WITNESS STATEMENT OF SUE MALENA WILLIAMS

I, Sue Malena Williams, Chief Executive Officer, Cabrini Health Australia and Board Member, Victorian Institute of Forensic Mental Health, of 154 Wattletree Road, Malvern VIC 3144, say as follows:

1 I make this statement in my personal capacity but with authorisation from Cabrini Australia Limited (**Cabrini Australia**) and the Victorian Institute of Forensic Mental Health (**Forensicare**).

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

3 My full name and title, together with postnominals, are as follows: Sue Malena Williams RN, ICU cert, BBus. Management, MBA.

Qualifications and experience

4 I have the following qualifications:

(a) Intensive Care Certificate

(b) Bachelor of Business; and

(c) Master of Business Administration.

5 I have also completed the Advanced Management Program at Harvard University and the Company Directors Course at the Australian Institute of Company Directors.

6 My professional experience includes previously holding the following roles:

(a) Chief Executive Officer (CEO), Peninsula Health;

(b) Chief Operating Officer (Hospitals), Healthscope Ltd;

(c) National Manager, Mental Health Services, Healthscope Ltd;

(d) General Manager, Melbourne Clinic; and

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(e) Director of Nursing, Royal Melbourne Hospital (**RMH**).

7 Attached to this statement and marked 'SMW-1' is a copy of my Curriculum Vitae.

Current roles and responsibilities

8 The roles I currently hold include the following:

(a) CEO, Cabrini Australia; and

(b) Board Director, Forensicare.

9 As CEO of Cabrini Australia, my responsibilities include the oversight of a $550m health and technology business, which comprises of five hospitals, a general practice, an asylum seeker and refugee centre, and a diversified technology business.

10 As a Board Director of Forensicare, my responsibilities (together with the other Board Directors) are set out in Part 14 of the *Mental Health Act 2014* (Vic) and include the development of statements of priorities, strategic plans, financial and business plans and the monitoring of compliance with those statements and plans, as well as the monitoring of the performance of Forensicare to ensure that it continuously strives to improve the quality and safety of the mental health services it provides. I am also:

(a) a member of the Board's Finance Committee; and

(b) Chair of the Board's People and Culture Committee.

ROLE OF PRIVATE AND PUBLIC PARTNERSHIPS

Opportunities for enhanced public/private health service partnerships

11 There are opportunities for enhanced public/private health service partnerships in relation to:

(a) increasing the inpatient bed capacity in the public mental health system;

(b) supporting and retaining the mental health workforce; and

(c) reducing gaps in service delivery.

Increasing inpatient bed capacity in the public mental health system

12 It is clear from the Royal Commission's Interim Report that there is an acute shortage of inpatient beds in the public mental health system. There are timing and costs issues associated with addressing this shortage. There is also likely to be less public funding available due to the economic effects of COVID-19. Even if there was a major capital injection, it would take two to three years to commission, build and staff additional inpatient facilities. Conversely, there is an excess supply of inpatient beds in the private

mental health facilities and there could be immediate access to such beds. This has arisen due to the rapid growth in private mental health services in a setting of declining private health insurance (**PHI**) rates. In the first quarter of 2020, the PHI rate in Victoria decreased to 40.2% – this was lower than the national average.[1] It is therefore important to consider how the public and private sectors can work together to utilise the excess capacity in private mental health facilities and to service the unmet demand in the public mental health system.

Supporting and retaining the mental health workforce

13 Based on my experience at Forensicare and Peninsula Health, it is often difficult to recruit and retain the mental health workforce (including psychiatrists, nurses and allied health professionals) in the public mental health system. The reasons for this include the following:

(a) public psychiatrists are paid a lower salary compared to their medical and surgical counterparts, as well as private psychiatrists (whose salaries can be up to double that of public psychiatrists);

(b) the working environment in public mental health services is associated with patients with higher risks and increased levels of stress; and

(c) occupational violence (including verbal and physical abuse) continues to be a significant issue in public mental health services despite significant investment by the Victorian Government to address this issue.

14 The above challenges contribute to the high employee turnover rate in the public mental health system, with a significant proportion of its workforce leaving to join the private sector or to pursue other career opportunities. In contrast, the workforce in the private sector is less exposed to these challenges due to their different case-mix. For example, the public sector primarily caters for consumers living with low prevalence mental illnesses such as schizophrenia and other mental illnesses that cause psychosis, whilst the private sector cares for people living with high prevalence mental illnesses such as depression, anxiety, and drug and alcohol issues.

15 Options that could be considered to reduce the employee turnover rate in the public mental health sector may include the following:

(a) rotation of the mental health workforce (including clinicians, nurses, allied health professionals and management) between the public and private sectors; and

(b) shared training opportunities between the public and private sectors.

[1] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Statistics March 2020* (Statistics, 19 May 2020) 3.

16 Benefits of such arrangements to the mental health workforce may include:

(a) some respite from the high-risk and high-stress environment in public mental health services; and

(b) greater breadth of experience.

17 From my experience, there are always learning opportunities for staff members when they are in a different working environment, and they often do not realise how much they have learned until they return to their regular working environment.

Reducing gaps in service delivery

18 There are also opportunities to develop public/private partnerships to reduce gaps in service delivery. As indicated in paragraph 14 above, it is clear that the public mental health system mainly caters for consumers living with low prevalence mental illnesses, whereas the private sector mainly caters for consumers living with high prevalence mental illnesses. As a result, there are gaps in service delivery and some people fall through the cracks. A person may not have PHI and is unable to access the private sector, but is also unable to satisfy the high threshold for access to the public mental health system due to a shortage of beds. Even if that person can access public mental health services, there may not be available community bed-based services. Conversely, the private sector may be better equipped to cater for people living with certain mental illnesses, such as eating disorders.

Benefits and risks for the public and private sectors

19 Benefits of public/private partnerships to the public sector can include increased inpatient bed capacity and better access to services by consumers, while benefits of these partnerships to the private sector can include utilisation of excess bed capacity. In addition, the potential benefits to the mental health workforce in both private and public sectors are discussed in paragraphs 13 to 17 above.

20 The risks of public/private partnerships for the public sector include the potential lack of similar experience in the private sector and regulatory restrictions. In particular, the private sector does not usually cater for consumers living with low prevalence mental illnesses such as psychosis and is restricted by law from caring for involuntary patients. Some private mental health units have high dependency facilities to care for patients requiring closer observation, but all involuntary patients require transfer to a public mental health facility. Legislation could be changed to enable private hospitals to care for public patients, but this would require increased training and may result in increased insurance premiums for private hospitals.

Driving innovation and improved models of service

21 I have had some experience with public/private partnerships in a previous role as the National Manager of Mental Health services at Healthscope Ltd. In most cases, innovation to provide improved models of service through public/private health service partnerships was small-scale and usually relied on local arrangements/relationships between public and private health services. Today, given the current demand pressure on the public sector and excess capacity in the private sector (please see paragraph 12 above), there may be more opportunities to innovate on a larger scale. This would require funding models that incentivise the two sectors to work together to create capacity in the public mental health system. Innovation could also be fostered through staff rotations between the two sectors, joint training programs, policies and model of care development.

22 In particular, in order for public/private partnerships to drive innovation and improved models of service, there needs to be changes in relation to:

(a) recognising the respective strengths of the public and private sectors;

(b) funding models;

(c) training models and

(d) commissioning approaches.

Recognising the respective strengths of public and private sectors

23 There needs to be greater dialogue between the public and private sectors in order to determine which sector is better placed to provide particular services, taking into account which sector has the capacity, capability and ability to deliver the particular service more efficiently or at a lower cost. For example, if a private mental health provider has a certain area of expertise, it can work in partnership with a public mental health service to enable greater access by public patients to the relevant services, and vice versa. As discussed in paragraph 20 above, there are, however, limitations in relation to the type of consumers cared for by private mental health providers.

Funding models

24 Importantly, funding drives behaviour. Funding should be used to incentivise public mental health services to collaborate with private providers or not-for-profit providers in joint initiatives by, for example, subjecting the provision of funding to such collaboration. Otherwise, there will only be incremental change.

25 In addition, there can be greater collaboration and innovation if public mental health services are given more autonomy over how they spend State funding (as opposed to the State allocating fixed amounts of funding to various areas of service delivery such as

inpatient and outpatient services). In particular, under a capitation model, health services may be given a fixed amount of funding per consumer per year with the freedom to choose how they spend the funding. For example, a health service may be allocated $30,000 to provide care to a mental health client per year. In this scenario, the health service may elect to provide more intensive community support for this patient to reduce the risk of hospital readmission. Other patients may require a mixture of inpatient admission and community follow-up, but the community follow-up may be purchased from another provider rather than the public sector providing all of the services. This provides health services with the flexibility to determine the services they provide, how the services are provided and by whom, which may result in a different model of care or a different emphasis on services in response to consumers' needs. The health services would bear the risk of a consumer requiring more resources for treatment over a long period, but may be able expend relatively less resources if the patient has fewer hospital admissions.

26 While I am not aware of any examples of the capitation model being used in the public sector, I am aware that it is used in the private sector. For example, Ramsay Health Care uses this model for its mental health facility in South Australia. I believe that it would be useful to trial this model in a smaller public health service.

Training models

27 Currently, most of the public/private staff rotations have been independently negotiated between individual health services and private providers. Some examples include the rotation of advanced medical trainees between St Vincent's Hospital and the Royal Melbourne Hospital and The Melbourne Clinic and between Barwon Health and The Geelong Clinic. There is an opportunity to expand these training models to include medical, nursing and allied health staff and I think doing so would build capacity, increase the breadth of experience and improve the understanding of both sectors.

Commissioning approaches

28 Commissioning approaches need to change at a number of levels to achieve system-wide impact. At the State-wide level, consistency amongst the public mental health services can be maintained (while giving the services more autonomy on spending) by having overarching State-wide principles that services must comply with when developing joint initiatives. These principles should be flexible enough for joint initiatives to suit a local area or region; if they are too detailed, it would be too difficult for services to innovate and develop the initiatives.

29 At the local level, all stakeholders should participate in the planning process of any joint initiative and agree on the initiative's objectives. Stakeholders include public and private mental health providers, Primary Health Networks (**PHNs**), and community service

providers (including not-for-profit and non-government organisations). Further, the planning process should include not only managers and policy-makers, but also extend to clinical staff, as they may have ideas about how to streamline operational processes.

30 Joint initiatives should be appropriately funded, given sufficient time to be developed, and properly evaluated so that policy-makers can identify initiatives that can be scaled up or adopted by other services.

Critical elements of successful public/private health service partnerships

31 Having worked in both public and private sectors, my experience is that people who work in the public sector do not really understand how the private sector operates, and vice versa. In order for public/private partnerships to be successful, it is important that both sectors understand how the different sectors operate and their respective capabilities. Other critical elements of successful public/private partnerships include having mutual trust between the relevant public and private providers, incentives that encourage collaboration, and consistency in training and supervision of the workforce. For example, State-wide standards can raise the bar for both sectors.

32 Some areas where public/private health service partnerships might operate and be scaled up are short stay admissions in public beds for stabilisation, use of private beds for stable mental health clients two to three days from discharge, and use of private or not-for-profit providers for day services such as drug and alcohol services.

33 One example is that when I was the General Manager of the Melbourne Clinic, we reached agreement with St Vincent's Hospital Melbourne (**SVHM**) and RMH to provide bed services to them at an agreed discounted bed day rate. As the rate was applied irrespective of whether the beds were utilised, SVHM and RMH were incentivised to fill the beds. The model worked well as the patients were relatively stable and two to three days from discharge. Continuity of care was maintained by having registrars at Melbourne Clinic who were on rotation from SVHM and RMH. This model could be scaled up so that an entire ward may be made available for use by public patients.

34 Another example is that Cabrini Hospital is currently in early discussions with a health insurer and a public hospital about a potential public/private partnership. The partnership could take a number of forms. Currently, mental health clients who present to an emergency department (**ED**) in a public hospital may be sent to the Psychiatric Assessment and Planning Unit (**PAPU**) (which is either adjacent to, or within, the ED) where they usually stay one to three days before a determination is made as to whether they are admitted to an inpatient ward or are sent home. Our view is that some of these patients could be triaged to a private mental health facility for stabilisation rather than being admitted to the public hospital's PAPU.

35 The models in these examples can be scaled up and used to create capacity in the public mental health system either at the outset (whereby patients are triaged when presenting at a public hospital) or close to when patients are discharged. Alternatively, they can be used to reduce service gaps such as when it is difficult for a person to satisfy the criteria to gain access to public mental health services.

THE ROLE OF PRIVATE PROVIDERS IN MENTAL HEALTH

Long-term role of private mental health providers in Victoria's mental health system

36 The recent COVID-19 situation has provided a good example of how the public and private sectors can work collectively to address capacity issues. I believe that both sectors generally consider that the agreement between the State and Federal Governments to enable public patients to be cared for in private hospitals to provide surge capacity has worked well, and that broad system reform is required. Increasingly, both sectors are forming the views that neither sector can provide all the services that are required to effectively meet demand, and that long-term partnerships can be utilised to achieve this and as a result are likely to remain. There appears to be a genuine appetite for public/private partnerships for inpatient and out-of-hospital care. Opportunities exist in the acute, sub-acute and mental health sectors.

37 As outlined in paragraphs 24 to 29, funding drives behaviour so commissioning models should encourage public and private sectors to work together for mutual benefit. The principles regarding the provision of funding should be established at a state level as part of the commissioning process, however there needs to be flexibility at a local level to enable health services and private providers to identify where the greatest benefit can be realised and how outcomes will be measured. For example, a private provider may have capabilities in community care and the public service may elect to purchase these services, rather than duplicate the effort.

Better support between the public and private sectors in caring for people with mental illness

38 The public mental health system (including community providers) and private mental health providers (including not-for-profit organisations) can better support each other in caring for people living with mental illness by collaborating in the discharge planning process to provide better continuity of care.

39 Due to the high demand for public mental health services and the current bed shortage, there is increased pressure on public mental health services to discharge patients. This may result in gaps in service delivery and create issues in providing continuity of care, particularly if these consumers are discharged to private mental health providers in the community. I think better collaboration between the public mental health services and

private mental health providers in the discharge planning process could improve the continuity of care for these consumers. The public mental health services may, for example, ensure that private providers are involved with the discharge planning of a patient or vice-versa.

Opportunities for, and barriers to, private hospitals providing more mental health care

40 As noted in paragraph 31 above, my experience is that the public sector does not have a clear understanding about how the private sector operates, and vice versa. I think that if there was greater understanding of the respective sectors and their core capabilities, both sectors would be more willing to collaborate. This can be done in a variety of ways including, for example, through meetings, partnerships, joint training initiatives and staff rotation – all of which can help to cross-fertilise ideas, break down barriers, and allow the workforce to better navigate the systems in both sectors. These can in turn allow private hospitals to provide more mental health care.

41 Please also see paragraphs 12 and 20 above.

FUTURE TRENDS IN HEALTH CARE

Major societal trends impacting health systems in the next decade

42 The economic and societal impacts of the COVID-19 pandemic will be long-lasting. This pandemic will fast-track the effects of worsening economic conditions and societal pressures, leading to increased social isolation, destitution, incidences of domestic violence, and drug and alcohol abuse (noting that these were already issues prior to the pandemic). Separately, there has been an increased incidence of mental health issues in students due to bullying at schools, including at high schools and universities. As a result of these trends, the mental health and wellbeing of people will be a more significant problem and the mental health system will be under great stress for many years ahead. The mental health system therefore needs to plan ahead to better address this problem.

43 One way that health systems are adapting to the impacts of the COVID-19 pandemic is to provide more telehealth services (being services which are provided via phone or video). Telehealth has grown enormously since the pandemic, with over 10 million telehealth consultations occurring in Australia since early March 2020.[2] I am unable to confirm what proportion of these have been for mental health. The government is likely to regulate this at some stage, but I suspect telehealth is here to stay. While it is not a complete substitute for face-to-face mental health treatment, it may reduce the frequency

[2] Department of Health (Cth), 'Deputy Chief Medical Officer press conference about COVID-19 on 18 May 2020' (Transcript, 19 May 2020).

of face-to-face consultations and enable the workforce to have more regular contact with mental health consumers in the community.

44 An example of where telehealth is used is at the Cabrini Asylum Seeker and Refugee Health Hub. The use of telehealth to deliver mental health services to asylum seekers and refugees has ensured that they have continued to receive mental health services while restrictions are in place. These consumers fall through the cracks as they do not have access to Medicare and cannot access public services.

45 Beyond telehealth, it is too early to comment on how health systems are more broadly adapting to the impacts of the COVID-19 pandemic. Nevertheless, a positive side-effect of the pandemic is that bureaucracy is reduced when negotiating with the government, and new initiatives can be fast-tracked and implemented in a more timely fashion. For example, when elective surgery was ceased as a response to the COVID-19 pandemic, across Australia the State and Federal Governments were able to negotiate comprehensive agreements that kept private hospitals viable in exchange for the private hospitals providing access to intensive care beds and undertaking public elective surgery. These highly complex agreements were able to be negotiated in one month due to mutual collaboration and goodwill between the public and private sectors. Under normal circumstances, I think a similar agreement with the government would have taken many months to finalise.

46 Another societal trend that is likely to continue are the declining levels of PHI uptake. Even prior to the pandemic, people were reluctant to purchase PHI due to increasing PHI premiums and other personal circumstances (for example, static salaries and increased living costs). The economic downturn due to the pandemic is likely to compound this issue, with many people losing their jobs or being forced to work reduced hours. Many of these people will be questioning whether they should continue to pay for PHI. Indeed, as noted in paragraph 12 above, the PHI rate in Victoria fell to 40.2% at the end of the first quarter in 2020. This situation is likely to worsen when the JobKeeper Payment scheme ceases. This may in turn place an even greater reliance on the public mental health system.

47 This issue presents an opportunity for the Federal Government to consider the viability of PHI and private health providers going forward (including from the perspective of acute mental health services), and to make difficult policy decisions in relation to funding models (please see paragraphs 24 to 26 above). In particular, I believe that there should be policy decisions that help to ensure that private health insurance premiums are affordable and out-of-pocket expenses are reduced.

Supporting health system leaders to collaborate in response to societal changes

48 In order for health system leaders to better consider major societal changes impacting health systems and to collaborate to respond to these changes, there should be more cross-sector opportunities for collaboration. This would allow greater mutual understanding of how the two sectors work, as well as encourage cross-fertilisation of ideas and identification of opportunities for partnership arrangements.

49 When I was on the Board of Directors of Better Care Victoria, we sought to build capability by rotating potential leaders to other health services (both public and private) and by seeking input from other industries, including from, for example, technology start-ups.

50 There could also be think tanks that focus on particular areas, such as public/private partnerships, workforce models and funding arrangements. These think tanks would involve discussions among representatives of public and private health services as well as consumers, carers and policy advisors. Having people from different industries with diverse perspectives in a discussion could generate good ideas and facilitate innovation. Representatives should include not only people empowered to make major policy decisions but also people at the coalface (clinical staff, carers and consumers) who understand the downstream impacts of system changes.

Characteristics of successful programs of reform

51 In order to be successful, major programs of reform need a number of key things:

(a) a clear understanding of the problem that is being solved;

(b) input from key stakeholders (antagonists and protagonists);

(c) a willingness to try different things;

(d) adequate resourcing to properly implement reform; and

(e) funding models that encourage collaboration and foster innovation.

GOVERNANCE AND PERFORMANCE MONITORING

Improving governance arrangements in public health systems and delivering improved outcomes for consumers and carers

52 The current devolved governance arrangements in Victoria work well and provide public health service Boards with the autonomy to deal with complex governance issues. It is also important that a Board has the right skill mix to fulfil its financial, clinical governance, audit and risk, as well as consumer and carer responsibilities. In the past, the process of appointing a new Board member of a public health service could be slow, although this may have improved in recent times.

53 Up-to-date and accurate information is important to aid decision-making. Old and disparate Information Technology (**IT**) systems in public health services can make reporting difficult and labour-intensive. Based on my past experience in the public mental health system, reporting requirements can also be onerous. There is often a plethora of Key Performance Indicators (**KPIs**) (with more and more KPIs added over the years) with no process of review. Regular review needs to occur to ensure that KPIs are relevant and measurable, and that they provide the right information on quality and safety, operational performance and financial sustainability.

54 Relevantly, KPIs should also be described in a way that is easily understood by all staff to ensure alignment of core strategic goals. For example, a KPI on ED wait times for a mental health patient requiring admission has a very different meaning to a CEO compared with a junior nurse in a mental health unit. For the CEO, the KPI is all about not breaching the ED wait time target. For the junior nurse in a mental health unit, their key contribution to achieving this KPI is to ensure that all patients in the unit are discharged by 10.00 am, so that there is a bed available to admit the mental health patient from the ED.

55 A number of options could be considered to improve consumer and carer outcomes, including patient-led handover (where a nurse conducts a handover at the bedside and includes the consumer and their families in the planning of care). Involvement of community providers in the discharge-planning process (i.e. involving them as the discharge plan is being developed, not only on the day of discharge) may also be beneficial.

Integrating governance arrangements of mental health services and acute health services in the public system

56 It is arguable that separating governance arrangements of mental health services and acute health services in the public system can increase focus on mental health services. However, my view is that separating governance arrangements will lead to duplication of effort and increase costs. It will also reduce cross-fertilisation of ideas between divisions within a health service. There are more merits in integrating the governance arrangements and ensuring that mental health services are considered a core component of the public health services. In particular, this would:

(a) avoid duplication of common corporate services and reduce costs and overheads;

(b) provide mental health services with an equal voice within public health services;

(c) improve the identification of physical or mental comorbidities and access to care for patients with both mental health and acute health issues (where mental health

services and acute health services are located on the same site or are close to each other). Indeed, many of the patients who present at EDs have both types of issues; and

(d) provide an opportunity for managers to work across different services, thereby allowing them to gain greater breadth and depth of experience.

57 A potential limitation of a fully integrated service is that acute services may dominate decision-making by virtue of their size and complexity. This could be avoided by ensuring that there is dedicated time on agendas to discuss mental health service issues.

Performance oversight of public mental health services

58 To better enable performance oversight of public mental health services, there needs to be monitoring of KPIs within services in relation to:

(a) the delivery of safe and high quality care (for example, KPIs on sentinel events, seclusion rates and adverse events such as occupational violence);

(b) culture (for example, KPIs on sick leave, turnover rate, agency rates, staff satisfaction and exit interviews);

(c) financials (so as to ensure the viability of the service); and

(d) operations (for example, length of stay in ED, transfer rates from judicial system and readmission rates).

COMMISSIONING

Improving commissioning approaches

Supporting new care models

59 The current public health system relies on a direct funding relationship between the State Government and service providers. Whilst a 'one size fits all' approach is administratively easier, it tends to dis-incentivise service providers to innovate or develop new models of care.

60 Commissioning that encourages and supports new models of care is more likely to occur by focusing on the outcome rather than only defined activities. While objectives should always be part of a commissioned service, they should serve only as a guide for the service provider. This will give the provider more freedom to develop different and new models of care within an evidence-based framework that the commissioning agent and the provider agree on. If the commissioning process emphasises outcomes, flexibility and responsiveness, this allows both the commissioning agent and the provider to respond to changing consumer needs.

61 Also, patient choice should be a priority as it fosters innovation and the development of new models of care. In particular, if the commissioned process includes a funding model that enables patients to choose how they want their care to be delivered, providers will be incentivised to develop new flexible models of care. Where there is a large market or population, a panel of providers may be commissioned to deliver the same outcomes. This may also encourage innovation between providers and offer greater choice for consumers.

62 Providers and commissioning agents should be able to share information on learnings during the life of the commissioning; this would allow modification of the service model and greater innovation during the lifetime of the contract. These learnings should also feed into the next phase of commissioning to ensure an even better outcome.

Incentivising early intervention

63 Early intervention can be incentivised during the commissioning process by ensuring that:

(a) there is easy access to commissioned services through streamlined referral pathways; and

(b) a funding mechanism that 'follows the patient', regardless of the particular service that was first requested by the primary referrer (please see, for example, the mechanism discussed in paragraph 68 below).

Supporting people with complex needs

64 To encourage the provision of treatment, care and support to people with complex needs, the commissioning approach needs to be able to combine different sources of funding, and to rationalise often conflicting systems or barriers between the Federal Government, State Governments, and the private sector. Pooling funds is the best way of achieving this.

Responding to the 'missing middle'

65 I assume that the 'missing middle' in the mental health system is the group of people who cannot afford private mental health services and do not qualify for current government programs (for example, people who are not sick enough to require inpatient admission but are too complex to be cared for by a GP).

66 Commissioning would be the most efficient and co-ordinated process for delivering an expected defined set of services for this population group. The missing middle requires integrated community and hospital services.

67 One approach would be to aggregate current State and Federal Government funding for programs and reallocate the funding to 'commissioning agents' closer to the ground. The PHNs were established to be these commissioning agents. In November 2015, as part of the Mental Health Reforms, PHNs were allocated $350 million of funding to co-ordinate and commission community mental health services. These services are directed from GP referrals.

68 If the current fragmented State and Federal Government funding (programmatic and block funding) that is currently financing mental health hospitalisations was added to this PHN pool, this would enable a patient in the missing middle to seamlessly move from primary to tertiary care under the guidance of their GP. Conversely, if the patient was discharged from hospital, they would seamlessly move back to community care – that is, the funding would seamlessly follow the patient. The PHN would be charged with commissioning access to public and private hospitals in their catchment, creating choice and value for the patient. Also, the PHN would be able to call upon Independent Hospital Pricing Authority for commissioning advice with regard to costing hospital episodes.

69 If the PHI sector continues in its current form, the PHNs' commissioning would also involve integrating insurance contributions from members with a PHI product for private hospital utilisation.

Addressing the maldistribution of funding for mental health

70 The maldistribution of funding for mental health is a significant issue, particularly in rural and regional areas where workforce resources are scarce and access to clinicians is difficult. There is a need to consider how Medicare Benefits Schedule funding can be used to deliver care in these areas; for example, telehealth may be provided to supplement face-to-face service delivery. Nurse practitioners may also be able to treat consumers living in rural and regional areas and bill Medicare to improve the delivery of services in those areas.

71 Relevantly, I think that there may be an opportunity to develop funding models that require large metropolitan services to work with rural and regional mental health services to improve the delivery of services where there may be workforce shortages. If funding is provided solely to large metropolitan providers, the services are likely to be provided in metropolitan areas only. Conversely, if funding is provided to all stakeholders (including metropolitan, rural and regional providers) in a particular region, and is provided subject to all stakeholders being involved in the planning and delivery of services, the maldistribution of funding and services may be better addressed.

WORKFORCE

Implications of disparities between public and private mental health sectors

72 My understanding is that there are workforce shortages in most disciplines in the public mental health sector, including medical, nursing and allied health.

73 As discussed in paragraph 13, there are significant disparities between the public and private mental health sectors in respect of salary, working environment and incidence of occupational violence. These disparities can result in difficulties in recruiting and retaining the mental health workforce in public health services.

74 Staff shortages in the public sector due to high staff turnover result in an increased use of agency nurses and other temporary staff, or more permanent staff working overtime which can in turn lead to a greater increase in staff turnover and burnout. Agency nurses are paid premium rates but often have less responsibilities than permanent staff due to their unfamiliarity with the health service environment, which can also cause resentment amongst permanent staff. There has also been a trend towards the casualisation of the workforce as many nurses are electing to work four permanent shifts per week, supplemented by an agency shift at a higher pay rate. A number of health services have responded to this issue by increasing the number of graduate nurses undertaking training in mental health, which helps to increase staff numbers and build the mental health workforce.

75 Whilst increasing the number of staff trained in particular disciplines helps to address workforce shortages, turnover will continue to be an issue without adequate retention strategies. This includes having opportunities for career advancement, recognition, further training and strategies to ensure that staff feel safe in the work environment.

76 The incidence of occupational violence in public hospital EDs and mental health services is a particular issue impacting turnover in public mental health facilities. Whilst significant work has been undertaken by the Victorian Government to address this issue, staff continue to be injured in the workplace. Further investment in environmental controls, such as the use of security guards and staff training in de-escalation techniques, need to be made to address this issue. Boards also need to take a leadership role in creating a culture that works towards ensuring no staff member is injured in the workplace.

Whole-system workforce planning, development and collaboration

77 It would be good to have a whole of system approach to workforce planning, development and collaboration across public and private services and professional disciplines. This should include modelling on demand and forecast staffing requirements, consideration of the type and mix of the workforce, and the development of joint initiatives to improve the recruitment and retention of staff. Please also see paragraphs 13 to 17 above.

LEADERSHIP AND CHANGE MANAGEMENT

Supporting the development of leadership within health services

78 It is important to have people from different sectors and backgrounds in leadership roles. This promotes more diverse thinking and generation of new ideas. One option for consideration is a graduate program where participants rotate through different health services across the public and private health sectors or other health-related industries. This could include a 3-month rotation to a large metropolitan mental health service, followed by a 3-month rotation to a rural or regional health service, followed by a rotation through a private mental health facility and a final rotation to a community provider or PHN. This would provide the participants with a broader insight into the mental health system and the potential collaborations that could occur.

79 In order to support the development of leadership within health services, emerging clinicians (i.e. clinicians with the potential to be future leaders in their fields) could also be given opportunities to lead projects under the supervision of a mentor. In doing this, it will be important to give the individuals adequate time to complete their project so that they are not set up to fail.

80 In addition, if ideas are put forward (whether to the government or to the management of health services) but are rejected, the deciding party should provide feedback and reasons for the rejection. People will understand if a rationale is given for a decision; otherwise, they are likely to give up and be less inclined to propose new ideas in the future.

Key success factors of change management programs

81 Key success factors of any change management program for the reform of the mental health system include the following:

(a) clear objectives for the program, and ensuring that all stakeholders understands these objectives;

(b) good communication processes in place from the organisational leadership team to staff and from staff to the leadership team;

(c) sufficient time and resources to undertake the program of work;

(d) evaluation of the program to determine if its original objectives have been achieved;

(e) where the program is not achieving its objectives, recognition of the need for change and clear communication of any changes to all stakeholders; and

(f) evaluation of the program to determine if it is scalable (for example, across a region or the entire mental health system).

HEALTH SERVICE GOVERNANCE

Governance of specialist public health services

82 In my view, the most important factor in relation to governance of specialist public health services is ensuring that the Board has the right mix of skills, as it provides the strategic direction of the health service. The Board should collectively have:

(a) expertise and experience in relation to health services, mental health, IT, audit, finance, governmental matters, and quality and safety;

(b) a mix of private and public health sector experience; and

(c) diversity (including gender and ethnic diversity).

83 The Board also needs to have members who are prepared to ask difficult questions, as this would give the Board the opportunity to address any issues raised as a result, consider plans to rectify these issues, and build capability in the health service.

84 Another important factor in relation to governance is having the right CEO – someone who leads with integrity, communicates effectively, is both engaged and accessible, and brings innovation to the table. The role of a CEO in the public sector is particularly challenging because they have to manage year-on-year budget and productivity cuts, increasingly onerous reporting and increased incidences of occupational violence. The Department of Health and Human Services (**DHHS**) should consider how to keep capable CEOs in their roles, as the CEO is the linchpin of a health service.

85 The Board and the CEO should be supported by the right resourcing and capability, including capable senior managers and reporting systems that enables good oversight of what is happening at the coalface.

86 A significant governance challenge for public mental health systems is the administrative burden of reporting obligations, as the quality of IT in the system is invariably poor. Based on my experience at Peninsula Health and Forensicare, the system uses disparate IT systems that do not communicate with one another. It is therefore very time-consuming for management to comply with reporting obligations. There is a need for the Victorian Government to make a greater investment in IT across the system.

87 Financial sustainability is also an ongoing challenge for public mental health services, with ongoing productivity cuts of 1.5% making it difficult for some mental health services to achieve their budgets. Forensicare has been in a fortunate position in the last 2-3 years largely due to growth funding, but some other mental health services are struggling to achieve their budgets.

Role of the Forensicare Board in supporting the transition to a new model of care

88 Forensicare's governance structure ensures that new models of care and changes/improvements to service delivery are reported to both relevant Board Committees and the Board. This reporting is managed through agendas that are informed by work plans and engagement with Management.

89 Work on Forensicare's new model of care is progressing in parallel with forensic mental health service planning and capital planning. The Board has oversight over these activities and any new service delivery model would be subject to independent evaluation following implementation.

90 If there are clinical or capacity issues within individual services of Forensicare, the CEO or relevant Executive Director will escalate such issues to the Board for consideration. The Board has also been inviting staff members from services across Forensicare to discuss issues with the Board, so that the Board can consider how Forensicare can better support those particular services. In addition, the Board participates in a Board to Business program, which is an ongoing program that is designed to give Board Directors an understanding of the day-to-day operations that cannot necessarily be achieved through Board papers and meeting attendance alone. It gives Directors an opportunity to visit sites and meet staff across the organisation (including Thomas Embling Hospital (**TEH**) and prison sites) to see first-hand the services being delivered to consumers.

91 The purpose of a model of care is to ensure Forensicare's consumers receive treatment and care that promotes recovery. To this end, new models of care can impact on service delivery and how service delivery is monitored. For example, a new model of care was developed for the Apsley Unit at TEH in advance of its opening in early 2019, given that the purpose of the Apsley Unit is to provide short-term care for severely unwell male prisoners (as opposed to the long-term care provided to forensic patients in other units of TEH). The Apsley model of care is an innovative approach to mental health treatment that is both evidence-based and trauma-informed, and it promotes consumer engagement, treatment, and recovery resulting in reduced readmission. Whilst the Board's governance approach does not change when new models of care are introduced, in that the Board continues to monitor performance and quality and safety, the introduction of a new model of care necessarily means closer Board oversight upon its commencement. This includes using KPIs that are specific to the new model of care to enable effective oversight. For example, length of stay for the new Apsley model of care is monitored given that the model is intended to facilitate shorter lengths of stay.

Review of data by the Forensicare Board

92 The Forensicare Board has agreed on a suite of KPIs that are reported monthly, quarterly or annually (as applicable) which cover the themes of quality, safety, and consumer experience and outcomes. As the current Board members are relatively new, we have sought to review more data over the past year to gain a better understanding of the services being delivered by Forensicare and their outcomes. I think having a greater volume of KPI reporting should be balanced against the need to allocate more time to service delivery, and we are currently undertaking a review of our KPI suite to ensure this balance is achieved.

93 The Board has a dedicated Quality and Safety Committee which has a designated member with consumer/carer experience. This Committee oversees all quality and safety performance elements, including consumer complaints and clinical performance. In addition, the Board is supported by four other Board Committees to assist it in fulfilling its responsibilities: the Audit and Risk Committee, the Executive Performance and Remuneration Committee, the Finance Committee, and the People and Culture Committee. Each Board Committee has their own internal discussions on a particular area, and the Chair of each Board Committee then provides monthly reports up to the Board (so that the Board has oversight of these Committees).

Role of the Forensicare Board in actioning any concerns or issues

94 Due to the monthly reports from the Board Committees, the Forensicare Board will scrutinise performance against KPIs and is kept well-informed about all key issues. Any issues that involve high risks or require organisation-wide changes are also escalated by the Board Committees to the full Board for further consideration. The Board will then require action as appropriate. All action items are added to the action register and will be monitored by the Board with the aim of closing them out.

95 In addition, the Board has a range of mechanisms by which it can monitor performance – for example, it can request further information on a program or work function, or an internal audit.

96 For example, as the Board is concerned about Forensicare's employee turnover rates and results from the 2019 People Matter Survey (**PMS**), the Board required Management to develop an action plan to respond to the PMS results. The People and Culture Committee was established as a response to the PMS results as well as employee recruitment and retention issues, and this Committee is overseeing the implementation of the action plan.

97 Also, as the Board is very concerned about the occurrence of occupational violence at Forensicare, we asked our internal auditors to conduct a review of occupational violence

incidents and Management's responses to such issues. We then devised an action plan in response to the results of the review. The Audit and Risk Committee oversaw the review by the internal auditors and the Quality and Safety Committee is overseeing the implementation of the action plan.

Role of the Forensicare Board in relation to adverse events

98 In respect of consumers, Forensicare has an Incident Severity Rating (**ISR**) system that aligns to the Victorian Health Incident Management System. All incidents with ISR 1 – 3 are reported to the Quality and Safety Committee and to the Board. The Quality and Safety Committee is mandated through its Charter to review serious incidents and consequently it receives the serious incident review in full.

99 KPIs related to serious incidents are also reported to the Quality and Safety Committee and the Board. Action items from serious incident reviews are tracked and reported on as part of the KPI suite.

100 If there is a serious event that is not directly within the scope of Board meetings, the CEO would escalate this to the Board Chair verbally.

Comparative performance data currently available to the Forensicare Board

101 As Forensicare is the State-wide provider of specialist forensic mental health services in Victoria, it is difficult to obtain comparative performance data which we can benchmark ourselves against. In particular, there is no national suite of KPIs that are specifically designed for forensic mental health services – it would be useful if such a suite existed.

102 Whilst the data available from Victorian Agency for Health Information is helpful to the Forensicare Board in understanding performance in the context of other area mental health services, the Board considers outliers closely, including to determine whether the result is driven by Forensicare being a provider of forensic mental health services. To this end, the Board will seek comparable performance data from forensic mental health providers interstate and overseas. When doing so, the Board is careful to ensure that any data obtained from other jurisdictions is comparable and, if it is not comparable, whether such data can be used to identify trends for comparison. There is, however, no formalised exchange of data.

Role of the Forensicare Board in relation to occupational violence

103 The Forensicare Board takes instances of occupational violence seriously and consequently monitors them closely. All instances of occupational violence where a staff member is seriously injured (either physically or psychologically) are immediately reported to the Board Chair.

104 The Board also receives data on occupational violence, including data on the number of occupational violence incidents reported, Code Grey incidents, lost-time injuries, WorkCover claims, and mandatory workforce training relating to occupational violence. This information informs the risk that violence presents to Forensicare staff, consumers, carers, family members and visitors, and enables the Board to identify and implement strategies to mitigate this risk. The Board has also included Workplace Health and Safety on its Enterprise Risk Register.

105 The Board recently commissioned an internal audit on the systems Forensicare has in place to prevent occupational violence across the organisation. The internal audit identified areas for improvement, which has resulted in the recent employment of a Health Safety and Wellbeing Manager. Further, as a result of this internal audit, we are currently considering options for improved clinical security with the aim of minimising the risk of occupational violence.

106 In addition, as mentioned in paragraph 96, the Board has established a dedicated People and Culture Committee that is focussed, in part, on monitoring in more detail the Management's response to occupational violence.

Current regulatory settings for health service governance

107 As a result of the 'Targeting Zero' review,[3] the State has made substantial improvements to the regulatory and oversight functions of Boards through the passing of the *Health Legislation Amendment (Quality and Safety) Act 2017* (Vic). In particular, these reforms have strengthened the Board's role in the oversight of quality and safety by clearly prescribing the responsibilities and functions of the Board, including by making it clear that the Board is responsible for monitoring performance. This responsibility encompasses identifying and addressing quality and safety issues as well as improving the quality and safety of the mental health services delivered.

Role of the Forensicare Board in the Statement of Priorities process and dialogue with the government

108 The Forensicare Board is involved in the development of the Statement of Priorities (**SoP**) and endorses the SoP before it is sent to the Minister for Mental Health for approval. In addition, the Board monitors Management's progress on action items as against the SoP, and the KPIs specified in the SoP are reported to the Board on a monthly and quarterly basis (as applicable).

109 In my view, the SoP provides an important opportunity for the Board to understand the priorities of the government and to ensure that we are focussed on the outcomes that the

[3] Department of Health and Human Services, *Targeting Zero: Report of the Review of Hospital Safety and Quality Assurance in Victoria* (Report, October 2016).

government is seeking. While it is an annual process, Forensicare would benefit from ensuring a stronger alignment of the SoP with the strategic goals of the organisation.

110 My time as Acting Chair confirmed the importance of maintaining constructive and collaborative relationships with key government stakeholders through active and ongoing communication. For example, the CEO currently meets with DHHS together with Justice Health every six weeks to discuss high-level, shared strategic and system issues, which I think is important in ensuring both the government and Forensicare are aligned in the management and resolution of such issues. We have also actively engaged with the Chief Psychiatrist on issues related to seclusion and this has been very helpful.

111 The Board Chair and I, during my time as Acting Board Chair, also took the opportunity to meet with relevant Ministers to ensure they were abreast of key issues and to have ongoing dialogue with the government.

112 In addition, I am of the view that engagement with the government needs to occur not only at an individual health service level, but also at a sector level given that mental health services across the sector invariably share consumers. Such engagement ensures consistency in the health services' approach to service delivery.

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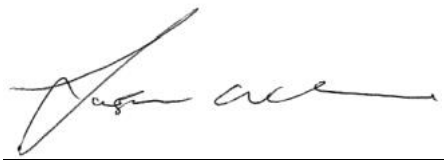

print name SUE MALENA WILLIAMS

date 07/07/2020

ATTACHMENT SMW-1

This is the attachment marked 'SMW-1' referred to in the witness statement of Sue Malena Williams dated 07/07/2020.

CURRICULUM VITAE

Susan Malena WILLIAMS - RN, ICU Cert, BBus, MBA, GAICD

EDUCATION

- Australian Institute of Company Directors Course, GAICD 2015
- Advanced Management Program, Harvard University, 2009
- Master of Business Administration, Monash University, 1999
- Bachelor Business Management Monash University, 1994, (Top graduating student)

ACADEMIC ACHIEVEMENTS

- H. J Heinz Award for Best Final Year Student in the Department of Management, Monash University, 1994
- AIM (Victoria) Award for equal Top Graduating Student in the Department of Management, Monash University, 1994

EMPLOYMENT HISTORY

Chief Executive Officer **2019-current**
Cabrini Australia

Strategic responsibility and oversight of a large health and technology business, with an annual budget of $550m and 4500 staff.

Chief of Health Operations **2017- 2019**
Cabrini Health

Strategic and operational responsibility for the largest division at Cabrini Health, overseeing 5 hospitals, an aged care facility and general medical centre.

Key Achievements

- Financial turnaround of the health division through improved revenue capture, cost saving initiatives, service reconfiguration and other operational improvements
- Worked with the Chief Property Officer to commission a $120m building program and delivery of 2 new operating theatres, on time and under budget
- Established processes to improve integration between acute, sub-acute and primary care
- Achieved ACHS accreditation with 14 met with merits
- Successful negotiation, planning and implementation of an $8m contract performing 240 public elective surgical cardiothoracic cases for the Alfred Hospital
- Led the restructure of Cabrini Health’s pathology business in response to regulatory changes, whilst fully maintaining the benefits and conditions of Cabrini Health pathology staff

- Improved stability and welfare of the nursing workforce utilizing innovative recruitment and retention initiatives. This has already reduced agency utilisation to <3% and sick leave to <3.5%.
- Improved the quality and profitability of the Terrace café's at Malvern and Brighton through a carefully crafted outsourcing contract. This was delivered maintaining the employment and conditions of all staff.
- Cabrini lead on a project to form a joint venture with the Australian Healthcare Alliance to establish a new model of care for Mental Health in SE Melbourne including a purpose designed mental health facility.
- Improved engagement of our highly skilled medical workforce through active participation and input into key strategic decisions including:
    - Reconfiguration of the clinical units within the new Gandel Wing
    - Development and implementation of Cabrini wide cancer and palliative care strategies
    - Reconfiguration of rehabilitation services to improve quality and sustainability
    - Improved transparency and quality of consumable contracts including a ($19M) Cardiac device tender
    - Facilitated efficiency of admission through the development of a direct admission policy at Cabrini Malvern
    - The successful planning and delivery of the Alfred public elective surgery tender

Peninsula Health **2014 - 2017**
Chief Executive Officer

Strategic and operational responsibility for a major metropolitan healthcare network providing acute, sub-acute, mental health, aged care and extensive community services to a population of over 300,000 people, Situated in a major growth corridor, the organisation has a budget of over $530 million, 5200 staff and 800 volunteers.

Key Achievements:

- Significant improvement in organisational performance with Peninsula Health consistently ranked at the top of its peer group on financial, activity, patient experience, and quality and safety metrics.
- Commissioned over $100m in redevelopments including a 49 cubicle Emergency Department, a hybrid operating theatre, new outpatient department and 92 inpatient beds on time and under budget
- Developed a 5 year digital health strategy which included the full implementation of an electronic medical record
- Established strategic partnerships to meet local and regional needs including:
    - Development of a regional cardiac referral and admission service in SE Gippsland
    - Implementation of "eyeConnect" a telemedicine diagnostic and image capturing device for use in emergency departments in collaboration with the Royal Victorian Eye & Ear Hospital

- Developed and implemented a research strategy including a partnership with Monash University to appoint an inaugural Professor of Medicine and construct a $20million academic precinct at Frankston Hospital
- Achieved ACHS accreditation with 18 met with merits
- Reduced nurse agency utilisation to 1% through improved recruitment, training and retention strategies
- Progressed the growth and further development of a Patient Alarm Call Service monitoring over 35,000 elderly clients in their homes in Victoria and Southern NSW.
- Establishment of partnerships with private industry to commercialise the Patient Alarm Call Service and develop enabling technology to monitor patients with chronic diseases in the home.

Spotless Group **2013-2014**
Divisional Manager Health Australia & New Zealand

Recruited to increase revenue and margin growth prior to relisting on the ASX. Strategic and operational responsibility for 200 managed services contracts in acute, sub-acute and aged care facilities across Australia and New Zealand and major partner on 5 hospital public private partnership projects including Sunshine Coast University Hospital, Orange and Bathurst Hospitals**,** Royal Children's Hospital, Bendigo Hospital and the Royal Adelaide Hospital

Key Achievements:

- Improved profitability by 40%, through new and organic revenue growth, operational efficiencies and improved life cycle management.

KPMG **2011- 2013**
Partner Health & Human Services

Partner with KPMG's Health and Human Service practice and member of KPMG's "Global Centre of Excellence" which worked with overseas member firms providing expert advice and input into the delivery large healthcare assignments. This role provided a unique opportunity to gain a deep understanding of the Australian and international healthcare systems. I worked with and provided advice to a diverse cross section of senior healthcare managers, bureaucrats, politicians and ministers.

Key Achievements:

Leadership role overseeing complex projects including some of the following:

- Financial turnaround projects in large health services across Australia including Flinders Medical Centre in Adelaide and Metro North Health Service in Queensland
- Developed initiatives to optimise private revenue capture in public hospitals for NSW Treasury & NSW Health
- Developed a contestability framework for public elective surgery for the Victorian Health Department

- Assisted with financial and operational due diligence on a number of healthcare acquisitions
- Developed options for the relocation and potential privatisation of a large public health facility in Queensland
- Led a number of major process redesign projects to improve patient access and into Emergency Departments in Victorian and Queensland public hospitals
- Undertook a structural and strategic review of a large not-for-profit private hospital organisation
- Developed a service plan for the management of diabetes for the Western Australian Health Department

Healthscope **2007 – 2011**
Chief Operating Officer Hospitals

Integration, operation and financial management of 44 hospitals in every state and territory of Australia. Responsible for a $AUD1.3billion budget, operation of 4500 beds and oversight of 13,000 staff. Hospital portfolio included the following:

- Acute, psychiatric and rehabilitation facilities
- Nine public/private collocated hospitals
- A management agreement to operate 3 large not for profit hospitals for the Adelaide Community Hospital Alliance (ACHA) following a breach of banking covenant
- Operation of Modbury public hospital and a number of major public health contracts in the Northern Territory, NSW, Tasmania and Adelaide

Key Achievements:

- Development of integrated networks of acute, psychiatric and rehabilitation hospitals across Australia
- Oversight of a $450m hospital redevelopment program and commissioning of 2 Greenfield hospitals on time and under budget.
- Sustained revenue and margin improvement in a highly regulated labour intensive industry
- Achieved a $30m improvement in working capital through reduced debtor days and improved cash collection
- Development of strong and mature relationships with private health insurers
- Delivery of $8m in supply savings through improved procurement processes, tender outcomes and contract management
- Development of national clinical governance and performance monitoring framework for 44 hospitals
- Established extensive undergraduate and post graduate medical, nursing and allied health training programs across Australia
- Reduced nurse agency utilisation, realizing savings of $10m through improved recruitment, retention and training strategies
- Delivered synergies within the hospital portfolio following the acquisition of pathology, radiology and medical centre businesses

Healthscope **2004 – 2007**
Victorian State Manager

Operational responsibility for 15 hospitals (1300 beds) and a network of 16 community houses catering for clients with acquired brain injury with a budget of $390m and 4,000 staff

Key Achievements

- Successfully integrated 8 ex-Affinity hospitals, achieving significant margin improvement across all sites.
- Established integrated networks of acute, rehabilitation and psychiatric hospitals in the northwest and southeast of Victoria

Healthscope **2002 – 2004**
National Manager Psychiatry

Developed and implemented a strategy to expand the mental health portfolio including the establishment of psychiatric units in acute facilities with underutilised bed capacity. Portfolio grew from 3 stand-alone psychiatric facilities to 7 stand-alone facilities and 4 mental health units in acute hospitals over a 3-year period. (395 beds and a revenue budget of $80m.)

Key Achievements:

- Converted four under-utilised acute facilities into stand-alone mental health facilities with an average EBITDA margin of 30%
- Established four mental health units in acute hospitals with underutilised bed capacity
- Rapidly expanded day programs and established a community outreach service enabling mental health clients to be cared for in the home.
- Made key strategic appointments including the appointment of three Professor Directors of Psychiatry in collaboration with Melbourne University

Healthscope **2001 – 2002**
General Manager the Melbourne & Geelong Clinics

Operational and strategic responsibility of the largest private mental health facility in Australia and a 36 bed mental health facility in Geelong.

Key Achievements

- Improved financial performance through organic revenue growth, cost saving initiatives and operational efficiency
- Oversight of a major expansion of The Melbourne Clinic with no business interruption
- Established a partnership with the Royal Melbourne Hospital to treat low risk public mental health clients at The Melbourne Clinic

North Western Healthcare Network **1999 - 2001**

Director of Nursing & Principal Network Nurse

Director of Nursing of the Royal Melbourne Hospital and Principal Network Nurse of the North-western Healthcare Network, the largest healthcare network in Victoria. Responsible for the recruitment, retention and training of over 4500 nurses across 6 sites and operational responsibility for support services, outpatients and a large hospital in the home programs.

Key Achievements

- Development of workforce initiatives that significantly improved nurse recruitment, retention and productivity of nurse across multiple sites.
- First employer in the state to introduce flexible rostering practises including a mix of 4, 8 and 12 hour shifts as well as "unit based staffing" models in the Intensive Care Unit
- Reviewed rostering practises at the Royal Melbourne Hospital realizing $1m in recurrent labour savings.

BOARD APPOINTMENTS/SENIOR COMMITTEES

Ministerial Boards/Advisory Committees

- Forensicare Board (Victorian Institute for Mental Health) 2019-current
- Better Care Victoria Board member 2016 - current
- DHHS Strategic IT Advisory Committee 2016 - 2017
- Violence in Healthcare Taskforce member, 2016- 2017
- Bullying and Harassment Advisory committee member, 2016 – 2017
- Ambulance Victoria Advisory Committee, 2016 - 2017
- Chair, State Trauma Committee, 2015- 2017

Other Boards/Senior Committees

- Chair Monash Partners Comprehensive Cancer Consortium, 2016 – 2018
- Master Plan Delivery Board – Frankston Train Precinct Redevelopment 2015- 2017
- Executive Director, Adelaide Community Health Alliance Board (ACHA), 2007 - 2011
- Board Member, Cardiac Joint Venture, The Mount Hospital, WA, 2009 – 2011
- Member, Strategic Planning Group for Private Psychiatric Services, 2004 -2007

INVITED SPEAKER PRESENTATIONS (Last 2 years)

- Keynote speaker Monash University Graduation Ceremony, Faculty of Medicine, Nursing and Health Sciences, Monash University, May 2019
- Australian Healthcare Innovation Conference, "Digital Transformation in the Private Sector", Sydney, May 2019
- Digital Health Transformation Summit, "Digital Health in the Private Hospital Sector", Melbourne, March 2019
- National Infrastructure Summit, "Redevelopments - a Private Hospital Perspective", Sydney November 2018

- Victorian Healthcare Week, “Design and Delivery of Healthcare Facilities – A Private Hospital Perspective”, Melbourne, August, 2018
- Models of Care, Today, Tomorrow, Pitcher Partners, “Towards Better Health Models”, Melbourne, July 2018