end of year evaluation report
- Completing training framework report

3. CRAM Trainer Responsibilities

3.1 CRAM Trainers must have completed the CRAM Train the Trainer workshop to a satisfactory level.

3.2 Trainer are responsible for:

- Availability to attend allocated training dates and to conduct training on a rotational basis
- Liaising with their line manager regarding allocated training dates to ensure rostering requirements
- Being current in their mandatory training
- Having a clear understanding of MoH and Justice Health and Forensic Mental Health Network (Network) policy and procedures relating to CRAM
- Providing advice and acting as a mentor to staff in regards to the FH CRAM framework
- Providing the FH CRAM Coordinator with information as and when requested
- Reporting any concerns or issues to the CRAM Coordinator

4. Participant Responsibilities

4.1 Participants are responsible for:

- Enrolling self to a CRAM Workshop via My Health Learning
- Identifying the training day on their wish roster to ensure availability to attend
- Attending the correct location, on time and for the duration of the training
- Wearing their uniform or smart casual clothing to the workshop
- Following all reasonable instructions from the CRAM Trainers during the Workshop

5. Line Managers Responsibilities

5.1 Line Managers are responsible for:

- Ensuring their staff are compliant with CRAM mandatory requirements
- Rostering staff/CRAM Trainers to their scheduled CRAM Workshops
- Raising concerns or request further in-service training for staff as required
- Following up on concerns raised by the CRAM Coordinator or CRAM Trainers

6. CRAM Workshops

6.1 CRAM Workshops will be published through My Health Learning, as per scheduled dates

6.2 The CRAM Coordinator is responsible for scheduling these workshop dates

6.3 The CRAM Coordinator will roster trainers to these dates and liaise with the trainers and line managers regarding rostering requirements

6.4 It is the responsibility of the CRAM Trainers to liaise with their line manager to ensure they are rostered to their allocated CRAM Workshop

6.5 The CRAM Coordinator will provide all line managers with a CRAM Compliance Report on a six monthly basis for review and action

6.6 Prior to a CRAM Workshop the **CRAM Coordinator** is responsible for:

- Reviewing the enrolments via the My Health Learning classrooms to ensure minimum enrolments to facilitate the scheduled Workshop.
- Where necessary, cancelling the scheduled workshop and informing the LMS Helpdesk, CRAM Trainers and line manager of attendees (who in turn will inform attendees).
- Confirming trainers attendance

6.7 Prior to the Search workshop the **FHCSO** is responsible for:

- Sending participants a reminder email at least 1 week prior to the workshop

6.8 Prior to a CRAM Workshop the **CRAM Trainers** are responsible for:

- Printing out the CRAM Workshop sign on sheet.
- Collecting the CRAM Resource Box from the Education Room, Clovelly Administration Area
- Setting up the room at least 15 minutes prior to the workshop commencing.

6.9 At the commencement of a CRAM Workshop the **CRAM Trainers** are responsible for:

- Ensuring all participants complete the sign on sheet
- Ensuring a Evaluation form (pre workshop knowledge section) is completed

6.10 During a CRAM Workshop the **CRAM Trainers** are responsible for:

- Providing both individual and group support and feedback.
- Ensuring the safety of the training venue and participants.
- Collaborating with other CRAM Trainers to ensure all trainers are of the same opinion regarding each participant's skill level.
- Ensuring Evaluation forms are completed and collected

6.11 Post CRAM Workshop the **CRAM Trainers** are responsible for:

- Completing a workshop debrief to discuss what went well and any issues that were encountered during the workshop
- Scanning and emailing the completed sign on sheet and evaluations to the:
  - FHCSO@justicehealth.nsw.gov.au
  - FHEducation@justicehealth.nsw.gov.au
  - CRAM coordinator

- Ensuring the workshops resources are fully stocked and re-stock any items required.
- Returning the CRAM Resource Box to the Education room, Clovelly Admin area
- Reporting any concerns or issues to the CRAM Coordinator via email.
- Reporting any concerns regarding a participants attendance or behaviour directly to the participants line manager
- Removing any damaged equipment immediately and report this to the CRAM Coordinator.

7. Record Keeping

7.1 After the workshop, the trainer(s) will scan and email the sign on sheet and Evaluations to:

- FHCSO@justicehealth.nsw.gov.au
- FHEducation@justicehealth.nsw.gov.au
- CRAM coordinator

7.2 The CSO will:

- Complete the 'completions' on My Health Learning
- Save the sign on sheet and Evaluations to HPRM Container G274/20

7.3 The CRAM Coordinator is responsible for reviewing and amending the training package and documenting on the Continuous Improvement Log and management of evaluations.

8. Trainers Roster

8.1 The CRAM Coordinator will manage the training roster for the CRAM workshops to ensure all sessions have facilitators rostered to these dates.

8.2 The CRAM Trainers Roster can be found G:\FLBH\Forensic Hospital\FH Education\FH Facilitators List & Rosters\2020 FH Education Programs Trainers & Rosters.

8.3 Where a trainer has been allocated to a workshop date but is unable to facilitate this session due to other commitments, it is the responsibility of that trainer to find a replacement trainer and inform the CRAM Coordinator of the change. The CRAM Coordinator will update this information on the CRAM Trainers Roster.

9. Training Resources and Storage

9.1 All CRAM resources can be found in the CRAM Resource Box (Education Hub, Clovelly Administration Area), HPRM G274/20 and G:\FLBH\Forensic Hospital\FH Education\CRAM

9.2 It is the responsibility of the CRAM Coordinator to ensure the resources in the CRAM Box are well stocked

9.3 It is the responsibility of the CRAM Trainer to check all CRAM resources pre and post training sessions and stock any resources that need replenished

9.4 List of resources required

- Power Point Presentation (DG64974/17 and G:\FLBH\Forensic Hospital\FH Education\CRAM\PPP)
- Videos (DG64974/17 and G:\FLBH\Forensic Hospital\FH Education\CRAM\Videos)

- Butcher paper and pens – (Education Hub, Elouera Administration Area)
- CRAM Report Template (CRAM Resource Box, DG15804/18 and G:\FLBH\Forensic Hospital\FH Education\CRAM\proformas)
- TPRIM Template (CRAM Resource Box, DG15808/18 and G:\FLBH\Forensic Hospital\FH Education\CRAM\proformas)
- CRAM Framework (CRAM Resource Box, DG15813/18 and G:\FLBH\Forensic Hospital\FH Education\CRAM\proformas)
- 5W's Tip Sheet (CRAM Resource Box, DG64985/17 and G:\FLBH\Forensic Hospital\FH Education\CRAM\proformas)
- FH Procedure CRAM
- Policy 1.078 Care Coordination, Risk Assessment, Planning and Review (under review Jan 2020)
- Evaluation Form (Survey Monkey)
- Progress notes (CRAM Resource Box)

10. Evaluation of Training

10.1 The CRAM Program 2020 will be evaluated in December 2020 using data gathered from My Health Learning and Evaluation forms

10.2 The CRAM Training Coordinator will analyse the available data and complete a CRAM Program Evaluation Report including recommendations

10.3 Recommendations will be implemented using the CRAM Program Improvement Log (DG13262/18) to monitor progress

Appendix 7: Forensic Hospital Training Framework. A Violence Prevention and Management (VPM) 2020

Introduction

The Violence Prevention and Management in the Workplace Training Program has been developed by HETI to meet the requirements of the PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations.

The VPM Program will provide Forensic Hospital (FH) staff with the necessary skills, knowledge and attitudes expected in the prevention and management of aggressive, intimidating, threatening or violent behaviours.

The VPM Program comprises a total of 3 eLearning modules and 4 face-to-face workshops (Personal Safety and Team Restraint Techniques) for clinical staff and 3 eLearning modules and 1 face-to-face workshop (Personal Safety) for non-clinical staff. The eLearning modules are only required to be completed once.

Both clinical and non-clinical staff, need to complete a VPM Refresher Workshop annually to ensure currency of skills.

VIOLENCE PREVENTION AND MANAGEMENT IN THE WORKPLACE TRAINING PROGRAM			
Course	**Training mode**	**Audience**	**Pre-requisite**
Promoting Acceptable Behaviour in the Workplace	eLearning module (30 mins)	All staff (PD2017_043 all staff categories)	N/A
Violence Prevention and Management – Awareness	eLearning module (30 mins)	All staff (PD2017_043 all staff categories)	N/A
Violence Prevention and Management – Legal and Ethical Issues	eLearning module (30 mins)	Staff working in high risk environments (PD2017_043 category 2 and 3 staff)	Awareness – eLearning module
Violence Prevention and Management – Personal Safety	Face-to-face workshop (one day)	Staff working in high risk environments and staff identified as potentially involved in physical restraint of other individuals (PD2017_043 category 2 and 3 staff)	Awareness – eLearning module Legal and Ethical Issues eLearning module

Violence Prevention and Management – Team Restraint Techniques	Face-to-face workshop (three days)	Staff identified as potentially involved in physical restraint of other individuals (PD2017_04 category 3 staff)	Awareness eLearning module Legal and Ethical Issues eLearning module
			Personal Safety workshop
Violence Prevention and Management – Clinical Refresher	Face-to-face workshop (one day)	Staff identified as potentially involved in physical restraint of other individuals (PD2017_043 category 3 staff)	eLearning modules Personal Safety Workshop Team Restraint Workshop
Violence Prevention and Management – Non- Clinical Clinical Refresher	Face-to-face workshop (1/2 day)		eLearning modules Personal Safety Workshop

FH staff are considered either Category 2, 3 or 4 staff as per PD2017_043

Category 2 staff are those identified, following a risk assessment, as working in high risk areas.

High risk workplaces may include (but are not limited to) Mental Health, Emergency Departments, Aged Care, Midwifery and Early Childhood units, Maternity, Methadone clinics, Brain Injury clinics, Neurology units, Community Health and Drug and Alcohol services. Other work areas may be identified, via the risk assessment process, as being at significant risk of experiencing violent incidents.

Category 3 staff are those identified as being potentially involved with leading or undertaking the physical restraint of other individuals.

Staff working in high risk environments and those in security and duress response roles must be able to minimise the risk of harm to the safety of self and others arising from potential, imminent and actual aggression and be trained to, as a last resort, actively restrain a patient in a safe, effective, and least restrictive, manner in the event of actual violence.

Category 4 staff are those who supervise Category 2 and 3 staff. They must receive the appropriate training for their category, and in addition must be trained to be capable in the following:

Implementing risk management

Implementing incident investigation and reporting

Post incident staff monitoring and support

Post incident follow up

Understanding their responsibilities in preventing violence from occurring and

Understanding how risks are controlled

Developing procedures, in consultation with staff, to control or eliminate workplace violence.

Risk Assessment

The personal safety and physical restraint techniques presented in the VPM Workshops have been assessed for potential safety risks to staff and patients by clinicians with expertise in physiotherapy. This risk assessment has been completed by HETI. The techniques should be delivered in training and practiced in the workplace as they are presented and without alteration.

Aims

The VPM Orientation Program is Ministry of Health (MOH) mandated (red flag) and the VPM Refresher Program is CE mandated (blue flag), the aim is:

For 100% of new staff to have completed the VPM Personal Safety and Team Restraint Techniques Workshops through the FH Orientation Program prior to commencing employment in the FH

For 100% of new staff to have completed the allocated VPM eLearning modules within 3 months of commencement of employment

For 100% of staff to have completed their VPM Refresher Program annually and within the specified timeframe as per My Health Learning (MHL) VPM pathway

To incorporate VPM Drills into the FH training and education

To evaluate the 2020 VPM Program and provide a VPM Evaluation Report

Proposed Outcome

Non-clinical staff will be able to:

Explain the concept of violence in the workplace

Describe how to assess risk in the workplace

Explain how the FH manages violence in the workplace

Apply engagement skills

Apply de-escalation skills

Apply the use of personal safety techniques

Demonstrate personal safety physical skills

Clinical staff will be able to:

Explain the concept of violence in the workplace

Describe how to assess risk in the workplace

Explain how the FH manages violence in the workplace

Apply engagement skills to build a therapeutic relationship

Apply de-escalation skills when required

Apply the use personal safety techniques

Demonstrate personal safety physical skills

Explain how Therapeutic Security relates to VPM

Explain the cycle of aggression

Explain the Hierarchy of Responses

Explain how risk factors can influence violence prevention and Management

Explain how Trauma Informed Care and Practice relates to violence prevention and management

Explain the connection between building and maintaining therapeutic relationships and violence prevention and management

Explain the connection between limit setting and violence prevention and management

Explain the concept that restraint is a last resort response to violence

Explain the concept of reasonable force and duty of care in response to violence

Explain the legal implications of using restraint

Explain the physical health considerations during restraint

Explain the manual handling principles during restraint

Explain the patient's perspective in relation to restraint and seclusion

Apply the use of team restraint techniques

Demonstrate team restraint techniques

2020 Plan to Address Aims

The mandatory VPM Personal Safety and Team Restraint Techniques Workshops will be provided bi-monthly through the FH Orientation Program for new staff.

The VPM Refresher Program will be frequently existing staff. The following VPM training dates are available:

VPM Training 2020

Date	Session	Date	Session

January		**July**	
20th	Non-Clinical Refresher	2nd	Clinical Refresher
27th	Clinical Refresher	9th	Clinical Refresher
February		17th	Graduate Clinical Refresher
5th	Orientation	21st	Non-Clinical Refresher
6th	Orientation	**August**	
7th	Orientation	5th	Orientation
10th	Orientation	6th	Orientation
25th	Non-Clinical Refresher	7th	Orientation
26th	Clinical Refresher	10th	Orientation
March		17th	Clinical Refresher
13th	Graduate RN Orientation	19th	Clinical Refresher
16th	Graduate RN Orientation	24th	Clinical Refresher
17th	Graduate RN Orientation	26th	Non-Clinical Refresher
19th	Graduate RN Orientation	**September**	
April		7th	Clinical Refresher
1st	Orientation	9th	Clinical Refresher
2nd	Orientation	11th	Non-Clinical Refresher
3rd	Orientation	17th	Clinical Refresher
6th	Orientation	24th	Non-Clinical Refresher
8th	Clinical Refresher	**October**	
16th	Non-Clinical Refresher	6th	Clinical Refresher
27th	Clinical Refresher	8th	Non-Clinical Refresher

May		21st	Orientation
15th	Non-Clinical Refresher	22nd	Orientation
21st	Clinical Refresher	23rd	Orientation
27th	Orientation	26th	Orientation
28th	Orientation	**November**	
29th	Orientation	9th	Clinical Refresher
June		11th	Clinical Refresher
1st	Orientation	13th	Non-Clinical Refresher
9th	Clinical Refresher	**December**	
11th	Clinical Refresher	2nd	Orientation
15th	Clinical Refresher	3rd	Orientation
17th	Clinical Refresher	4th	Orientation
22nd	Non-Clinical Refresher	7th	Orientation

Coordinator and Trainers

Position	Name	E-mail	Phone number
CNC/VPM Coordinator	Adriel Lage	Adriel.Lage@health.nsw.gov.au	3558
CNC/VPM Coordinator	Linzi Stark	Linzi.Stark@health.nsw.gov.au	3109
NUM1	Rocky Randeria	Raksha.Randeria@health.nsw.gov.au	3396
RN	Kelda Moore	Kelda.Moore@health.nsw.gov.au	3380
SW	Heather Fairfax	Heather.Fairfax@health.nsw.gov.au	3119
RN	Lee Selemusi	Lidimoni.Selemusi@health.nsw.gov.au	3380
CNC	Shona MacLeod	Shona.Macleod@health.nsw.gov.au	3198
NUM1	Luke Goodeve	Luke.Goodeve@health.nsw.gov.au	3374
Nurse Manager	Emma Harrington	Emma.Harrington@health.nsw.gov.au	3166
RN	Jabir Sayed	Jabir.Sayed@health.nsw.gov.au	3374
SW	Jerome Chong	Jerome.Chong@health.nsw.gov.au	3203
RN	Darrell Newsham	Darrell.Newsham@health.nsw.gov.au	3374
RN	Alex Hunt	Alex.Hunt@health.nsw.gov.au	3380
NE	Orlaith Lavery	Orlaith.Lavery@justicehealth.nsw.gov.au	3177
CNC	Laura Travers	Laura.Travers@justicehealth.nsw.gov.au	3190
CDLBandFMHN	Andrew Ellis	Andrew.Ellis@justicehealth.nsw.gov.au	3178

Procedure

Training Requirements

VPM Personal Safety and Team Restraint Techniques Workshops are MOH mandated for all FH and Contract staff as per PD2017_043

The FH VPM Refresher Program is CE mandated for all FH and Contract staff

All clinical and non-clinical staff must:

Complete the VPM Personal Safety and Team Restraint Techniques Workshops (either day 1 for non-clinical staff or the full 4 days for clinical staff) through the FH Orientation Program

Complete the required 3 eLearning modules within 3 months of commencement of employment

Complete the VPM Refresher Program (8 hours for clinical staff and 4 hours for non-clinical staff) annually

Trainer: Participant Ratio's

The maximum number of participants for each workshop is 15

A minimum of 2 facilitators will facilitate the workshop, to allow for assessment of skills during practical sessions

Training ratio's maximum of 6:1 (participants: trainer)

Training Venue and Mats

The training venue must:

Be large enough to provide an area that is free from posts, stanchions and grates for mats to be laid out for practical sessions

Have an area that has tables, chairs, and a laptop and data projector access.

Have access to first aid equipment and access to a telephone to contact emergency services

VPM Workshops can be facilitated in the EandT Demountable, JHAC Lecture Theatre, JHAC rooms 2A-C, FH MHRT 3 and FH Recreation Hall

Training mats can be found in the Demountable, FH Recreation Hall and Stores, if mats are required for any venue, the VPM Coordinator will organise mat relocation

Any damage to the training mats must be reported to the VPM Coordinator as soon as practicable

Health Questionnaire

Participants must complete a VPM Health Questionnaire prior to commencing physical skills training.

The use of the questionnaire is intended to ensure that all staff participating in the workshop are made aware of the physical and psychological demands of the training. It is used as a tool to improve the safety of workshop participants by identifying injuries and/or health concerns which may preclude participants from safely participating in the physical skills practical sessions.

Training Completion Record

The Training Completion Record must be completed by the trainers to document an individual's completion of the VPM workshop.

The tasks listed on the record are predominantly learning activities that give the trainer a chance to check achievement of learning outcomes. This document is not intended to be used as a formal competency assessment; rather it reflects the satisfactory completion of learning outcomes and engagement in practical activities throughout the workshop

The Training Completion Record is to be completed at the end of each workshop by the facilitating trainers, this should involve a discussion between all trainers to ensure all opinions are taken into consideration regarding a participant's skill level.

Trainers Re-accreditation

VPM Trainers must complete a re-accreditation process annually.

To be considered current, the VPM Trainer must complete the following as a minimum on an annual basis:

A Personal Safety Workshop

A Team Restraint Workshop

4 Refresher Sessions

Attend VPM Trainers Day's

The VPM Coordinator will coordinate the re-accreditation process.

andJHFMHN VPM Instructors will complete a re-accreditation assessment of the trainer's capacity to facilitate the theoretical and practical skills of the VPM Program. As well as demonstrating the theoretical and practical components of the program, the trainer must demonstrate ongoing commitment to the philosophy of preventing and managing violence in a person-centred manner.

VPM Coordinator Responsibilities

Adriel Lage and Liniz Stark are the current FH VPM Coordinators

The VPM Coordinator is responsible for the administrative and organisational requirements necessary for the successful implementation of the VPM Program.

The duties of the VPM Coordinator include:

Annual training schedule

Arranging availability of trainers and venues

Local governance of VPM training within the FH, including reporting to the relevant manager/department

Offering guidance to trainers and ensuring they are proficient in providing training under the relevant guidance and documentation of the VPM program

Developing and coordinating re-accreditation for VPM Trainers

Oversight of participant attendance and compliance via My Health Learning

Collating Sign on Sheet, Training Completion Records, Medical Questionnaires

Evaluating the VPM program on an ongoing basis and providing a yearly report

Scheduling Train the Trainer Workshops as necessary

Ordering any necessary equipment

Signing participants off on My Health Learning via Operational Assessor

VPM Trainer Responsibilities

VPM Trainers must have at least 4 years of recent experience in the area of mental health

VPM Trainers must have completed the VPM Train the Trainer workshop facilitated by a VPM Instructor. This workshop and the associated 1 day assessment must have been completed to a satisfactory level.

VPM Trainers are responsible for:

Attending all VPM trainers' days.

Satisfactorily completing an annual re-accreditation process.

Ensuring availability to attend allocated training dates and to conduct training on a rotational basis.

Liaising with their line manager regarding allocated training dates to ensure rostering requirements.

Being current in their mandatory training.

Having a clear understanding of MOH and Justice Health and Forensic Mental Health Network (andJHFMHN) policy and procedures relating to VPM.

Actively contributing to VPM development in clinical practice within the FH.

Providing advice and acting as a mentor to FH staff in regards to VPM in the workplace.

Identifying participants who are 'not yet satisfactory', documenting this on their Training Completion Record and addressing this with the participant, the participants' line manager and VPM Coordinator.

Providing the VPM Coordinator with information on the VPM training program as and when requested.

Reporting any concerns or issues to the VPM Coordinator.

Participant Responsibilities

Participants are responsible for:

Enrolling self to a VPM Refresher Workshop via My Health Learning prior to their due date as outlined in My Health Learning.

Identifying training day on wish roster to ensuring availability to attend.

Reading the Participant Information Sheet and ensure they adhere to the advice provided during VPM Workshops

Attending the correct location, on time and for the duration of the training

Following all reasonable instructions from VPM trainers during Workshops

Completing the My Health eLearning modules

Informing a VPM Trainer if an injury is obtained during a VPM Workshop

Completing the online Survey

Line Managers Responsibilities

Line Managers are responsible for:

Ensuring their staff are compliant with VPM mandatory requirements

Ensuring their staff are provided with time to complete the eLearning and practical components of the program.

Rostering staff/VPM Trainers to their scheduled VPM Workshops.

Raising concerns or request further in-service training for staff as required.

Following up on any injuries reported from VPM training or ongoing medical conditions that preclude them from performing VPM in the workplace or training.

Complete a risk assessment on staff which are unable to complete the VPM Workshop requirements or are unable to perform VPM in the workplace.

Follow up on concerns raised by the VPM Coordinator or VPM trainers.

VPM Workshops

VPM Workshops will be published through My Health Learning, as per scheduled dates.

The VPM Coordinator is responsible for scheduling these workshop dates.

The VPM Coordinator will roster trainers to these date and liaise with the trainers and line managers regarding rostering requirements.

It is the responsibility of the VPM trainers to liaise with their NUM's to ensure they are rostered to their allocated VPM Workshop.

The VPM Coordinator will provide all line managers with a VPM Compliance Report on a monthly basis for review and action.

Prior to a VPM Workshop the **VPM Coordinator** is responsible for:

Reviewing the enrolments via the My Health Learning classrooms to ensure minimum enrolments to facilitate the scheduled Workshop.

Where necessary, cancelling the scheduled workshop and informing the LMS Helpdesk, Manager Security and Fire Safety (MSFS), Wormwald Trainer, allocated VPM Trainers and line manager of attendees (who in turn will inform attendees)

Confirming trainer's attendance

Prior to a VPM Workshop the **VPM Trainer** is responsible for:

Printing out the VPM Workshop sign on sheet.

Setting up the room at least 15 minutes prior to the workshop commencing.

At the commencement of a VPM Workshop the **VPM Trainer** is responsible for:

Ensuring all participants complete the sign on sheet.

Ensuring all participants complete a Health Questionnaire.

If concerns are identified in the health questionnaire, the trainer must discuss this immediately with the participant prior to commencement of the physical component of the training.

VPM Trainers must not train any participant who they feel may be at risk of injury to self or others if they undertook the training.

If a participant is unable to participate in a VPM Workshop the staff member is to return to the FH to discuss an agreed strategy for re-deployment with their Line Manager

Informing the participants of the assessment/Training Completion Record process which will be undertaken by the trainers throughout the workshop.

During a VPM Workshop the **VPM Trainer** is responsible for:

Providing both individual and group support and feedback.

Ensuring the safety of the training venue and participants.

Collaborating with other VPM Trainers to ensure all trainers are of the same opinion regarding each participant's skill level.

Showing concern and caution towards sick and injured participants and follow all relevant Work Health and Safety requirements.

Providing participants with feedback relating to the outcome of their Training Completion Record.

If a participant does not meet a satisfactory completion level throughout the workshop, the trainers must clearly explain to the participant the rationale for not meeting the satisfactory criteria and the steps that are required to be taken next as per section 7 below.

Post VPM Workshop the **VPM Trainer** is responsible for:

Completing a workshop debrief to discuss what went well and any issues that were encountered during the workshop

Completing the Training Completion Records

Complete Training Review

Completing an IIMS if a participant is injured during VPM training and informing the line manager and VPM Coordinator of the injury via email.

Scanning and emailing the completed Sign on Sheet, Health Questionnaires, Training Completion Records and Trainers Review to the:

FHCSO@health.nsw.gov.au

FHEducation@health.nsw.gov.au

VPM Coordinators

Use internal mail to send physical copies to FH Education

Ensuring the workshop resources are fully stocked and re-stock any items required

Reporting any concerns or issues to the VPM Coordinator via email.

Removing any damaged equipment immediately and report this to the VPM Coordinator.

Staff Identified as Unable to Complete VPM Training or in the Workplace

Where a staff member has not meet a satisfactory level of completion throughout the VPM workshop, the VPM Trainer must:

Clearly explain to the participant the rationale for not meeting the satisfactory criteria and provide any support required

Explain to the participant that they will contact their line manager and VPM Coordinator to explain that they have been unable to meet the satisfactory criteria and that these positions will liaise with them regarding management of this issue

Email the VPM Coordinator via email within 24hrs of the workshop, this email must outline the reason for the participant being unable to meet the satisfactory criteria and attach a copy of the participants Training Completion Record

On receipt of the email the VPM Coordinator may liaise with the VPM Trainer where additional information is required

The VPM Coordinator will liaise with the participant and their line manager to complete a Work Health and Safety Risk Management form. This risk assessment must outline the staff member's capacity to undertake VPM techniques in the workplace and the strategies required to maintain the staff member's safety and possible future attendance to complete the VPM training.

Where a staff member has been identified with a persistent/ongoing injury/condition which may preclude an individual from completing the requirements of the VPM Program through training or the workplace, a risk assessment of the staff members injury/condition must be

completed by the line manager as outlined in point 7.3 and discussed with their line manager and JHFMHN Human Resources Department.

Record Keeping

The VPM Coordinator will forward a My Health Learning Sign on Sheet to the allocated trainers at least 2 working days prior to the workshop

After the workshop, the trainer(s) will scan and email the Sign on Sheet, Health Questionnaires and Training Completion Records to the:

FHCSO@justicehealth.nsw.gov.au

FHEducation@justicehealth.nsw.gov.au

VPM Coordinators

The CSO will:

Complete the 'completions' on My Health Learning

Save the Sign on Sheet, Health Questionnaires and Training Completion Records to HPRM Container:

Clinical Staff: G154/20-01

- G4S Staff: G154/20-02

Honeywell: G154/20-03

Medirest: G154/20-04

Contingent: G154/20-05

Health Questionnaires and Training Completion Records are to be saved to the staff members individual P File

The VPM Coordinator is responsible for reviewing and amending the training package and documenting on the VPM Continuous Improvement Log

The VPM Coordinator is responsible for marking participants off on My Health Learning via Operational Assessor

Trainers Roster

The VPM Coordinator will manage the training roster for the VPM workshops to ensure all sessions have facilitators rostered to these dates.

The VPM Trainers Roster can be found G:\FLBH\Forensic Hospital\FH Education\FH Facilitators List and Rosters.

Where a trainer has been allocated to a workshop date but is unable to facilitate this session due to other commitments, it is the responsibility of that trainer to find a replacement trainer and inform the VPM Coordinator of the change. The VPM Coordinator will update this information on the VPM Trainers Roster.

Training Resources and Storage

VPM Trainers Guides and Resources can be found in; HPRM G154/20 and G:\FLBH\Forensic Hospital\FH Education\VPM\Training Resources

Sign on Sheet (My Health Learning)

Seclusion and Restraint Registers via intranet

Butcher paper and pens – collect from Education Hub or demountable

Hard copies of the resources can also be found in the filing cabinet in the EandT Demountable

It is the responsibility of the VPM Coordinator to ensure the VPM resources are well stocked

Training mats – located in the demountable, JHAC Lecture Theatre and inside the FH

Infection Control

It is the responsibility of the VPM Trainers to ensure the training mats are clean pre and post use. If cleaning is required the VPM trainers must contact the VPM Coordinator as soon as practicable.

The VPM Coordinator will organise cleaning of the training mats.

Evaluation of Training

The VPM Program 2020 will be evaluated in December 2020 using data gathered from My Health Learning and Evaluations.

The VPM Training Coordinator will analyse the available data and complete a VPM Program Evaluation Report including recommendations.

Recommendations will be implemented using the VPM Program Improvement Log to monitor progress.

Health
Justice Health &
Forensic Mental Health Network

DG 68420/20

FH Staffing Profile 2020 – Consultation Plan

Consumer consultation:

Consumer consultation will be undertaken via an extraordinary meeting and written submission from the patient population to gain a consumer perspective. The questions the patient group will be asked are:

Proposed questions:

The Forensic Hospital is currently reviewing our staffing and we want your feedback.

- Which unit are you on?
- What supports do you value most in the hospital?
- What programs do you value most in the hospital?
- Do you receive enough care and activities?
- How can we improve your care and activities to maintain hope?

General staff consultation:

There will be 3 differing methods to staff consultation will include:

1. Focus Groups (4 x 1 hour workshops which will be open for general discussion regarding the review. These will multimodal including face to face meeting and PEXIP);
2. Dropbox located in staff rooms;
3. Email: JHFMHN-FHStaffingProfileReview@health.nsw.gov.au

Questions for staff:

- What is your discipline/role?

- Are all of your current duties specific to your role and Why?

- What are the strengths and advantages of the current Forensic Hospital staff profile and Why?

- What barriers or challenges do you see with the current staff profile and Why?

- Are there any disciplines missing from our current staff profile and why?

- What opportunities do you see for service growth, from a staff profile perspective and why?

Industrial bodies:

Industrial bodies should have the finalised TOR sent to them and we invite their feedback based on their interface with Forensic Hospital staff.

Executive:			
Comments: - Understanding of the current drivers within the Network - Understanding of historical arrangements			
Position	**Duration**	**Scheduled**	**Reviewer**
Co Dir FMH – Jason Sevil	60 mins	Friday 17 July, 1130 - 1230	Jo, Fiona, Natalie, Kevin Ba/Br
Andrew Ellis – Clinical Director Forensic Hospital	30 mins	Friday 17 July, 1030 - 1100	Jo, Fiona, Natalie. Kevin Ba/Br
Director Allied Health - Katherine Jones	30 mins	Friday 17 July, 1100 - 1130	Fiona, Natalie, Kevin Br

Consumer			
Position	**Duration**	**Scheduled**	**Reviewer**
Consumer Consultant – Patricia DellOlio	60 mins	Friday 24 July, 1300 – 1400	Jo, Fiona, Natalie, Scott

Consumer Advisory Group	60 mins	Friday 24 July, 1300 – 1400	Jo, Fiona, Natalie, Scott
Family and Carer Consultant – Erika Ballance	45 mins	Friday 24 July, 1015 – 1100	Jo, Fiona, Natalie, Kevin Ba/Br

Nursing			
Position	**Duration**	**Scheduled**	**Reviewer**
DNS – Kevin Baron	45 mins	Friday 31 July, 1015 – 1100	Jo,
DDON – Karen Lawes	45 mins	Friday 31 July, 0930 – 1015	Jo, Kevin Ba
FH-AHNM	45 mins	TBC	Jo, Kevin Ba
NUM2/3 Group	60 mins	Friday 24 July, 1200 – 1300	Jo, Kevin Ba
NMEPD – Adriel Lage	45 mins	Friday 31 July, 1100 – 1145	Jo, Kevin Ba
NMSSRP – Emma Harrington	30 mins	Friday 17 July, 0930 – 1000	Jo, Kevin Ba
CNC Group	45 mins	Friday 24 July, 0930 – 1015	Jo, Kevin Ba
NUM1 Group	45 mins	Friday 24 July, 1415 – 1500	Jo, Kevin Ba

Administration team:			
Position	**Duration**	**Scheduled**	**Reviewer**
Executive Assistant – Bernice Leafe	30 mins	Monday 27 July, 1030 – 1100	Natalie, Kevin Br
Executive Assistant – Alison Smith	30 mins	Monday 27 July, 1000 – 1030	Natalie, Kevin Br
PAS Coordinator – Liz Masih	30 mins	Monday 27 July, 0900 – 0930	Natalie, Kevin Br
MHRT Coordinator - Shirley Anitelea-Launiu	30 mins	Monday 27 July, 1130 – 1200	Natalie, Kevin Br
CSO Group – Nicole Beaumont and Michelle Coggins	30 mins	Friday 17 July, 1300 – 1330	Natalie, Kevin Br
Ward Clerk Group	30 mins	Monday 27 July, 1100 – 1130	Natalie, Kevin Br

Allied Health			
Position	**Duration**	**Scheduled**	**Reviewer**
Manager Allied Health – Kevin Brown	45 mins	Thursday 23 July, 1245 – 1330	Fiona
Senior Psychologist – Andrew Kaw	45 mins	Thursday 23 July, 1330 – 1415	Fiona, Kevin Br
Senior Therapist – Danielle Cooke	45 mins	Thursday 23 July, 1415 – 1500	Fiona, Kevin Br
Senior Social Worker – Heather Fairfax	45 mins	Thursday 23 July, 1145 – 1230	Fiona, Kevin Br
Rehabilitation Coordinator – Scott Gill	45 mins	Thursday 23 July, 1100 – 1145	Fiona, Kevin Br

Focus Groups			
Focus Group Date	**Duration**	**Time and Room**	**Reviewer**
Monday 20 July	60 mins	1400 – 1500, MHRT Room 1	Kevin Ba, Kevin Br, Scott
Tuesday 21 July	60 mins	1330 – 1430, MHRT Room 3	Kevin Ba, Kevin Br, Scott
Wednesday 22 July	60 mins	1330 – 1430, MHRT Room 2	Kevin Ba, Kevin Br, Scott

Thursday 23 July	60 mins	0830 – 0930, AH team meeting	Kevin Ba, Kevin Br, Scott

Health
Justice Health and
Forensic Mental Health Network

TRIM Ref: DG18629/20

Mr Brett Holmes

General Secretary

NSW Nurses and
Midwives Association
5 O'Dea Avenue,

Waterloo NSW 2017

Re: Staffing Profile review - The Forensic Hospital 2020.

Dear Mr Holmes,

I write to advise that Justice Health and Forensic Mental Health Network (the Network) is intending on reviewing the Forensic Hospital staffing profile.

To confirm the Forensic Hospital provides specialist mental health care for adults and young people, both male and female. The patient demographic includes; forensic, correctional and high risk civil patients.

The current staff profile includes; Nursing, Allied Health, Administration and Medical staff, and has predominately remained unchanged since the Forensic Hospital commenced operation in 2008. However, since that time the Forensic Hospital has been confronted by a number of challenges, including but not limited to:

- Significant expansion in the provision of service and level of care provided to Forensic Hospital patients
- Substantial efforts and an ongoing commitment to improving work place safety through the development of systems of support to reduce risk
- Staffing vacancy rates and overtime costs
- Significant staffing costs, most notably, of nurses undertaking non-nursing duties.

The aim of the staffing profile review for the Forensic Hospital is to ensure the continued efficacy and safety or our staff and patients. The review will focus on Nursing, Allied Health and Administration duties. Whilst the Network is yet to fully scope the review, at this early stage we are anticipating the review could take up to nine

(9) months to complete. Our intention is however to engage the services of external consultants who have expertise of mental health facilities and patient care.

The review is only in relation to staff and not any matters related to the physical structure, design or layout of any of the Forensic Hospital buildings/units.

As mentioned, the Network is in the early stage of mapping this review. Collaboration with the NSWNMA is valued and the Network intends to be open and transparent with you in relation to our plans for 2020.

Further information will be provided as we scope the review and confirm the engagement of the external consultants, however, should you require any further information please do not hesitate to contact Mr Kevin Baron, A/Director of Nursing and Services on 9700 3145.

Yours sincerely

Wendy Hoey

Executive Director Clinical Operations

15 May 2020

Justice Health and Forensic Mental Health Network

ABN 70 194 595 506

PO Box 150 Matraville NSW 2036

Tel: (+61 2) 9700 3000 Fax: (+61 2) 9700 3744

Website: www.justicehealth.nsw.gov.au

Health
Justice Health and
Forensic Mental Health Network

TRIM Ref: DG113901/19

Mr Gerald Hayes
Secretary

Health Services
Union Level 2, 109
Pitt Street

SYDNEY NSW 2000

Re: Staffing Profile Review – The Forensic Hospital 2020

Dear Mr Hayes

I write to advise that Justice Health and Forensic Mental Health Network (the Network) is intending on reviewing the Forensic Hospital staffing profile.

To confirm the Forensic Hospital provides specialist mental health care for adults and young people, both male and female. The patient demographic includes; forensic, correctional and high risk civil patients.

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The review is only in relation to staff and not any matters related to the physical structure, design or layout of any of the Forensic Hospital buildings / units.

As mentioned, the Network is in the early stage of mapping this review. Collaboration with the HSU is valued and the Network intends to be open and transparent with you in relation to our plans for 2020.

Further information will be provided as we scope the review and confirm the engagement of the external consultants, however, should you require any further information please do not hesitate to contact Mr Kevin Baron, A/Director of Nursing and Services on 9700 3145.

Yours sincerely

Wendy Hoey

Executive Director Clinical Operations

15 May 2020

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Health
Justice Health and
Forensic Mental Health Network

TRIM Ref: DG18625/20

Dr Tony Sara,
President,
ASMOF Suite 46,
Level 3

330 Wattle Street

ULTIMO NSW 2007

Re: Staffing Profile review - The Forensic Hospital 2020.

Dear Dr Sara,

I write to advise that Justice Health and Forensic Mental Health Network (the Network) is intending on reviewing the Forensic Hospital staffing profile.

To confirm the Forensic Hospital provides specialist mental health care for adults and young people, both male and female. The patient demographic includes; forensic, correctional and high risk civil patients.

The current staff profile includes; Nursing, Allied Health, Administration and Medical staff, and has predominately remained unchanged since the Forensic Hospital commenced operation in 2008. However, since that time the Forensic Hospital has been confronted by a number of challenges, including but not limited to:

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The review is only in relation to staff and not any matters related to the physical structure, design or layout of any of the Forensic Hospital buildings units.

As mentioned, the Network is in the early stage of mapping this review. Collaboration with ASMOF is valued and the Network intends to be open and transparent with you in relation to our plans for 2020.

Further information will be provided as we scope the review and confirm the engagement of the external consultants, however, should you require any further information please do not hesitate to contact Mr Kevin Baron, A/Director of Nursing and Services on 9700 3145.

Yours sincerely

Wendy Hoey

Executive Clinical Operations

15 May 2020

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