Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF FELICITY TOPP

I, Felicity Topp, Chief Executive Officer, of Peninsula Health, 2 Hastings Road, Frankston in the State of Victoria, say as follows:

1 I am authorised by Peninsula Health to make this statement on its behalf.

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

Please detail your background and experience, including your qualifications.

3 I have the following qualifications:

(a) Diploma of Applied Science (Nursing);

(b) Critical Care Nursing Certificate;

(c) Bachelor of Nursing;

(d) Graduate Diploma in Health Counselling;

(e) Master of Public Health; and

(f) Vincent Fairfax Fellowship in Ethical Leadership.

4 I started my career as a nurse and an intensive care nurse for over 10 years. I have 34 years of experience in the public health system to date. I have been in management or leadership roles for approximately 50% of that time (since 2001) at various public health services – Melbourne Health, Barwon Health, Peter MacCallum Cancer Centre and Peninsula Health.

5 My experience with the mental health system has been with two public health services:

(a) I was seconded to Barwon Health in May to August 2017 to support Barwon Health through a difficult period of change, during which one of my key areas of focus was to lead the Mental Health Program to deliver key recommendations made through external reviews; and

(b) I have been the Chief Executive Officer (**CEO**) of Peninsula Health since February 2018.

6 Attached to this statement and marked **FT-1** is a copy of my curriculum vitae which provides further details on my background and experience.

Please describe your current role and your responsibilities, specifically your role as CEO[1] at Peninsula Health.

7 The attachment marked **FT-1** briefly sets out my current role and responsibilities as CEO at Peninsula Health.

GOVERNANCE OF PENINSULA HEALTH

Please outline the status, governance and services of Peninsula Health.

8 Peninsula Health is a 'public health service' incorporated under section 65P of the *Health Services Act 1988* (Vic) (**HSA**) and is a body corporate.

9 The strategy and operations of Peninsula Health are overseen by a Board of Directors (**Board**) of between 6 and 9 directors appointed by the Governor in Council on the recommendation of the Minister for Health,[2] noting that the Board currently has nine non-executive Board members.

10 Peninsula Health delivers public health care services within its local geographical areas of Frankston, Mornington Peninsula and parts of the City of Kingston. This catchment area extends from the Bayside areas bordered by Carrum in the north, Langwarrin and Hastings to the east and Portsea in Flinders to the South. Peninsula Health covers an area of approximately 850 km² with a population of 300,000 people, which can increase by around 100,000 people in peaks tourist season.

11 Whilst Peninsula Health delivers an extensive healthcare service, not all physical and mental health services are provided. To this end, consumers within the Peninsula Health catchment area required to seek treatment for specialist services, such as neuro surgery, cardiac surgery and other specialist statewide services, must travel to a tertiary facility for treatment.

12 Peninsula Area Mental Health Service (**AMHS**) is a clinical division of Peninsula Health, and services a slightly different geographic region to Peninsula Health.

13 Insofar as mental health services are concerned, Peninsula Health provides the following mental health services:

(a) <u>Acute in-patient</u>: 50 acute in-patient beds, comprising 29 adult beds, 6 adult Psychiatric Assessment and Planning Unit (**PAPU**) beds and 15 aged beds;

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[1] The functions of the CEO are set out in section 65XB of the *Health Services Act 1988* (Vic).
[2] HSA, sections 65S and 65T.

(b) Community:

(i) Mental Health Telephone Triage;

(ii) Access and Assessment Team (AAT) provides acute and non-acute mental health assessment as well as brief intervention;

(iii) Consultation Liaison Mental Health in the Emergency Departments (**ED**);

(iv) Consultation Liaison – General Hospital;

(v) Police, Ambulance and Clinician Early Response (PACER);

(vi) Adult Community Mental Health Program includes Frankston and Mornington Teams. Both teams have a case management function and an intensive treatment function;

(vii) Youth Mental Health team for consumers aged 16-25 years; and

(viii) Aged Community Mental Health Team, which has a case management function and an intensive treatment function, and incorporates a Residential Support program;

(c) Specialist services/clinics

(i) Families where a parent has a mental illness (FaPMI);

(ii) Forensic clinical specialist;

(iii) Wellness clinic; and

(iv) Clozapine clinic;

(d) Residential Services

(i) Community Care Units;

(ii) Adult Prevention and Recovery Care (**APARC**);

(iii) Youth Prevention and Recovery Care (YPARC); and

(iv) Carinya Residential Aged Care- Psychogeriatric.

14 Peninsula Health does not provide services to children under the age of 16 years. This is challenging as consumers within the Peninsula Health catchment area often attend one of Peninsula Health EDs (Frankston or Rosebud) seeking acute mental health treatment for themselves or loved ones aged up to 16 years. We have to refer these consumers to other health services. Youth services are also limited within our catchment area.

15 Peninsula Health also does not provide the following statewide services, meaning that consumers within its catchment area must travel (sometimes significant distances) to access those services:

(a) psychiatric intensive care;

(b) eating disorders;

(c) forensic services;

(d) mother-baby services; and

(e) secure extended care inpatient services (**SECU**).

16 Until March 2019, mental health services at Peninsula Health were overseen by a Chief Operating Officer. With the impending retirement of the Chief Operating Officer, an executive reorganisation was undertaken. Relevantly, towards the end of 2018 and in the beginning of 2019, I had become aware of some clinical, quality and leadership issues within our mental health service. As such, the executive reorganisation provided an opportunity to embed in our mental health service an experienced executive who is also an experienced mental health practitioner, to ensure that our mental health service is provided with comprehensive executive support. It is anticipated that the responsibility for executive operational oversight of the mental health services will transition to be undertaken by the Executive Director of Acute Operations in due course.

STATEMENT OF PRIORITIES

Please explain the relevance of Peninsula Health's annual Statement of Priorities (SoP) to the services, objectives and priorities of Peninsula Health under sections 65ZFA and 65ZFB of the HSA.

17 Peninsula Health's Board has developed a 5-year strategic plan which sets out our strategic goals. Peninsula Health's annual business plan is prepared based on our strategic plan. Our annual business plan includes our annual objectives to meet our strategic goals. In developing our annual business plan, we also consider the Department of Health and Human Services' (**DHHS**) SoP guidelines for the relevant years.

18 In addition to the annual business plan, we are also required to prepare an annual SoP. Our annual SoP is unlikely to deviate from the annual business plan objectives unless DHHS funded a strategy that fell outside the scope of Peninsula Health's strategic plan.

19 It is important to note that Peninsula Health's strategic plan must, in practice, be approved by the DHHS' Mental Health Branch and Performance Branch, the Victorian Health and Human Services Building Authority (**VHHSBA**) and the Minister for Health. I am not entirely sure, but I do not believe that the Minister for Mental Health reviews and approves the strategic plan.

Under section 65ZFA, the SoP is prepared by the Board in consultation with the Secretary and then approved by the Minister for Health. Briefly, how does this process work in practice?

20 Peninsula Health receives annual guidelines for the completion of the SoP from DHHS. Peninsula Health reviews the DHHS guidelines in the context of its strategic plan, goals and objectives and its annual business plan, and then develops its annual SoP to best align with its internal strategy and the DHHS guidelines and objectives.

21 It is very clear in the DHHS guidelines the types of priorities that DHHS expects Peninsula Health to support. For example, in this year's guidelines, DHHS makes specific reference to access to mental health services and, as such, Peninsula Health's SoP will be developed with that guideline in mind, but also in the context of Peninsula Health's particular strategic goals. In practical terms, Peninsula Health's SoP would not (as a general rule) extend beyond what our organisation is already planning (as part of its annual objectives to meet its strategic plan goals) and the SoP does not drive our strategic operations.

22 Part A of the SoP is the strategic overview and priorities. Action items are aligned with deliverables to acknowledge the work being undertaken by hospitals and health services and their strategic alignment with broader governmental priorities. Part B (Performance Priorities) of the SoP are performance measures and related targets that DHHS has identified as a priority for the financial year. Hospital and health services specific targets, such as elective surgery waiting lists, are agreed through the budget process and are reported in the SoP. Part B has limited specific mental health performance reporting, while Part C (Activity and funding) is populated by DHHS following budget finalisation and Part D (Commonwealth funding contribution) is populated by DHHS following finalisation of funding/budget.

Can Peninsula Health have mental health-related 'strategic priorities' added to its SoP? Has it done so, to your knowledge?

23 Peninsula Health can have mental health-related 'strategic priorities' in Part A of its SOP and it has done so. The strategic priorities are fairly broad and we can generally have any strategic priority added to our SoP that aligns with our strategic plan and planned activities for the coming year.

24 Peninsula Health's 2018/2019 SoP contained specific mental health-related program goals, including the introduction of the "Safewards" program in the mental health inpatient and ED units. In addition, management of occupational violence (which tends to be most prevalent in mental health service areas) was included in our SoP. This is aligned to the generic goals set out in Part A of the SoP.

25 In line with these mental health-related program goals, in 2018/2019, Peninsula Health undertook a cultural review of its entire mental health service to identify and mitigate against, amongst other things, occupational violence. Peninsula Health also implemented a People & Culture Board Sub-Committee, a member of which is the Clinical Director of our mental health services.

Can the DHHS require Peninsula Health to prioritise mental health by including mental health-related goals, strategies and deliverables in Peninsula Health's SoP? Has it done so, to your knowledge?

26 DHHS can require Peninsula Health to prioritise mental health by including mental health-related goals, strategies and deliverables in Peninsula Health's SoP but, to my knowledge, DHHS has not done so until this coming year's SoP. In its SoP guidelines for 2019/20, DHHS specifically referred to improving access to mental health treatment as a priority in Part A of the SoP. The performance targets in the SoP have, however, remained unchanged from previous years.

Is this inclusion of specific goals, strategies and deliverables in the SoP an effective way of achieving improvement in mental health services? Why or why not?

27 The SoP gives Peninsula Health's Board and executive management an understanding of where the Victorian government's priorities are for the upcoming 12 months. It therefore focuses our Board's attention on those specific priorities.

28 My experience, however, is that the SoP reporting framework focuses on acute physical healthcare and does not adequately address mental healthcare. While the strategic priorities in the SoP have been focussed on physical health access and quality, more recently they have included diversity, Aboriginal Cultural Safety, Disability and occupational and family violence. All of these can be aligned to mental health services and at Peninsula Health all these strategies are aligned across the orgnisation.

29 While I suspect that Board members would consider the key performance indicators (**KPIs**) in Part B (Performance Priorities) of the SoP, these KPIs do not provide any meaningful information in respect of deliverables, quality of care and patient outcomes of our mental health services.

30 If our executive management does not provide reports to the Board in respect of its internal business plans or annual priorities, the SoP may be the only strategic report the Board receives. At Peninsula Health, we have an annual business plan, which is developed from directorate annual business plans (one of which would be mental health) that are aligned with our strategic objectives. In the annual business plan, we have clear objectives and deliverables for our mental health service. The development of these plans are separate from the development of the SoP. I consider these plans to be more

effective than the SoP in achieving improvement in mental health services, as they have more comprehensive objectives and deliverables that we regularly report to the Board. This allows the Board to be kept up to date with our mental health program and to have a better understanding of the quality of care provided by our mental health services.

PRIORITISATION BY THE BOARD

What standing agenda items and regular reporting are used by the Board to monitor the performance of Peninsula Health's area mental health service?

31 Peninsula Health's Board is provided with the following information on a regular basis at its Board meeting and subcommittees meetings:

(a) standard SoP performance indicators;

(b) critical incident reporting of clinical incidents with an incident severity rating (**ISR**) of 1, 2 and 3;

(c) occupational violence statistics are reported to the People and Culture Board Subcommittee (noting that the tracking of these statistics has been driven by DHHS through funding received across the whole service);

(d) bullying and harassment statistics are reported to a Board subcommittee;

(e) compliance reporting;

(f) audits and reviews (both internal and external); and

(g) risks identified and monitored on risk registers.

How does the Board engage in service improvement planning in relation to mental health services?

32 Peninsula Health's Board is involved in discussions and planning though Board Meetings and subcommittees. Over the past 16 months, they have been involved in developing the:

(a) strategic plan;

(b) annual SoP;

(c) annual business plan;

(d) organisation-wide and area-specific service planning;

(e) quality, safety and clinical governance plan;

(f) people and culture workforce plan;

(g) informatics strategic and annual plan; and

(h) capital works/master planning.

If the Board of a health service wants to improve the prioritisation of mental health services within the health service, what steps could it take to achieve this outcome?

33 I believe that the Board of a health service can, at any time, ask the executive management to prioritise mental health services as with any other service.

34 Relevantly, in order for the Board to ask the right questions during Board meetings and be confident that it is being provided with the right information, it needs an understanding of clinical governance of mental health services in the same way as it has an understanding of clinical governance of acute services. Currently, as mental health services have been siloed at the DHHS and health service levels (see paragraphs 89 and 90 below), there are limited opportunities for both Board directors and executive managers to gain an understanding of the nuances and complexities associated with the delivery of public mental health services.

35 The mental health program at a government level is separated out from the physical health performance area. The mental health program reports to a Minister different to the physical health program. In my experience, Board education on clinical governance, quality and safety concentrate on physical health examples. I have not been involved in, or offered in my role as an executive, nor have I seen, education specific to mental health for Board members.

What factors influence the level of attention given by the Board to mental health services? For example, does it depend upon mental health having a 'champion' amongst the directors, or is this systemised?

36 The current KPIs in respect of mental health services in the SoP focus mainly on process and do not provide the Board of a health service with the information required to properly understand the role of mental health services within a public health network, as well as the deliverables and performance outcomes. Mental health teams collect a large amount of activity and process data. This data does not necessarily give the Board or me an indication of the quality of service or whether we are meeting community demand and nor do the SoP indicators give this information.

37 Consequently, while Boards are good at asking questions about services, and interrogating information received, they also need to be educated; there needs to be a conscious effort by executive management to bring the Board's attention to mental health services (whether by way of a 'champion' or through the executive). This may be done by presenting to the Board relevant issues (provided that these issues have been escalated to executive management) and meaningful information that measures the performance and the quality of the mental health services.

OVERSIGHT BY THE EXECUTIVE LEADERSHIP TEAM

What kinds of regular performance and activity information about the Peninsula AMHS do you receive in your role as CEO? What level of performance oversight does this give you?

38 As CEO of Peninsula Health, I receive the following information in respect of Peninsula Health's mental health services:

(a) SoP KPIs related to mental health (monthly);

(b) clinical incident reports (monthly); critical incidents would be reported on the day to the Chief Executive;

(c) occupational violence reports (bi-monthly);

(d) daily verbal reports on workflow, capacity and compliance;

(e) regular internal financial reporting (monthly); and

(f) PRISM, Monitor and Inspire reports provided by DHHS (quarterly and bi-annually).

39 These reports and information do not, however, provide any performance oversight as to patient outcomes, access to services, waiting lists and community activity.

40 In comparison, the physical health services (both acute and subacute) have comprehensive dashboard monitoring of a number of performance metrics on all activity, including length of stay, operating theatre waiting lists and waiting times, outpatient waiting lists and waiting times, benchmarking against other health services, and there is an increasing level of information/reporting related to quality of care.

41 Peninsula Health is in the process of developing a similar dashboard for its mental health services that can be available to executive management and all managers within the health service, but is challenged by the lack of coherent and consistent statewide agreed measures for performance and outcomes (see paragraphs 86 to 88 below).

Does Peninsula Health track its own KPIs in mental health, above and beyond those set out in the SoP and other standard reporting required by government? What measures do you track?

42 Peninsula Health's mental health services track their own KPIs, which are above and beyond those set out in the SoP, but these are currently reported to DHHS and locally (within the mental health services) and are not reported at an organisational level. Peninsula Health has recently engaged external consultants to undertake a governance review and is in the process of establishing clear reporting lines of local KPIs to both the executive management and Board. The meaningfulness of local KPIs is, however,

diminished by the fact that benchmarking against other health services does not occur in respect of service delivery, performance outcomes and quality care indicators for mental health services, except those reported through the SoP. These indicators are very limited.

FUNDING AND PRIORITISATION – DIFFERENCES IN ADMINISTRATION

How are annual funding increases or changes determined in an ABF environment? How does this differ from a block funding environment and which arrangements best account for changing levels of demand?

43 The funding in an ABF environment is driven by activity, and price is determined by costs and includes some indexation and other changes such as salary increases related to Enterprise Bargaining Agreements (**EBAs**). In a block-funding environment, the funding has an indexation factor included and there is new money for growth. In the last 3 financial years (including this financial year), Peninsula Health has been provided with growth funding for mental health which has been approximately 8% year on year for specified initiatives with targets attached. Examples of where this growth funding has been provided are:

(a) Early Intervention Psychosocial Support response;

(b) Intensive Clinical Community Mental Health Care;

(c) APARC supplementary support;

(d) Crisis Hub; and

(e) Community service contact hours.

How does the hospital's mental health activity and performance results impact on funding quantum or activity forecasts/targets in subsequent years?

44 Our annual mental health budget is based on the funding received to meet community activity targets and inpatient services. Funding is indexed against CPI and has been for the past few years set at approximately 1.5%, with the difference from CPI being the required productivity savings. This funding is insufficient to fund the current staff profiles, overheads and capital required to deliver services.

45 In relation to grants with activity targets attached, such funding is often provided during the course, or towards the end, of a financial year and the health service has no ability to spend it or achieve the targets in that financial year, or to roll over the funding into the next financial year to achieve the targets. As it is hard to achieve the required targets, this funding is not always continued the next financial year.

46 In relation to block funding, we get a number of specific grants that are very descriptive against service deliverables.

What is the scope for a public health service CEO to advocate with DHHS for higher funding for mental health in a financial year?

47 As CEO of a public health service, advocating for the health service as a whole is challenging. Advocating for higher funding for mental health services is even more difficult, as there is lack of clarity as to how the Mental Health Branch and the Performance Branch of DHHS interact with each other and who is making the decisions on mental health funding. This makes it very difficult for CEOs (especially new CEOs) to navigate. Recently, I met with the DHHS' Commissioning Performance and Regulation team to discuss the organisation's 2019/20 budget which I thought was inclusive of mental health. When I asked to discuss specifics on the mental health budget I was advised that I would have to arrange this with the Director of Mental Health as they had no oversight of the mental health budget.

48 In the past 12 months, there has been one formal meeting with the Director of Mental Health (Mental Health Branch) to discuss our mental health service performance – as compared to four meetings with the DHHS' Commissioning Performance and Regulation team – and there has been little opportunity to discuss mental health funding at this meeting. I have also noted that there is confusion as to where quality, safety and risk issues related to our mental health services should be discussed. Do I discuss these issues at the performance meeting where Safer Care Victoria attend, or the mental health branch meeting? This remains unclear to me.

49 I have had multiple conversations with the Chief Psychiatrist and Chief Mental Health Nurse at my request who have always made themselves available to provide advice, discuss relevant issues and provide guidance as to how to navigate the bureaucracy.

50 I have found it difficult to navigate where and with whom to discuss the need for capital funding. For example, at Peninsula Health we do not have enough space or adequate facilities to run our community mental health programs that we have been funded to deliver. As a result, we have sought to advocate for funding from multiple branches within DHHS.

51 For completeness, we do get increases to programmatic funding but this is usually sporadic and is constrained as to how it can be used. As mentioned in paragraph 44, this funding is often received during the course, or towards the end, of a financial year, such that delivering the required services from the additional funding is incredibly difficult. Our per diem bed-based rate for acute mental health services is usually indexed by way of the Consumer Price Index minus a productivity target.

The Commission understands that public health services are not funded for 100% of the cost of the services they are expected to deliver (with the expectation that the shortfall will be made up from own-source revenue, including private patient fees), and that the shortfall is larger for some services than others. For example, the Auditor-General found[3] that DHHS meets around 62% of the cost of delivering an acute mental health bed compared to 82% of the cost of delivering an acute general bed.

What are the consequences of such a large discrepancy between costs of service delivery and the funding provided for a health service?

52 The key consequences of a large discrepancy between costs of service delivery and the funding provided to a health service is that we are unable to:

(a) meet the community demand for mental health services;

(b) achieve our performance targets; and

(c) have adequate facilities and amenities to provide services.

What determines how the available mental health funding is allocated by the health service?

53 The DHHS policy and funding guidelines set out the requirements in relation to funding. Peninsula Health directs all mental health funding allocated to it to its mental health program.

The Commission has heard evidence that health services sometimes cross subsidise shortfalls in one area of their health service from other services.

(a) Can you explain whether cross-subsidisation occurs in relation to Peninsula Health's mental health services and, if so, the nature and extent of this cross-subsidisation (for example, from mental health services to general health services, or vice versa)?

54 Peninsula Health's annual budgets are set based on the mental health funding available to it, noting that there is a corporate/facility charge and annual productivity targets, which are prescribed by DHHS. DHHS provides us with a model for the budget through specified grants and it is aligned to the sort of services prescribed by DHHS.

55 **Cross-subsidisation within Peninsula Health**

56 Peninsula Health does not divert mental health funds to other physical health services and vice versa. In our most recent budget development for 2019/20, mental health

[3] Access to Mental Health Services (2018) page 41.

funding has been ring-fenced for mental health services. We do not consciously try to divert money from one part of the health service to another.

57 There is cross-subsidisation between our different mental health programs. For example, the money received for acute mental health services is not sufficient to fund the staffing profile required and the inability to recruit staff to deliver the sum of our community programs with consequential savings would be used to offset this deficit. There will be some services that exceed budget and others that may not. If overall there is a surplus, these funds may be recalled by DHHS or they will hit the bottom line of the organisation. Favourable variances usually occur because of the inability to recruit to new programs because:

(a) the current community mental health facilities cannot accommodate the staff required for the program and it is challenging to attract and retain staff to work in physical amenities which are less than desirable; and

(b) there is great difficulty in recruiting experienced staff to deliver mental health services and, in particular, to its community mental health services.

58 If we had the physical capacity in our community programs and we were able to recruit to the levels required to deliver services, we would be significantly over budget.

59 In particular, over the past couple of years, the mental health grants received by Peninsula Health have outweighed our ability to employ and accommodate staff within our existing facilities. As a result, not all of these grants have been spent to deliver the services for which the grants were provided. For example, Peninsula Health was provided funding to start the Hospital Outreach Post-suicidal Engagement (**HOPE**) program but we have been slow to implement the program as there was a lack of guidance from DHHS as to the model of care for the program and recruiting staff was difficult.

60 If we did not meet community service contact hours, for example, then the mental health branch may recall funding aligned to this activity.

61 Accordingly, if the mental health budget was in surplus (generally because we were unable to deliver services for which the grants were provided due to the lack of staffing and facilities), then in a purest sense, this surplus cross-subsidises whole of organisation deficits.

Cross-subsidisation within Peninsula Health's mental health services

62 As funding received for services such as the acute bed-based services is insufficient, I believe that cross-subsidisation within mental health services is common across all health services. To illustrate, the 2019/20 budget for acute mental health services is $15.5

million and the costs associated with this budget are approximately $15.6 million – this amount is largely made up of staffing costs only and does not include additional corporate costs and things like security and additional staff costs to manage complex patients. Cross-subsidisation is also not unusual in an activity-based funding model, given that some services would be more profitable than others.

63 As such, mental health funding must be shared across the whole of mental health services to assist in trying to deliver a balanced budget. Some services will be cross-subsidised within mental health services, and in our service this is most obvious with our acute bed-based services.

Recall of grants

64 Most specified grants are now subject to recall by DHHS, which is designed to help eliminate cross-subsidisation. As such, our 2019/20 budget has budgeted for all specific grants to be spent and services delivered, with a contribution of 20% for grants over $150,000 for corporate cost recovery.

65 Some of the specified grants that have been received in the last 2 years (and are subject to recall in 2019/20) are in relation to the following:

(a) Early Intervention Psychosocial Support Response Service;

(b) Intensive Clinical Community Mental Health Care;

(c) APARC supplementary support;

(d) Crisis Hub; and

(e) Community service contact hours.

66 Each of these grants has specific outcomes and has been budgeted to ensure that all outcomes are achieved, failing which the grants are subject to recall (noting that this may be negotiated between the health service and DHHS). If all grants are recalled by DHHS, there will not be any cross-subsidisation in 2019/20. As I have only had experience on the cross-subsidisation issue for one financial year at Peninsula Health, I am uncertain how this issue would manifest in 2019/20, but it is very likely to put significant additional pressure on the mental health services budget.

To what extent does a health service's annual report reveal whether cross-subsidisation has occurred in a year? Are there any consequences if it has?

67 A health service's annual report does not reveal whether cross-subsidisation has occurred in a year. Even if cross-subsidisation has occurred, there are no real consequences from an accounting perspective because financial reporting to the

Victorian government is not done on a service by service basis (within the health service). There will always be services both in the physical health sector and mental health sector that perform better financially than others.

Are there particular features of the current funding and performance measurement arrangements which incentivise health services to cross-subsidise within mental health or from mental health to other services, or vice versa?

68 With the increased attention on specified grants there are no particular features of the current funding and performance measurement arrangements which would incentivise health services to cross-subsidise within mental health or from mental health to other services, or vice versa. There might be opportunities not to actively recruit into vacancies to try and carry surpluses in some programs to offset deficits in other programs. This can also occur in the physical health services, where balancing the overall budgets of a complex health service is incredibly challenging.

How has the funding that Peninsula Health receives for the delivery of physical health services grown over the past ten years compared with the growth of funding it has received for mental health services over the same period?

69 The funding Peninsula Health has received for mental health services over the last three financial years, including the current financial year, has grown by about 8% each year, as compared with other services where growth in funding has been 1.5% in most years (other than in 2017/18 when it was 3% to account for the doctors' EBA).

70 Nevertheless, funding is insufficient for Peninsula Health to effectively provide its mental health services to meet the growing demand. Capital funding has been particularly difficult to attain and while Peninsula Health has received some funding to refurbish its acute adult and aged inpatient units, there has not been any capital infrastructure grants to expand its community mental health facilities. As discussed above in paragraph 57, this is one of the reasons why Peninsula Health has been unable to recruit staff for certain roles and therefore meet our community mental health demand. Peninsula Health's community programs are running out of old, inefficient facilities that makes providing contemporary care difficult.

71 This issue has hampered Peninsula Health's delivery of community mental health services. We have had multiple conversations with DHHS' Mental Health Branch in respect of these issues, and have put up several business cases to the Mental Health Branch for capital expenditure for community mental health facilities. These business cases have been noted but have not been actioned.

72 The solution to the issues raised in paragraph 57 (in relation to community mental health services) is not as simple as extra funding. There is also a need to:

(a) promote mental health services as an employment and career choice;

(b) create a good environment for staff to work in, that is safe and contemporary;

(c) increase leadership training and support;

(d) increase clinical support (more psychiatrists); and

(e) define a model of care and service requirements with measurable outcomes that is adequately funded.

To what extent do the current funding arrangements for mental health take adequate account of patient complexity? Are there any trade-offs in health services when treating patients with complex needs?

73 The current funding arrangements do not account for patient complexity. In this regard, I note that:

(a) Peninsula Health's current facilities (both inpatient and community) are not designed to, nor capable of managing the current demand and supporting the complexity of consumers coming into our services and Peninsula Health does not receive adequate funding to improve these facilities;

(b) in respect of acute inpatient units, which provide services to consumers living with extremely complex or severe mental illnesses, there are not enough inpatient beds to meet current demand; and

(c) current inpatient units are not designed to maximise patient and staff safety and therefore:

(i) staff are often exposed to occupational violence; and

(ii) because of the limited SECU bed numbers in Victoria, Peninsula Health is required to care for people in inadequate environments putting them and staff at risk.

74 The above issues are difficult to manage with the current funding arrangements. One of the measures Peninsula Health has taken to reduce the impact of these issues is to increase staffing numbers (both clinical and security staff) to manage extremely complex consumers. Such increases in staffing numbers are not, however, matched by an increase in funding.

IMPLEMENTATION OF REFORM

It is understood from Peninsula Health's 2018 Annual Report[4] that Peninsula Health is meeting, and in most cases exceeding, all of its KPIs for mental health. Are these KPIs adequate to measure:

The ability for service to meet demand; and

75 The current KPIs reported do not adequately measure the ability for Peninsula Health to meet current demand for its mental health services. The KPIs are unrelated to patient outcomes and do not allow us to properly assess whether our mental health services are meeting our goals of providing safe, effective, personal and connected care. Peninsula Health is, however, in the process of developing internal KPIs to build confidence in this regard.

The extent to which a full range of services are delivered in the community setting?

76 The current KPIs are not adequate to measure the extent to which a full range of services are delivered in the community setting. There is a striking lack of coherent and consistent statewide KPIs for community health programs, which makes it extremely difficult to understand whether the Peninsula Health AMHS is delivering and achieving good outcomes in the community setting.

Broadly, how has Peninsula Health tried to improve access to its mental health services in the last five years? Have these initiatives been directed by government or implemented independently by Peninsula Health?

77 Peninsula Health opened its 6 bed PAPU adjacent to the ED at Frankston Hospital, which has assisted with access to our mental health services and has helped relieve long waiting times for mental health patients in our ED. The Victorian government had separately funded this project.

78 Peninsula Health has received funding as part of the Frankston Hospital $562m redevelopment, which includes the redevelopment of is acute mental health service. We anticipate that these facilities will become operational in late 2024/early 2025.

79 Peninsula Health has also received funding to develop a Crisis Hub to assist in the management and care of mental health patients attending our ED.

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80 As indicated in paragraph 70, Peninsula Health has submitted business cases to the Mental Health Branch of the DHHS for capital expenditure for community mental health facilities, but these have not been actioned.

How has Peninsula Health tried to improve the responsiveness of its mental health services to the needs of the community in the last five years? Have these initiatives been directed by government or implemented independently by Peninsula Health?

81 Peninsula Health has independently implemented a whole of health service communication strategy called 'Huddle' in the last 18 months. There is a tier 1 'Huddle' at the unit level (mental health service as a whole participates) which discusses activity, access and service issues for the day and any significant issues would be elevated to the tier 2 'Huddle' at the executive level. On a daily basis, the executive management and senior managers meet for a 15 minutes stand up meeting to discuss any issues being experienced by a particular service. I believe this has:

(a) lessened the operational silo previously experienced by our mental health services by giving them greater visibility and support – any operational constraints or issues (for example, safety issues, occupational violence, ED waiting times, access constraints and staff vacancies) can now be elevated to the executive level on a daily basis;

(b) created greater engagement between mental health services and the rest of our health service and consequently, a better understanding of mental health services, noting there is still distance and lack of integration between our community mental health service and the rest of the organisation; and

(c) allowed the executive management to better identify and manage risks associated with the mental health services.

82 Peninsula Health has also independently implemented the following initiatives to encourage recruitment and retention of staff:

(a) investment in a cultural reform program, and implementation of occupational violence programs (noting that occupation violence tends to be most prevalent in mental health services);

(b) undertaking an overseas recruitment drive in 2017 to sponsor and fund international clinicians to work at Peninsula Health; and

(c) redesigned and centralised our nursing recruitment processes in order to maximise recruitment of nurses to the mental health services.

Are there reforms or service improvements that Peninsula Health would like to make to its mental health services, but hasn't been able to?

83 Peninsula Health would like, but so far has not been able, to make the following service improvements to its mental health services:

(a) provide adequate facilities to operate our community mental health facilities through capital funding (see paragraphs 70 and 71 above);

(b) improve access and funding for alcohol and other drug treatments;

(c) provide greater access to SECU beds (currently located within another AMHS), especially since the long waiting time to transfer extremely complex patients to SECU imposes an incredible safety risk on our staff;

(d) improve the ability to provide mental health services to children, as we currently do not provide services to children and have to refer any children arriving at our ED to another health service – it would be desirable to be able to provide such services close to these children's family support;

(e) increased funding for training/education for staff and support for developing emerging leaders; and

(f) provide wellbeing support for all healthcare workers, in particular in services where there is high exposure to occupational violence.

What constraints or pressures may hamper the implementation of mental health reforms or service improvements?

84 The following constraints or pressures may hamper the implementation of reforms or service improvements across the mental health system:

(a) the lack of a consistent and coherent statewide model of care and agreement on what constitutes a quality mental health service;

(b) statutory reporting frameworks that do not provide meaningful information in respect of deliverables, quality of care and patient outcomes in our mental health services;

(c) the lack of adequate funding for services and capital infrastructure;

(d) demand outweighing capacity and limited oversight of who we are not able to treat and support because of access constraints; and

(e) an inability to attract and retain qualified and experienced mental health clinicians (doctors, nurses and allied health).

85 The key constraints or pressures (which have not already been discussed elsewhere in this statement) are as follows:

Lack of a consistent and coherent statewide model of care

86 Based on my experience in my roles at Barwon Health and Peninsula Health, I have observed that there is a lack of clarity at the Board, executive management and middle management levels as to what constitutes a best practice model of care for a mental health service. In particular, I have struggled with understanding how mental health services are connected and I find it difficult to see how the community can access and navigate these services. For example, few staff members can describe to me what the model of care is across our program, what the staff requirements are, what performance measures can be achieved with this staff model and how these models align with budget. One or two people at the senior level within a mental health service may control the governance aspects of mental health services (for example, an Operations Director or Executive Director), but there is an overall lack of understanding of what our mental health services should deliver and be achieving. I believe that this is because there is not a consistent and coherent model of care across the mental health system, which is reflected in the absence of reportable outcome measures, in particular in the community service program and the varying names and descriptors used to describe services. Historically, there may have been coherency, but today the model is crisis driven, with staff managing day to day what is coming through the ED and managing the most acute and complex clients in the community setting.

87 In my experience working with mental health teams, it has been difficult to get a consistent understanding of what the service models are and how these services benchmark with other health services. At Peninsula Health we have patients who are moving very quickly through our acute inpatient units and staff raise concerns that patients are often being discharged before this is preferable. In addition, there are some patients who are in the inpatient and community bed based units who are admitted for extended periods of time. At Peninsula Health, there is limited oversight of this at an executive level. I was made aware of this at the end of 2018 by way of a relative complaining about a patient who had been an inpatient of our mental health service for eight months. This protracted length of stay had not been escalated to the executive management team. This would have happened for a non-mental health inpatient, where we have very detailed reports on patients in our acute and sub-acute units with long lengths of stay. In that case, as a result of the complaint, there were issues in respect of the clinical care the patient had received that were addressed. It is still, however, not clear to me whether this was a reasonable length of stay for a patient with complex mental health issues. We have since changed our management of patients with lengths of stay greater than 30 days.

88 Ideally, there should be a level of agreement in respect to a consistent and coherent statewide model of care (both in the acute inpatient and community care settings) that:

(a) reflects best practice in relation to, for example, clinician/staffing profiles, treatment expectations and outcomes, and service delivery models across the continuum of care;

(b) is accessible and meets the needs of the community;

(c) provides consistent terminology, service descriptors, deliverables, performance and outcome measures that are understood by consumers, staff, executive and Board;

(d) is funded appropriately (operational and capital); and

(e) is implemented across Victoria's healthcare system.

Insufficient integration of mental health services

89 Even though our mental health acute and aged program is located within the same building as the other acute physical health services, the mental health service is not sufficiently integrated with the rest of the health service. In previous operational roles, I have never needed, or been encouraged, to engage with mental health services. For some reason, mental health services remain distant and are not well integrated within the public health system. I believe this is because people are unclear of what mental health care is, and there is a "fear" of or uncertainty about engaging with mental health services due to the complexity of the mental health system. It has taken me a lot of effort to try and understand the service for which I am ultimately responsible. I am still learning and finding my way.

90 Peninsula Health implemented initiatives last year to address this issue. For example, we implemented the 'Huddle' (see paragraph 81 above) and have brought all our aged care services, which includes our acute, subacute and mental health aged care programs, together under One Peninsula Aged Care to discuss how best to care for our aged care consumers.

PRIORITISATION OF CAPITAL EXPENDITURE

How does Peninsula Health undertake service planning to inform capital investment projects and how does mental health feature in these efforts?

91 Peninsula Health undertakes service planning in consultation with the VHHSBA and takes into account statistical and demographic information, trends, demand on services and models of care across the whole health service (including its mental health services).

How does Peninsula Health prioritise applications for capital investment projects made to the VHHSBA?

92 Peninsula Health has a number of outdated and old facilities that require capital investment, and we have been working closely with DHHS over the past 10 years in relation to these facilities. To this end, a purpose-built rehabilitation facility was established in the early 2000s, the Mount Eliza centre was closed, and a new ED and theatre complex were built at Frankston Hospital. These projects were prioritised in order to meet demand and because the facilities were unsafe.

93 Peninsula Health has been working closely with DHHS and VHHSBA in recent years in respect of the Frankston Hospital redevelopment.

To what extent has Peninsula Health been successful in obtaining funding for capital improvement projects to support its mental health services? What led to these successful applications?

94 Peninsula Health was successful in obtaining funding for the PAPU in the ED of Frankston Hospital, as there was overwhelming demand for it.

95 We have received capital funding to undertake minor improvements in our acute and aged care units.

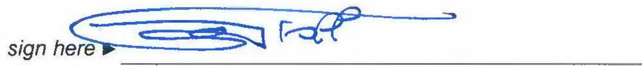
96 Peninsula Health has been unsuccessful in obtaining funding for community mental health facilities, despite being unable to deliver some services effectively as a direct result of insufficient space, infrastructure and staff.

Have mental health facilities been given an appropriate level of prioritisation in capital improvement projects within Peninsula Health compared to facilities and parts of facilities targeting physical health? Why or why not?

97 Capital investment in Peninsula Health has predominantly been in areas where capacity and infrastructure are unable to meet demand and was impacting significantly on reportable performance. For example, capital development over recent years has concentrated on redeveloping the ED, acute wards and some additional theatre capacity. As previously discussed, however, most of the KPIs for mental health do not reflect service delivery or performance outcomes and my recent experience in trying to escalate the need for capital funding to improve access for our community mental health services has been unsuccessful.

98 Capital improvement projects anywhere throughout the ageing Peninsula Health network is undoubtedly important but, in particular, the inability to deliver services in the community mental health area due to a lack of capital investment is a major issue for

Peninsula Health. In addition, it is important that we have good resources to manage consumers who arrive at our ED and require intensive mental healthcare; if we are unable to transfer such consumers to safe and secure mental health facilities, this can result in significant safety risks to both staff and consumers.

sign here ▶ 

print name Felicity Topp

date 23 July 2019

Royal Commission into Victoria's Mental Health System

ATTACHMENT FT-1

This is the attachment marked 'FT-1' referred to in the witness statement of Felicity Topp dated 23 July 2019.

Felicity Topp
Curriculum Vitae

EXECUTIVE OVERVIEW

Over 30 years working as a healthcare professional with extensive and diverse executive management experience with an in-depth understanding of the healthcare industry. I have earned a reputation as someone who will deliver "exceptional" rather than just "expected" results, a contemporary leader implementing innovative strategies leading cultural change and organisational improvement through engagement, visionary leadership and direction.

- **Strategy and operational management –** competent in developing executive level vision statements and business plans into workable solutions, whilst implementing strategies to improve the health care experience of people. Skilled in the development of business and care models that address operational challenges within financially constrained environments that will achieve strategic and operational objectives. Extensive understanding of financial systems with demonstrated achievement in delivering organisation financial and performance targets.

- **Managing stakeholder, government and public relations –** have built and developed an extensive network across the Victorian and National health care sector, government, and unions, enjoying positive working relationships with internal and external stakeholders at all levels. Skilled in managing conflict quickly and able to lead strategic negotiations to ensure positive outcomes for all parties.

- **Change management –** demonstrated ability to lead and drive change with experience across various sectors in health including acute care, subacute, residential mental health and community care, delivering strategies that have resulted in improved patient care and experience, delivering efficient services that are innovative and novel. I have earned a reputation as someone who is able to bring about positive change across all levels, ensuring stakeholders and staff are able to understand and focus on the end result whilst fostering a team approach.

- **People leadership and cultural values** – recognised as a leader who enjoys inspiring others to greater performance, building confidence through mentoring, coaching and training. Able to positively influence a diverse culture base, supporting and guiding teams to achieve a common goal, addressing areas of strength and weakness to ensure a balance of performance is maintained across each service.

CAREER SNAPSHOT

- Chief Executive, Peninsula Health, February 2018- to date
- Deputy Chief Executive /COO Peter Maccallum Cancer Centre June 2013 – January 2018
- Executive Director Medical Services- Barwon Health March 2011 – September 2013
- Director Operations/COO- The Royal Melbourne Hospital, Melbourne Health February 2009- February 2011
- Director Ambulatory And Continuing Care (ACC), Melbourne Health, 2006 To February 2009
- Deputy Director/Divisional Director Of Nursing, ACC Melbourne Health, 2004 to 2006
- Divisional Director Of Nursing Surgery and Intensive Care – Melbourne Health, 2001 to 2004
- Clinical Nurse Consultant - Intensive Care Melbourne Health, 1996 to 2001
- Nurse Unit Manager Cardiac Intensive Care – Prince Sultan Cardiac Centre Riyadh, Saudia Arabia

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QUALIFICATIONS

Vincent Fairfax Fellowship in Ethical Leadership Ormond College Melbourne 2017

Master of Public Health Monash University 2001

Graduate Diploma Health Counselling Victoria University 1998
Bachelor Nursing Deakin University 1994
Critical Care Nursing Certificate 1991
Diploma Applied Science (Nursing) Latrobe University 1985

PROFESSIONAL EXPERIENCE

PENINSULA HEALTH

Peninsula Health is one of 15 metropolitan public health services in Victoria. Peninsula Health consists of six main sites, close to 900 beds, two emergency departments, 24 dental chairs and more than 90 consulting spaces located across the Frankston and Mornington Peninsula local government areas. With over 900 beds, Peninsula Health is the major public health service for Frankston and the Mornington Peninsula. The health service consists of four major sites: Frankston Hospital, Rosebud Hospital, Golf Links Road Rehabilitation Centre, The Mornington Centre; three community mental health facilities and four community health centres in Frankston, Mornington, Rosebud and Hastings.

The services include medium-to-high complexity medical and surgical services, as well as a number of sub-specialties including emergency medicine, intensive care, obstetrics, aged care, rehabilitation, oncology, and mental health. Frankston Hospital is a major teaching hospital, training over 75 new doctors, 100 new nurses and 30 new allied health professionals each year. We have strong relationships with Monash University and Chisholm TAFE and these relationships are expected to strengthen over the next 10 years.

As the biggest employer in the region, Peninsula Health has a workforce of over 5500 staff, supported by 800 volunteers to deliver evidence based person-centred care. With proposed service developments and growth in teaching and research the workforce is expected to grow to over 6000 in the next 10 years.

CHIEF EXECUTIVE **February 2018- Current**

Deliver and implement Peninsula Health's Strategic Plan ensuring consistency with the Victorian public health sector priorities.

- Build partnerships with stakeholders to ensure current and future delivery of high quality, accessible, integrated, safe and person-centred health care services.
- Deliver on the agreed annual operational priorities
- Achieve State and Commonwealth public health service key performance indicators.
- Build a high-performance workforce where culture is based on a shared vision to achieve Peninsula Health's goals
- Achieve and exceed the requirements of all required legislation and standards through a culture of continuous improvement and innovation
- Ensure Peninsula Health is fiscally responsible and sustainable
- Strategic and Operational Leadership
- Quality and Safety Leadership
- People and Culture Leadership

PETER MACCALLUM CANCER CENTRE

Peter MacCallum Cancer Centre is Australia's only public hospital solely dedicated to cancer and one of an elite group of hospitals worldwide to have its own integrated cancer research program and laboratories. Every year, Peter Mac treats around 30,000 cancer patients, provide over 220,000 episodes of care, and care for inpatients requiring around 43,000 bed days. The research program encompasses 27 laboratories and over 520 scientists, clinician-researchers, research nurses and other health professionals involved in various aspects of cancer research.

DEPUTY CHIEF EXECUTIVE **June 2017 – January 2018**

Organisation was realigned to manage the requirements after the move from East Melbourne. I moved from the Chief Operating Officer/Deputy CEO to Deputy CEO. This has allowed the recruitment of an executive into the Chief Operating Officer role allowing me to concentrate on a portfolio that included Building and Infrastructure, Information Management and Technology, People and Change and strategic projects Metro Rail, Electronic Medical Record, and Proton Therapy Centre at the same time supporting operations as required.

Secondment Barwon Health May –August 2017

Following a review undertaken by the Chief Psychiatrist in the acute mental health program and resignation of the Barwon Health CEO I was asked by the Department of Health and Human Services to work with the Chief Executive of Western Health to support the organisation through a difficult period of change. Key areas of focus was to lead the Business Planning for the organisation and develop Statement of Priorities and lead the Mental Health Program delivering on all the key recommendations made through the external reviews. During this time I:

- Led the recruitment process for a Clinical Director and Co-Director for the mental health service
- Developed and implemented governance frameworks in the mental health service that aligned to the broader Barwon Health frameworks addressing clinical governance, workforce and operations for the service
- With the mental health team addressed all recommendations of the Chief Psychiatrists review to the satisfaction of the DHHS and Barwon Health Board
- Re-established relationships with staff, community partners and stakeholders and reinvigorated a number of community mental health programs
- Oversaw the finalisation of a review of the Child Mental Health Service and established a program of work to commence the reform of this service
- Led a capital program proposal to refurbish the acute mental health unit
- Completed the mental health services 17/18 budget

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DEPUTY CHIEF EXECUTIVE/CHIEF OPERATING OFFICER

Key Responsibilities

- Contributed to the development of the Peter Mac strategic plan leading and delivering on key components including sustaining financial performance allowing investment in key programs across the organisation
- Inspire teams to succeed and deliver on a complex program of work allowing a successful transition and relocation into the Victorian Comprehensive Cancer Centre
- Direct operational activities of Peter Mac to achieve key performance indicators consistent with Peter Mac's statement of priorities, and strategic and business objectives, in particular our financial sustainability plan
- Lead budget development for the organisation and financial performance monitoring in areas of responsibility
- Executive lead for the development and implementation of an extensive program of IM&ICT business strategies
- Support the Peter Mac Foundation in raising funds and prioritising into key research programs
- Initiate and implement actions to improve the financial effectiveness within clinical, education and research services.
- Review cost effectiveness of programs and suppliers and initiate and implement actions to improve productivity and services.

Key Achievements

- Developed and implemented a financial improvement plan that resulted in $ 7.4M surplus after the second year of implementation, $8.2 M surplus in the third year
- Established networks and fostered relationships across a number of partnering organisations to promote further Peter Mac's strategy and enhancing access to cancer care
- Increased the number of cancer patients treated by 1600 at the same time delivering a financial surplus
- Led significant components of the Peter Mac VCCC redevelopment program including chairing the Parkville Precent IM&ICT program, Peter Mac IM&ICT strategy, developing the financial modelling required for the integration of cancer services with The Royal Melbourne Hospital and The Women's Hospital, developing new models of cancer care and leading the organisational operations transition program into the new building
- Successfully transitioned Peter Mac from East Melbourne to Parkville on budget and meeting 90% of performance KPIs
- Implemented major system improvements resulting in improved quality and access to care
- Represented Peter Mac at the Australian Business Week in India January 2015, and USA in 2016

- Represented Peter Mac at the inaugural Cancer Conference in East Timor and participated in a Ministry of Health discussion on radiation therapy services in East Timor, March 2014
- Deputised for the CE for annual and long service leave and at a number of events and stakeholder engagement meetings

Personal
The move to Peter Mac has allowed me to demonstrate further my ability to lead an organisation through very difficult financial and operational issues at a time when the organisation was commencing a complex redevelopment and transition into a new hospital in Parkville with the integration of cancer services across three organisations. In three years Peter Mac has delivered on financial and operational performance targets, and is successfully leading the integration of cancer services for Victorian Comprehensive Cancer Centre. This period of time has been personally rewarding as I have felt I have contributed greatly to a number of recent successes through developing teams, contributing to a positive organisation culture and delivering on an extremely complex program of work.

BARWON HEALTH
Formed in 1998, Barwon Health is the major regional health provider for the Barwon South Western region. It is Victoria's largest regional health service with one of the busiest hospitals in the State. Barwon Health serves over 500,000 people through the efforts of over 6,000 people across 21 sites.

EXECUTIVE DIRECTOR
Medical Services **March 2011 – September 2013**

Budget $230M budget, 1300 EFT across a number of specialist programs including maternity and gynaecological services, paediatrics, cancer services, renal and dialysis services, specialist and generalist medicine, emergency services, imaging, allied health and pharmacy.

Key Responsibilities
- Lead the medical services program by developing strategic, operational and business objectives that aligns with the organisational strategic plan and statement of priorities
- Be an active member of the executive team who brings innovative ideas, challenges norms and supports team members in setting and achieving organisational goals
- Provide leadership across the service and support directors and managers in achieving operational and business goals
- Lead clinical governance and quality within the service and ensure the programs are providing quality, safe and efficient care
- Formulate strategies that ensure the program delivers a balanced budget
- Support staff in their development and assist them in meeting their professional goals

Key Achievements
- Developed an accountability framework and structure within the service which resulted in a financial turnaround from negative $4.6M (2010-11) to a small surplus
- Identified income opportunities for the organisation which resulted in the development of new programs across the service including additional medical consultant EFT, increased number of ambulatory clinics, antimicrobial stewardship program, expanded imaging services, maternity QUIT smoking service, paediatric consultant in ED, as examples
- Developed and implemented a staffing EFT profiler allowing better management of nursing EFT across the organisation which remains in use today (2017)
- Consolidated regional partnerships and developed regional services including cancer outreach, radiation oncology service outreach to Warrnambool, renal services in Portland,
- Chaired Barwon Region Integrated Cancer Service
- Led an emergency department improvement program which resulted in improved access KPI performance within the context of 6% annual growth in demand, reduced negative publicity and consumer complaints, more efficient use of resources, improved culture within the department
- Developed frameworks and strategies to ensure safe healthcare is being provided across the service.

Implemented a productive ward program based on the NHS framework, family initiated MET calls in the children's ward, clinical risk plan, department clinical /quality indicators

- Actively involved in the service reform and innovation program leading reform in key clinical areas - ED, Imaging, ward process and outpatients
- Consolidated the medical services research program through development of improved structures and reporting processes

Personal

Barwon Health allowed me to develop further my leadership style and be part of a dynamic executive team leading a large regional health service. The importance of involving the engaging the community in their health care and their involvement their health service stands out as a key learning and the tremendous value they bring to redesigning services. Additionally devolving accountability and responsibility and allowing directors and managers to deliver strategic and operational objectives has resulted in growth and innovation across the service and an enthusiasm to succeed.

MELBOURNE HEALTH

Melbourne Health is one of the major public health care providers in Victoria, Australia. Melbourne Health employs more than 7000 staff across its services and manages more than 1000 beds in the acute, sub-acute and community sectors.

Melbourne Health: The Royal Melbourne Hospital
DIRECTOR Operations — **February 2009 to February 2011**

Budget 270 million across 400 acute, 120 Subacute, and 160 Residential Aged Care beds reporting to the Executive Director the Royal Melbourne Hospital

The role of the Director of Operations was created to support the Executive Director of the Royal Melbourne Hospital. As the operations director I was responsible for the key operational management of the service and directly managing the Hospital Access Unit (Elective and Emergency), and the Outpatients Departments, with operational reporting lines of the Divisional Directors of Nursing across the Acute Divisions.

DIRECTOR Ambulatory and Continuing Care — **July 2006 to February 2009**

This portfolio lead the Aged Care, Community, Geriatric Evaluation and Rehabilitation Services for Melbourne Health and also included the acute portfolios of the Royal Melbourne Hospital Emergency Department and Specialist Clinics.

DEPUTY DIRECTOR Ambulatory and Continuing Care — **July 2004 to July 2006**
DIVISIONAL DIRECTOR NURSING Surgery and Intensive Care — **January 2001 to July 2004**
CLINICAL NURSE CONSULTANT Intensive Care — **June 1996 to July 2004**

Committees and Boards

Kyneton District Health Service – Non Executive Director June 2016 to current
Victorian Hospitals Industrial Association – Non Executive Director (Deputy Chair) November 2015 to current
Ministerial Taskforce Voluntary Assisted Dying 2018 to current

Community

Volunteer for Seeing Eye Dog Australia

Abstracts

2012: WHY DO PATIENTS WITH LESS-URGENT CONDITIONS CHOOSE TO USE THE EMERGENCY DEPARTMENT?
J. Toscano, N. Virgo-Milton, M. McCall-White T. Cotter, K.Ackland, S.Riches, F.Topp

2005: IS 24/7 NURSING CARE IN A 4 STAR HOTEL A SAFE ALTERNATIVE MODEL OF CARE?
S. Smith[1], S. Ritchie[1], S.Wlazly[1], T. Petsinis[2] F. Topp[1]
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2004: Implementation of a pressure ulcer prevention program: results of a short-term evaluation
Tabitha Rando, Anne Hayward, Kerry May, Angela Mellerick, Brigitte Cleveland, Adrian Lowe, Caroline Brand, Felicity Topp.

2003: Implementation of a state wide, structured transfusion nurse role: Integrating the role into a hospital environment and the transfusion team to assist in delivering sustainable, long-term improvements in Transfusion.

R. McKenna, K.Botting, S.Aranda, N.Gilby, M.Prince, N.Boyce, C.Hogan, E.Wood, F.Topp, D.Campbell.

2003: Pragmatic Implementation of Clinical Guidelines is a vital element in Patient Safety

Karen Botting, Chris Hogan, Michael Haeusler, Rosemary McKenna, Deliane Smith, Jeff Szer, Felicity Topp, Theresa Williamson. Blood Matters Collaborative Team, the Royal Melbourne Hospital.

2000: “Is there a role for the ICU nurse outside the ICU?" Felicity Topp, Kate Schlicht. The Royal Melbourne Hospital

2000: “Following up Intensive Care Patients: Does it make a difference?" Felicity Topp, Kate Schlicht. The Royal Melbourne Hospital

2000: "An advanced nurse practitioner role other hospitals should consider?" Felicity Topp