Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF TERRY MICHAEL WELCH

I, Terry Michael Welch, Chief Executive Officer at Maryborough District Health Service, of 75 - 87 Clarendon St, Maryborough, Victoria say as follows:

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

2 I make this statement on the basis of my 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) Bachelor of Health Sciences (Nursing) – La Trobe University (1991 – 1993);

(b) Certificate in Coronary Care – Mildura Base Hospital (1994);

(c) Graduate Diploma in Health Services Management – La Trobe University (1997 – 1999);

(d) Masters of Business Administration – Deakin University (2008 – 2010); and

(e) AICD Company Directors Course (GAICD) – Australian Institute of Company Directors (2010).

4 Prior to taking the role as Chief Executive of Maryborough District Health Service (**MDHS**), I was the Chief Executive Officer of Yarrawonga Health (2010 – 2015). In that role I had responsibility for 148 full time equivalent staff and an annual budget of $19 million. That role included all operational and strategic management of a 107 bed facility, also including a Community Health Centre. I reported directly to a Board of Management and liaised closely with the Department of Health and Human Services (the **Department**).

5 Between May 2004 and June 2010 I was the Director of Clinical Services at Yarrawonga District Health Service. Between May 2001 and May 2004 I was the Deputy Director of Nursing at Echuca Regional Health.

6 I hold the following directorships: Health Purchasing Victoria (appointed 1997), and Loddon Mallee Health Alliance (appointed 2015).

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

Please describe your current role and your responsibilities, specifically your role as Chief Executive Officer at Maryborough District Health Service.

8 I am the Chief Executive Officer of MDHS. I have held that position since 2015.

9 In this role I have responsibility for the management of 256 equivalent full time staff and a budget of $42.5 million per annum. The role encompasses all operational and strategic management of a 128 bed facility, which includes a Community Health Centre. The position reports directly to a Board of Management and liaises closely with the Department.

Maryborough District Health Service

What is Maryborough District Health Service?

10 MDHS is an integrated health service located across the local government areas of Central Goldfields and Pyrenees Shires in Central Victoria. It can be described as a traditional health service.

What services does Maryborough District Health Service provide?

11 MDHS provides a range of services including urgent care, theatre, acute inpatient, residential care, home and community based services to a population of around 15,000 people.

12 The main campus of MDHS is at Maryborough. Other services are delivered from Avoca and Dunolly campuses. The Maryborough and District Hospital is the main acute hospital which is equipped to offer medical, surgical and obstetric services. Dunolly also has four beds dedicated to acute care.

13 MDHS also provides aged care residential services in three facilities at Maryborough Nursing Home (44 beds), Dunolly Nursing Home (18 beds) and Avoca Nursing Home and Hostel (29 beds).

14 In addition to hospital services, there is a range of community health and welfare based services provided across Maryborough, Avoca and Dunolly and surrounding areas. Community Services offer individual services including Community Health Nursing,

Health Promotion, Generalist Counselling, Chronic Conditions Management, HARP (Hospital Admission Risk Program) Care Co-ordination, District Nursing & Palliative Care Services, alcohol and other drugs withdrawal and counselling, Housing, Dental Services, Planned Activity Groups and the Best Start Program.

15 There is also a range of allied health services including Physiotherapy, Occupational Therapy, Dietetics, Social Work and Counselling, Exercise Physiology and Speech Pathology. These are provided to the community, acute services and residential aged care facilities.

16 Services are accessed through:

(a) urgent triage and response where the need is acute or urgent; and otherwise,

(b) community based services.

Does Maryborough District Health Service provide mental health services? If yes, please describe these services.

17 Maryborough & District Hospital does not have an emergency department. All acute mental health presentations are managed in the 24-hour Urgent Care Centre (**UCC**) at the Maryborough campus. The UCC is staffed 24 hours a day, 7 days a week by Registered Nurses, and receives medical coverage by on call General Practitioners and Nurse Practitioners through a blended roster.

18 A nurse practitioner is a registered nurse with an advanced scope of practice. With this advanced scope of practice, nurse practitioners can work autonomously without the direct supervision of a doctor. In the UCC they can cover 99% of health needs (but not mental health).

19 The UCC is an integrated centre which services patients of all ages. The UCC is an extension of the General Practitioner (**GP**) clinic at the Maryborough campus and all patient attendances to the UCC are billed to Medicare in accordance with ordinary arrangements for a GP practice. The UCC is not separately funded.

20 There are no security personnel or dedicated secure areas for the management of mental health presentations within the facility.

21 Overnight there are only two Nursing staff rostered on in the UCC.

22 For presentations requiring assessment and management of Mental Health, we are supported by a triage service at Bendigo. Bendigo Health provides the Mental Health service to MDHS inclusive of the triage service.

23 Patients who present to the UCC requiring advanced management and support will be referred to Bendigo Health for mental health assessment. On presenting, MDHS staff triage all patients irrespective of their presenting symptoms, in line with the Australasian Triage Scale.

24 Once assessed onsite, and if in need of mental health assessment and support, MDHS staff will contact the triage phone line for the Bendigo Health Mental Health Team. The triage assessment takes place over the phone and provides a pathway for the ongoing management of the patient.

25 This pathway may result in discharge from UCC for follow-up by the Bendigo Team through their community program or transfer and admission to Bendigo Health.

26 Depending on the patient's condition, the transfer will either be by the police or, if the patient is deemed suitable, by ambulance.

27 There is no dedicated centralised transport service or specific vehicles for transfer of acutely mentally unwell patients. We have other centralised services (for example Adult Retrieval Victoria for medically unwell patients and PIPER for pregnant mothers) but there is no such service for acutely mentally unwell patients.

28 Most people who need admission are ultimately admitted, but there are significant delays. The delays can stem from a number of areas including delay from triage to assessment by the metal health team travelling to MDHS to carry out an assessment onsite, delays in the decision to accept transfer and delays in arranging a suitable mechanism of transfer. These delays are completely at odds with the performance indicators for timeframes accepted by the industry for similarly acutely unwell medical patients.

29 Often it is the delay which increases the risk to both the patients and staff. Some patients are seen in the UCC, triaged, treated, counselled and are then well enough to go home, to return to see the community team on a subsequent day. More acutely unwell patients who are waiting to be transferred will often have escalations in their behaviour and agitation. The room we have to try and manage such patients is a bland, uninspiring room. The worst case scenario for extensive delays occurs overnight and at the weekends.

30 We are fortunate to have Bendigo Health mental health staff on site at the Maryborough campus during business hours. This is an outreach program, with Bendigo Health renting the facilities at MDHS. We do not have oversight of the outreach service, but the location of the service means we can (as required) provide allied support, for example, dietetics or speech pathology.

31 Approximately 15 patients present with mental health illness each month to the UCC. Most of these patients require acute care and a number can be extremely unwell and need immediate intervention and treatment. The primary focus for staff at the UCC when mental health patients present with acute episodes is to manage the patient, just as for any other patient presenting. Overall, there are 6,000 presentations per year (500 per month) to the UCC.

32 The facilities are such that all patients are managed within the one department.

Who receives health services from Maryborough District Health Service?

33 We provide health services across the region described in paragraph 11-16 above. However, patients can come from any area and present either through the UCC (for urgent or acute care) or through the GP.

Where does Maryborough District Health Service fit within the mental health system?

34 I refer to background above.

Prevalence and experience of mental illness and mental health issues

What are the main issues relating to mental health in the Maryborough community?

35 There are a number of key issues relating to mental health in this community including:-

- There are often significant delays in facilitation of acute metal health admissions and providing support to patients. This can lead to significant patient distress, staff stress and anxiety and dysfunction in the operation of the UCC, particularly if the patient is exhibiting disruptive behaviours.

- With no funded onsite security, the only support is provided by Police from the local area. It is not uncommon for the only available local police unit to be required to provide assistance all night in the UCC.

- Patients experiencing acute symptoms of mental illness are managed within an unlocked examination room within the UCC. The inability to lock the room

provides enormous risk for patients, to themselves and all others in attendance in the UCC, during acute behavioural presentations.

- Because MDHS is not a mental health provider, there is no capacity for the Nurse Practitioners to 'schedule' or 'section' a patient. This presents significant risks to patients who need such protection.

- Often the acute presentations are from patients with a known diagnosis of a mental health condition. Over 1000 community members within the MDHS catchment have mental health plans and an estimated 25% of these are for children and adolescents.

- The lack of coordination of services at the primary level often results in patients being "lost" within the system. GPs providing primary care are the initial contact point for patients and families trying to manage a patient with mental illness.

- This initial contact may lead to a referral to a clinician as identified and chosen by the individual GP. Anecdotal evidence suggests that these referrals are made without knowledge of waiting times for the specialist and once the referral is made the GP can lose sight of that patient. There is no follow up of whether the patient actioned the referral and attended an appointment.

- The lack of a centralised intake and referral service with a case coordination focus, results in members of this community failing to access timely and effective care.

What are the factors that contribute positively and negatively to the mental health of people living in rural and regional communities?

36 The Maryborough region leads every social indicator at the 'wrong end'. For example, there is generational unemployment, poor school completion, truancy, high drug and alcohol use, high levels of family violence, a high rate of child protection incidence and an overall poor social profile. The community is institutionalised so that it does not know what 'good' looks like in the health context. There is also a high level of health illiteracy and patients are unable to navigate the public health system.

37 Social isolation remains a significant barrier and challenge for many within the community.

38 A direct lack of services locally means that access to support networks and services are prohibitive.

Is the risk of mental illness higher for any particular groups in rural communities? If so, which groups?

39 Without having completed a detailed study on this and having actual data, there is no question that mental illness for some groups will be higher.

40 From our discussions with professionals and cross sector collaborations, a key area of concern is young people, and supporting the mental health of the youth in this catchment area is a significant issue. Accessing services in a timely and effective manner with a lack of overarching service coordination and case management is a significant issue.

What impact are demographic and economic changes having, or expected to have, on the mental health of rural and regional communities?

41 There is a greater divide in the ability to access services based upon economic positioning of the individual and their health literacy.

42 It is undeniable that geography and therefore the physical distance from some services is a huge barrier for individuals and families to access timely service. This is two-fold: the distance is prohibitive as there is a severe lack of public transport and this costs money, which may also be prohibitive.

43 Health illiteracy and the inability to navigate the systems also inhibits an efficient outcome. The net effect of this is that support can be mismanaged or poorly managed by individuals and families which has significant impact on their mental health conditions.

44 Access to timely and effective mental health support within geriatric services is difficult due to distance challenges. The complexity of resident mental health needs is increasing and the system is failing to respond, particularly to those with challenging behaviours.

45 Patients who are residents in our aged care facilities often have challenging mental health presentations with dangerous behaviours. It is very difficult to manage and support them in residential care because they need one on one care. We cannot lock people in their rooms and the design of aged care residential units is moving towards choice and openness. The design is a disabler in managing these residents safely for their own wellbeing and for other residents and staff.

Access to responsive mental health services and support in rural communities

Are individuals in rural communities who are experiencing mental health illness and mental health issues likely to seek and engage with treatment and support?

(a) What are the unique factors in rural communities that may influence helping seek behaviours and access to mental health treatment and support?

(b) What role (if any) do community attitudes play?

(c) From your perspective, what could be done to overcome these barriers and challenges?

46 Many individuals in rural communities do not seek health care and are not able to navigate the public health system. This is particularly so in the context of mental health. Some of this is because of the "*we'll be right*" approach; the stoic rural way.

47 There is limited public transport in our catchment, with only a regular service internally within Maryborough. Many patients do not drive or cannot afford to.

48 With the social profile of this catchment, the prevalence of health illiteracy and challenges of navigating the health system are present every day and seen in all aspects of the health system. The lack of case management, care coordination and a centralised intake service at the primary care level only reinforces this disconnect.

49 We witness regularly, even for life saving treatments, many people will not go to treatment arranged for them because of the cost, for example, of travelling to Ballarat.

50 These people fall within the category of the "missing middle". For those who are better resourced, they will choose to go to Ballarat to avoid a lengthy delay in Maryborough – this is not an option for many of our residents.

51 Rural communities are heavily, if not solely reliant upon their GP to be their provider of mental health support and a referral point. For example if someone were to call a crisis helpline and were advised to seek assistance, the fall-back position for most would be to attend the UCC or GP clinic.

52 There are no "drop in" style centres which are available in regional metropolitan centres.

53 The GPs are faced with the challenge of referring the patient to the right specialist. For some GPs, despite having undergone all the necessary training, this can be challenging. Each provider needs a different referral and in most cases, the outcome of the referral will not be fed back to the GP.

54 The system does not support a coordinated intake, assessment and management of a referral from the GP.

55 UCCs, the face of emergency care in smaller communities, are ill-equipped to manage acute mental health patients. There are no effective mechanisms to protect staff and other patients, no funded onsite security (unlike larger centres), no onsite medical staff (they are all on-call), and there is limited enabling technology.

56 Regularly, lengthy delays from triage and assessment to transfer and admission, actually increase a patient's agitation and diminish the ability of UCCs to manage the acutely mentally unwell patient.

57 Isolation is another problem which precludes access to mental health services. Many women face this issue when their husband or partner passes away and they are left on their own, sometimes even on a farm. They may be in very poor mental health, but do not seek treatment and do not have the means (nor is there housing available for them) to move to accessible accommodation. These are the critical "missing middle" – often when we move them to our aged care residential units they recover quickly with proper nutrition and health care.

58 We have nowhere for these people when they are well enough to manage on their own. There is limited social housing in the region. Smaller communities such as Dunolly have no public housing for single or vulnerable community members. Communities like those found in our catchment, need a supported housing environment such as the ones in Ballarat and Bendigo.

59 There is a more general issue of homelessness in regional centres, although it is hard to prescribe. We look after 150 homeless people each year; many of them are living in the bush or on couches and are not visible. There are also transients who hitchhike to the next centre. There is little housing available and accessible through the rental market and rents are too expensive.

60 The stigma associated with mental health is enormous. In particular, we know through a recent Well Women's project undertaken by MDHS, that women do not access mental health services because of stigma and privacy. In regional towns, one of the challenges is that when a resident presents at the GP (which is the access point); they know the person who is at the reception desk. People are not likely to seek and engage with support in those circumstances.

61 This could be overcome by the use of an 'orange door' model – this is where you walk through the door and no-one knows the reason you are there. It involves one point of entry.

62 Stigma is also an issue for youth – we have a nurse practitioner and a doctor at the public secondary school each week. Initially this was not oversubscribed, but it is now very popular for the students because they trust it. This is a critical service because we are seeing youth with mental health related presentations at a higher level. The fact that it is funded at only one day per week, for one school is an enormous shortcoming.

What can be done to prevent mental ill health and better meet the mental health needs of people in rural communities?

63 With the GP being the primary point for mental health presentations at the primary level, a model of improved intake and service coordination will greatly enhance the system's ability to meet the mental health needs of the community.

64 There needs to be one entry point to obtain a referral for mental health services, which then provides the assessment and referral to the appropriate clinician and specialist. This will stop GPs having to write multiple referrals, provide increased support for community members who have limited health literacy and a holistic approach to mental healthcare.

65 For unfunded UCCs having to manage acute mental health presentations, a support system (such as those available for acute medical presentations and for acute Obstetric or neonatal/paediatric cases) needs to be established.

66 The goal should be the same for the management of a mentally unwell patient as it is for a medical patient.

67 Transportation arrangements also need detailed consideration. The current use of non-purpose built vehicles for transfer absolutely increases the risks our patients are exposed to.

68 The system needs to default care to the specialist centres, not default to the unfunded, under resourced rural UCCs.

69 The provision of funded specialist security teams within UCCs would provide a much improved internal response without requiring prolonged Police presence.

70 There is a lack of accessible housing for many people who live in rural communities. Housing is critical for those with chronic mental health.

What is the role of technology, such as telehealth, in responding to the mental health needs of people in rural communities?

71 Telehealth has enormous potential in regional communities and is completely unutilised. We use a video which we wheel into a room in UCC to connect with Bendigo when we need an urgent mental health triage assessment. The room could also include police (if they are with the patient) and nursing staff – this system is quite flawed. Dedicated equipment would change this. Having to wheel equipment into the room where someone is being aggressive poses obvious challenges. Our goal should be to connect with an Emergency Mental Health Provider via technology within an hour of the patient presenting at UCC.

Are there any barriers to technology being used effectively for rural service delivery?

72 The current infrastructure internally and within our community inhibits effective use of telehealth and other enabling systems.

From the perspective of a rural health service, what are the challenges in providing and facilitating care for patients experiencing mental illness or mental health issues, in relation to:

(a) navigating pathways of care

(b) referral options and waiting times

(c) affordability

(d) eligibility

(e) system capacity and resourcing

73 I refer to information provided elsewhere in this statement responding to these issues.

How does Maryborough District Health Service respond to individuals experiencing a mental health crisis or in need of specialist treatment?

74 The UCC is staffed by Registered Nurses across the 24hr period. Medical coverage is provided through a blended roster of GPs on call and Nurse Practitioners.

75 On arrival, all patients are triaged according to the Australasian Triage Scale. This includes any patient presenting with a condition related to their mental health.

76 The triage category determines the time and urgency for treatment.

77 The patient will undergo a detailed assessment (If it is safe to do so) from the Nurses and then the Medical staff will be consulted. The patient will be placed in the interview room which has been setup to the best of our ability for safety of our staff and the patient.

78 If the patient is behaving aggressively or staff feel at risk, Police will be called to provide support as there is no funded security personnel on campus.

79 If it is identified that specialist mental health support is required, MDHS will contact the mental health service provider triage line.

80 This process then re-triages the patient pending their assessment and feedback. Following assessment, it may be agreed the patient needs to be transferred or that they will wait to be assessed in the UCC.

81 This can be a prolonged process when compared to the management of a medical patient.

82 Subject to the patient's condition and behaviours, transportation may be arranged through the Police or Ambulance Victoria.

83 The area that we use to assess the patients is far from ideal as we do not have a dedicated area to manage mental health patients. We cannot have a BAR room for example as we are not a Mental Health Service provider. The room we use for mental health patients is a white room with nothing in it. We have had to repair the room 20 times because we have put patients in there and they have smashed the room. We also have no ability to lock down – this means that someone in the highest risk psychotic episode can go anywhere in the UCC. It is quite possible that a mental health patient will be treated in a room immediately adjacent to a cubicle in which a child, for example, is receiving medical treatment.

84 We cannot keep patients in high dependency (isolation) because MDHS is not a gazetted mental health centre.

85 As stated above, if a patient presenting with a mental health crisis needs to be calmed down, we call on the police. The call is made to the police immediately if there is a concern around suicide or there is aggressive behaviour. It is our role to try to calm patients down until the police can arrive.

How does Maryborough District Health Service respond to individuals who need mental health services and supports from the primary care system?

86 MDHS works closely with the GPs within the catchment to support the provision of mental health service delivery. We offer locally counselling and social support programs along with housing support programs.

87 We provide facilities for the Bendigo Mental Health Team to operate their community programs from.

88 The challenge for MDHS within the mental health service system is the inherent complexities of navigation and referral.

89 With acute medical health problems, we always have the fall-back that if in doubt or if we have concerns, we can refer to larger health services for either urgent or non-urgent assessment and for advice. After detailed assessment in the larger and better equipped facilities the person will return home. This is a fantastic failsafe system.

90 In the mental health sector, there are many barriers which limit out ability to make a referral for urgent assessments. The current fall-back position is prolonged stays in unfunded, ill equipped, nil secured facilities until the patient can be transferred.

91 We need early acute management of mental health patients with a 'no wrong entry' approach. The worst thing that can happen is someone is referred and managed for an acute episode when their episode would not necessarily meet the criteria for referral. As a clinician, I would rather apologise for a wrong rapid assessment rather than not treat a presenting patient. Separately, a delay in treatment for a mental health patient can pose a risk to clinicians (and to other patients). Some treatment is always better than deferring a mental health assessment and referral to a gazetted centre.

92 The parallel systems of response for an acute medical episode as compared to an acute mental health episode give rise to starkly different outcomes and risks to the patients and staff.

93 Sometimes our mental health patients wait exorbitant times in the UCC.

94 MDHS does not need our own mental health service workers. What we need is access to a system as efficient and effective as the system described above for medical and other patients. If we want a pregnant woman transferred out, we contact PIPER and they facilitate the transfer from there on. If we want an urgent medical case transferred, we contact ARV and it is facilitated and supported by them. These services do the work as

to where the patient is going, they provide expert support to our team, and they expedite fast and efficient transfer in an appropriate mode of transportation.

95 The disparity with the mental health system and response could not be greater.

96 Patients needing primary care in mental health are either referred to the visiting psychologist in our outpatient clinic or are provided with access to support in one of our medical clinics. Some patients are sent to see the hospital social work team. There is a long wait for primary care – sometimes it can be months. There are horrible delays, for example, where school students need primary care.

97 The most prevalent mental health concerns are depression and anxiety within our primary mental health space.

98 Our GPs report that almost 25% of the mental health plans are for children and adolescents, with 80% of these being for social dysfunction and behavioural challenges.

99 For many patients in regional areas, for those who can afford it private mental health care is the only option.

100 Patients who have been transferred to Bendigo for mental health services through the UCC can be referred back when the acute phase is settled. Some of these patients will be treated through Bendigo's mental health outreach service operating five days a week during business hours from our premises.

Service coordination

What are the impacts of fragmented services?

101 GPs within our catchment describe patients as getting lost from their line of sight due to fragmentation within the system.

102 Children and adolescents are impacted by fragmented mental health services. A doctor or nurse might see a child at school and provide them with a referral. However, no-one oversees the progress and pathway of that child. This leads to people being 'lost'. A 'wrap-around' service would avoid this.

103 A better option would be a referral to a specialist service provider and intake point for mental health services. This would require one referral, would then ensure allocation of resources effectively to improve timely assessment and access. Currently GPs refer to specialist with no awareness of waiting times. One may have a three month waitlist, another two weeks but the system is unaware of this.

104 The fragmentation and disconnect also means that support pre-crisis is difficult to access.

105 Fragmentation then leads to loss of confidence and trust in the system by the patients and healthcare providers.

Why is it important that mental health services and other health and social services are well coordinated?

106 A well-coordinated system will bring better health outcomes. These outcomes will be improved assessment and care for the patient resulting in improved trust for clinicians.

107 People should never be lost to a system. The current fragmentation at the primary care level as I have explained above could be vastly improved with centralised intake, referral and support. They would then keep the GP informed and the primary care response and outcomes would also be greatly improved.

108 Continued and coordinated care is available for medical services. For example, if you are pregnant, your record carries through the system on the VMR. There is nothing like this for mental health, that is, there is no case management or guidance to access local specialist after discharge from a mental health unit. In addition to coordination, we need some form of 'wrap around' process to support people and help them navigate the system.

What can be done to support people to access the breadth of services required to support their mental health and wellbeing?

109 As noted above, direct centralised entry points with local service provision will greatly support access and confidence for consumers needing support.

110 Services must be located locally, as drive in drive out services have never worked in communities such as Maryborough. The Bendigo Health Community Program works because it is here and local.

111 The 'orange door' model proposed to support family violence victims is the utopic model. That is, once someone enters that system, they are protected, supported and receive coordinated care and support. They are not bouncing from specialist to specialist, and their GP remains informed, where relevant.

Securing a quality workforce

What are some the workforce challenges experienced by rural communities and how does this impact on mental health outcomes?

112 Staff safety is a huge issue, particularly in the UCC. There is no security staff funded to be onsite, unlike larger centres. We have two nurses working alone in UCC overnight. It is very difficult if we have a patient who needs to be looked after by the police and staff, while also managing the other patient presentations to the UCC. The difference between the facilities we have and the response systems within rural centres as compared to what is available at larger centres, is enormous. Mental Health presentations and severe behavioural challenges have significant consequences on smaller centres. Medical staff are having to manage all aspects of primary care acute patients including mental health patients. A centralised coordinated system wold ease the burden enormously for GPs for both advice, but also reassurance for the care of their patients.

113 What can be done to understand workforce needs and better attract and retain mental health workers in rural communities?

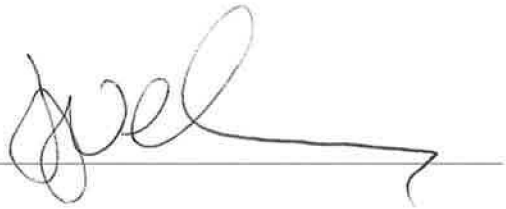
114 We need security available at the UCC to support staff working there, particularly after hours and during the night. The provision of security requires a lot of resourcing.

115 All UCCs need the ability to isolate and manage patients exhibiting extreme behaviours.

116 A system of improved response and turnaround will support staff's concerns for the welfare of patients and staff.

117 Our retention rates of staff is very good overall. We could certainly do with some increased GP numbers and support. Annexures

118 Attached to this statement and marked 'TMW-2' is a copy of a collection of flow charts showing alternative patient journeys.

sign here ▶ 

print name Terry Michael Welch

date 11 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TMW-1

This is the attachment marked 'TMW-1' referred to in the witness statement of Terry Michael Welch dated 11 July 2019.

Curriculum Vitae

Mr. Terry Welch

Career Summary

Chief Executive Officer - Maryborough District Health Service 2015 -

Chief Executive Officer - Yarrawonga Health 2010-2015

Highlights

- 2014 Rural Health Service of the Year CEO – Yarrawonga Health
- 2018 finalist medium health service of the Year CEO - MDHS
- 2018, runner up AHW CEO of the year
- $100 million masterplan funding for Maryborough Campus

Skills - Summary

Transformational leader with specific skills in Change Management – making good organisations great from values led management and strategic alignment.

Team developer – Building high performing committed teams.

Interpersonal skills – Renowned communication and collaborative skills.

Leadership – Proven leadership skills across multiple organisations and of communities.

Political Engagement – Proven ability to navigate and engagement with all levels of government.

Introduction

I am currently employed at Maryborough District Health Service as Chief Executive Officer, having commenced in Jan 2015. Maryborough District Health Service was a finalist in the 2018 Premiers Medium Health Service of the year.

Previously I was at Yarrawonga Health (YH), the 2014 Premiers Rural Health Service of the Year, as the Chief Executive Officer. I held this position for over four years.

In 2018, I was runners up (honorary mention) as CEO of the year at the prestigious Australian Healthcare Week awards.

Prior to this for the past six years I was employed as the Director of Clinical Services for YH.

During this period I have utilised my management experience, qualifications, expertise and knowledge to provide extensive service and organisational development.

I am widely recognised as transformational values based leader, delivering highly efficient and effective services, strong staff engagement, high satisfaction and business efficacy.

My ability to engage and advocate for the local community is well proven and credentialed.

Demonstrated outcomes from my leadership within this role have included:

- Achieving funding for **$100,000,000** funding for the masterplan of the Maryborough Campus, which has now commenced.
- Establishing the Centre of Inspired Learning at MDHS. Opened by Minister Hennessey in February 2018, this facility provides the platform for education and development programs for the community of Maryborough
- **Operational** and **Strategic** Management for Aged, Acute, Maternity and Community Health programs maintaining the highest level of services.
- **Financial** and resource management across the organisation with significant sustainable efficiencies achieved. Business efficiency planning/forecasting has enabled cost efficient developments to occur including Financial Services restructure, Radiology services privatisation and domestic services restructure.
- Improved **fiscal reporting** to the Board of Management to assist with improved governance,
- Maintenance and **enhancement** of Clinical Services and GP engagement through responsive management and support. At Maryborough this has include introducing the Nurse Practitioner Support model for improved GP work life balance.
- Enhanced **partnerships** with local and sub regional health centre's for improve corporate and clinical services. I am currently chair of the Loddon Mallee CEO Partnership.

- Ongoing maintenance of full accreditation status within the acute and aged care facilities, including National Standards Compliance, evidence of sound **quality** management processes

- Embedded the principles of **Studer** throughout the organisation, facilitating improved customer and staff satisfaction. In August I will be the first Australian presenting at their international conference on **cultural reform** and **workforce engagement**.

- **Positive** cultural change providing sound staff retention rates and improved staff satisfaction as evidenced through surveys such as the People Matter Survey. A demonstrated staff engagement increase of 20% during my tenure at MDHS

- Maintained a strong **public relations** program through print media and through public speaking engagements.

- Established and maintained a strong working **relationship** with Regional DHHS, MDHS Board of Management and other surrounding Health Services.

- As a graduate of the Australian Institute of Company Directors, I am a Ministerial Appointee on the **Board of Management** for Health Purchasing Victoria (HPV)

Labor candidate for Ripon Sarah De Santis (front, second from left), Victorian Premier Daniel Andrews and Minister for Health Jill Hennessy (fifth from left) met with MDHS CEO Terry Welch (fourth from left) and other health service staff this week to announce multi-million dollar funding for the hospital. 021118 16

Photo Dated 31st October 2018 Source: - Maryborough Advertiser

Pictured with Diploma of Nursing Students and key Corporate Partners at the program launch – February 2019

Presentations 2017 – 2019

- Australasian Studer Conference – What's right in Health Care May 22nd 2018 **Topic: - Aligned Goals, Values and Effort = Ultimate Engagement**

- Health Care Financial Management Association – March 9th 2017 **Topic: - Implementing major cultural change.**

- 2017 HFMA National Health Finance Congress – Challenging the status quo and delivering truly innovative healthcare - 15-17 of November 2017 **Topic: - It Takes a Team**

- 2019 – National CFO and executive forum – **Topic – Our Learnings – getting a regional service to flourish in a challenging setting.**

Current Directorships

Health Purchasing Victoria – **Director** appointed 2017

Loddon Mallee Health Alliance – **Director** Appointed 2015

Full Time Employment History

Jan 2015 - Current
Chief Executive Officer
Maryborough District Health Service

The position of CEO of Maryborough District Health Service encompasses the management of 256 EFT of staff and a budget of $42.5 million per annum.

This role encompasses all operational and strategic management in managing the 128 bed facility which also includes Community Health Centre

This position reports directly to a Board of Management and liaises closely with the Department of Health and Human Services.

June 2010 – Jan 2015
Chief Executive Officer
Yarrawonga District Health Service

Position Description
The position of CEO of Yarrawonga District Health Service encompasses the management of 148 EFT of staff and a budget of $19.0 million per annum.

This role encompasses all operational and strategic management in managing the 107 bed facility and Community Health Centre

This position reports directly to a Board of Management and liaises closely with the Department of Health.

May 2004 – June 2010
Director of Clinical Services
Yarrawonga District Health Service

May 2001 - May 2004
Echuca Regional Health
Deputy Director of Nursing

Education/Professional Development

Date:	2010
Course Name:	**AICD Company Directors Course (GAICD)**
Educational Institution:	Australian Institute of Company Directors

Date:	2008 - 2010
Course Name:	**Masters of Business Administration**
Educational Institution:	Deakin University

Date:	1997 - 1999
Course Name:	**Graduate Diploma in Health Services Management**
Educational Institution:	La Trobe University

Date:	1994
Course:	**Certificate in Coronary Care**
Educational Institution:	Mildura Base Hospital

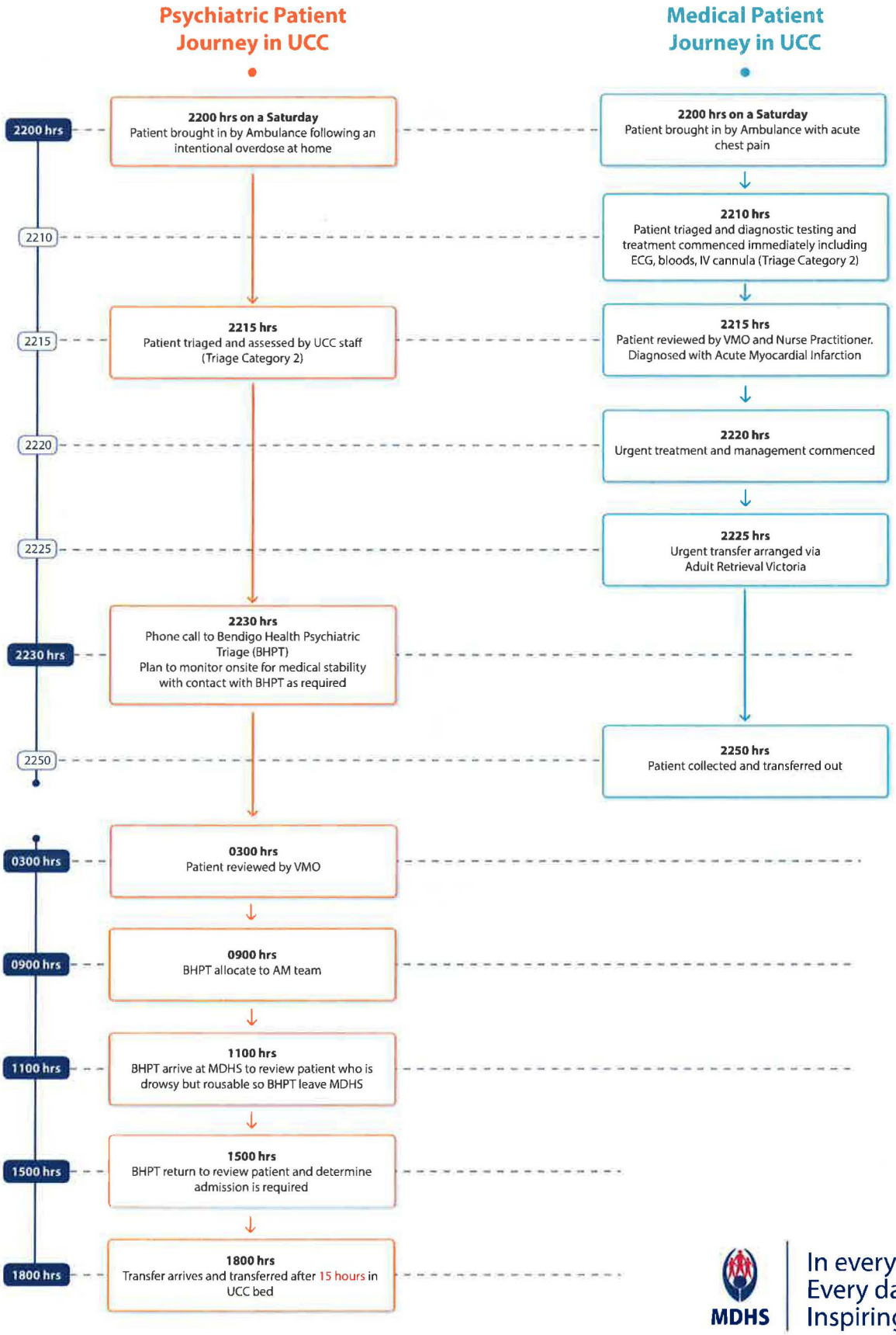
Date:	1991-1993
Educational Level:	**Bachelor of Health Sciences (Nursing**)
Educational Institution:	La Trobe University

Date:	1985-1990
Educational Level:	Secondary College
Educational Institution:	St Josephs College (Echuca)

ATTACHMENT TMW-2

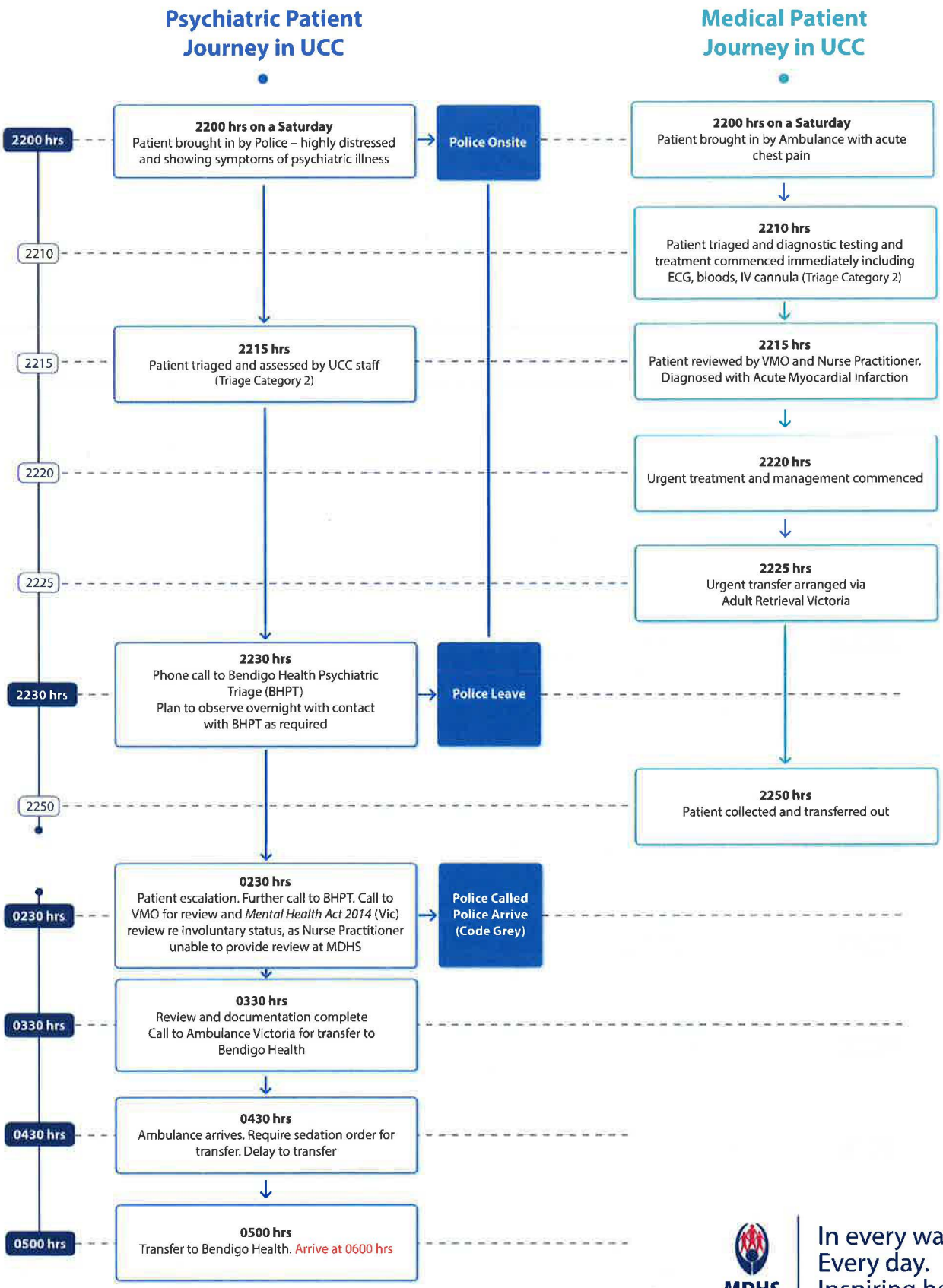
This is the attachment marked 'TMW-2' referred to in the witness statement of Terry Michael Welch dated 11 July 2019.

- Current State: Real Life Experiences -



MDHS | In every way. Every day. Inspiring health.

- Current State: Real Life Experiences -



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Every day.
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- Preferred Model -

Urgent Care Centre

Pathway for an Acute Mental Health Presentation

KPI 120/60

Triage by MDHS
(according to the ATS)

↓

Assessment by GP or Nurse Practitioner.
Treatment commenced if possible

↓

Contact made with
Emergency Mental Health Centre

↓

Adult Retrieval Victoria coordinate transfer

↓

Patient collected and transferred

KPI 120/60

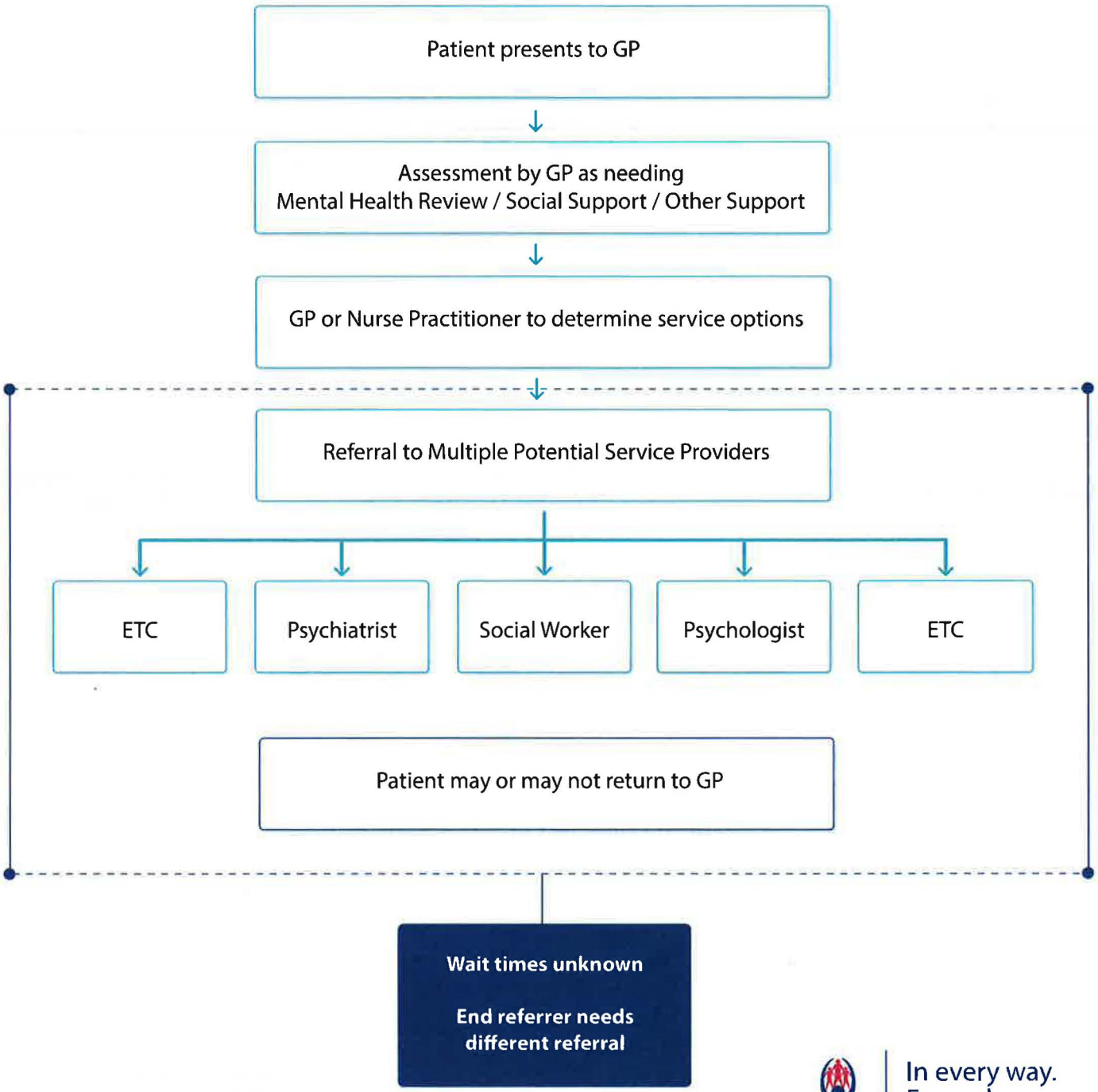
MDHS

In every way.
Every day.
Inspiring health.

- Current State -

Primary Care

Pathway for a Mental Health Presentation



MDHS | In every way. Every day. Inspiring health.

- Preferred Model -

Primary Care

Pathway for a Mental Health Presentation

Patient presents to GP

↓

Assessment by GP as needing
Mental Health Review / Social Support / Other Support

↓

Mental Health Intake Service

- One referral required from GP
- Intake assessment and triage
- Intake facilitator of referral and case management
- Communication back to GP

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