From: Sharon Kelly
Sent: 4 Sep 2013 18:03:00 +1000
To: Stathis, Stephen;Steer, Peter;Dwyer, Lesley
Cc: Geppert, Leanne;Krause, Judi
Subject: Re: Teleconference tomorrow - Summary of the Options. Should we talk beforehand??

Thanks Stephen,

I guess the challenge for us is that we have asked a implementation steering committee to consider the ECRG recommendations and come up with the best options and implementation plan, so I would feel we would need to be cautious in outlining our preferred options at this point in time. I do recognise however that the issues around Logan are time sensitive, so a tricky spot.

the big challenge we have is there is a finite amount of funding for all of the options and a new build such as proposed with the appropriate staffing attached etc would potentially find us short to support all of the other modelling and tier options we have put forward.

On an alternate note keeping the current facility open for an extended time post January with complete confidence in the safety of the clinical services being delivered will prove a challenge for WMHHS.

I look forward to the discussion tomorrow.

Regards
Sharon

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>>> Stephen Stathis 4/09/2013 5:21 pm >>>
Thanks Lesley

Yes. 11AM is fine. Could you call me on my mobile?

Cheers

Stephen

>>> Lesley Dwyer 4/09/2013 4:14 pm >>>
Thank you Stephen for providing the summary of options. All very tricky in their own right. Does speaking at 1100 work for you? - Sharon and I will both be together following the Executive meeting at Ipswich.
If this doesn't suit I am happy to fit in with yourself as we can step out of our meetings.

Let me know - and yes I am happy to Chair the meeting.

Lesley

Lesley Dwyer
Chief Executive

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>>> Stephen Stathis 9/4/2013 4:03 pm >>>
Dear Lesley and Peter

I wanted to e-mail both of you with my thoughts, leading up the tomorrow's teleconference at 1200.

Lesley, will you be chairing the meeting?? There is a clash in timetabling, and Peter will in another meeting at the time this teleconference has been arranged. I have been delegated to attend as proxy. Potentially Peter may be able to excuse himself from the meeting, but he wanted a back-up plan to ensure CHQ has some input. **I think it is important that you and I talk beforehand, so I can brief you on the options I am going to raise during the teleconference. My mobile is I will make myself available at any time tomorrow morning before 1200.**

Peter, I'd be interested in your views too before the meeting.

In relation to the SITE of the 8-10 bed Tier 3 bed-based service located in SE Queensland, there are 4 Options that the CEs hve to consider.

OPTION 1
As you know, on Friday, I visited the Logan Hospital to look through Ward 2C, which is the proposed, interim location for the Tier 3 bed-based model of service we are developing. It is currently a 14 bed acute, adult psychiatric inpatient ward (5 x 2 double bed rooms; 4 x 1 bed single rooms) PLUS a 5 bed high dependency unit. Total of 19 beds.

Here are some of my initial thoughts:

Advantages:

- Large, established site. Could easily accommodate 8-10 beds.
- Could be refurbished, with more than enough rooms for offices, schooling etc.
- Most hanging points etc. have already been considered. So generally speaking, is already safe (some extra work needed, particularly on the outside areas.
- Good access to public transport. NOTE:
- Being located in a hospital would be advantageous if/when emergences or other acute afety issues arise.

Disadvantages:

- Still fully occupied as an acute unit. Decamping to the new psychiatric unit - time still uncertain. I have been told 'sometime in October', though senior staff were unaware of the exact date. That will give us 3 months completely refurbish the site. I am not builder,

butthat is unreasonable. We won't be able to fully scope the site until all the ward is empty. The ward needs considerable refurbishment to make it appropriate as an adolescent extended rehabilitation treatment facility. Of most concern, the court yard will need to be sectioned off - it is not acceptable for adolescents to mingle with acute adult psychiatric patients. The court yard has actually been sectioned off before (for different reasons), but the fence had to be taken down for WHS reasons (I believe). So I suspect we will need time to negotiate this. The HDU area needs significant work. With the Christmas/NY Break, I just can't see plans being drawn up, designs doing out for tender, refurbishment completed, and staff relocated by the 26 January 'deadline'.

- The proposed Tier 3 bed-based model will have a significant input from NGOs. Not sure how this will be negotiated within a Q Health acute hospital setting.
- Governance: Remains a sticking point.
- Costs: Once again, I am no builder. But I estimate it would cost would be well into the 100s of thousands of dollars. Not sure where this $$ is coming from. My concern is that if Qld Health spends a considerable amount of money on the refurb, they will be less inclined to see this as an 'interim' facility.
- Culture: We are aiming to develop a community, bed-based extended rehabilitation and treatment model. Though we intend to develop a strong model that supports this model of service, using an old ward in a hospital is sending the wrong message. This will need to be managed carefully, especially for Barrett Staff.

In summary, I don't believe we will have the time to physically refurbish and establish a new Unit by the January deadline. The costs will be significant. Some refurb on the internal facilities, and major refurb of the adult court yard and other outside facilities is required. Not sure if Metro South will have the appetite for this - what is the advantage to them. The interim site will need to fit in with our model of service, not the other way around. I suspect there are numerous HR and WHS issues in situating a largely NGO run services within an acute Q Health hospital ward. I also have concerns about the culture of using hospital based site for a proposed community model.

OPTION 2
Interim NGO housing:

Advantages

- Timing: Quicker to establish.
- Appetite within the NGO sector is probably there
- Flexibility around location
- Supports the concept of a community, bed-based model

Disadvantages

- Costs: Similar to above - how much money would Qld Health want to spend on an interim model?
- Safety: Any upgrade would need to meet hospital standards re hanging sites etc. This will be difficult to do in a residential house - costs and timing may blow out
- Bed Numbers: Unlikely a current residential house would be large enough to house 8-10 young people. Two houses required; duplication of costs, length of time to refurb etc. Location may also be a sticking point.

In Sum: I just don't think this will work either. At least, not in the short term.

OPTION 3
A New, Custom Built Unit similar to the Y-PARCs:

This would take some months to complete. Based on Y-PARC facilities, we would be looking at a stand alone land area of approx. 3000 sq metres, preferably situated in metro Brisbane.

Advantages

- We could develop an appropriate 10 bed facility along the lines of those we saw at Y-PARC, though built to our own specifications. We would have the flexibility of a community-based model, though built close to hospital facilities.
- Commencing with a site that has been constructed to fit the model, rather than using an interim facility
- The money used to refurb an interim facility will be redirected to building the site
- Green field site on or near a hospital would be idea - perhaps Prince Charles?

Disadvantages

- Opening post 26 January. This would mean the Barrett remains open for longer (political considerations here), and may not located in Metro South (Political considerations etc.), Are there any excess buildings in the community that are large enough to completely
- Argument over the location of the site. Bill is keen that it be established in Metro South. I would like it established in the CHQ catchment (which does partly correspond with Metro South, but includes parts of Metro North, of course).

In sum: I personally believe this is the best Option, but will require political stomach to succeed. It gives us time to find a good site and custom built facility that actually meets the model, rather than massaging an interim site to fit a model.

OPTION 4

Similar to OPTION 3 but lwith Barrett still closing in January and young people are supported by an expansion of Tier 2a and Tier 2b services first, supported in some areas by an intensive mobile outreach service.

Advantages

- We actually have a some type of service up and running by January, though not a bed-based one
- Similar other advantages of Option 3 re the build

Disadvantages

- Possibly even less politically palatable than Option 3
- ECRG noted significant risks if Barrett closes without the support of another Bed Based Tier 3 service (clinical and political risks)

In sum: We would be looking at rolling out Tier 2a and Tier 2b services anyway. But the risks are just to high in closing the Barrett without another bed based model running to take its place.

Timing

I have spoken to Leanne. She is committed to have a model written up for a Tier 3 services by the end of September/early October, in time for when I get back from leave (8th October). We will also be working on an IMYOS, Day Unit and Resi model as well.

I have given an undertaking to the CHQ Board that we will have a model developed (and hopefully costed) to present to their October Board Meeting (last week in Oct, I believe).

Please let me know if you have any other questions, or would like to talk beforehand - as suggested.

Cheers

Stephen

Dr Stephen Stathis
Clincal Director
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