Health
Nepean Blue Mountains
Local Health District

TOGETHER
ACHIEVING
BETTER HEALTH

Nepean Blue Mountains Local Health District Financial Recovery Plan 2021-2024

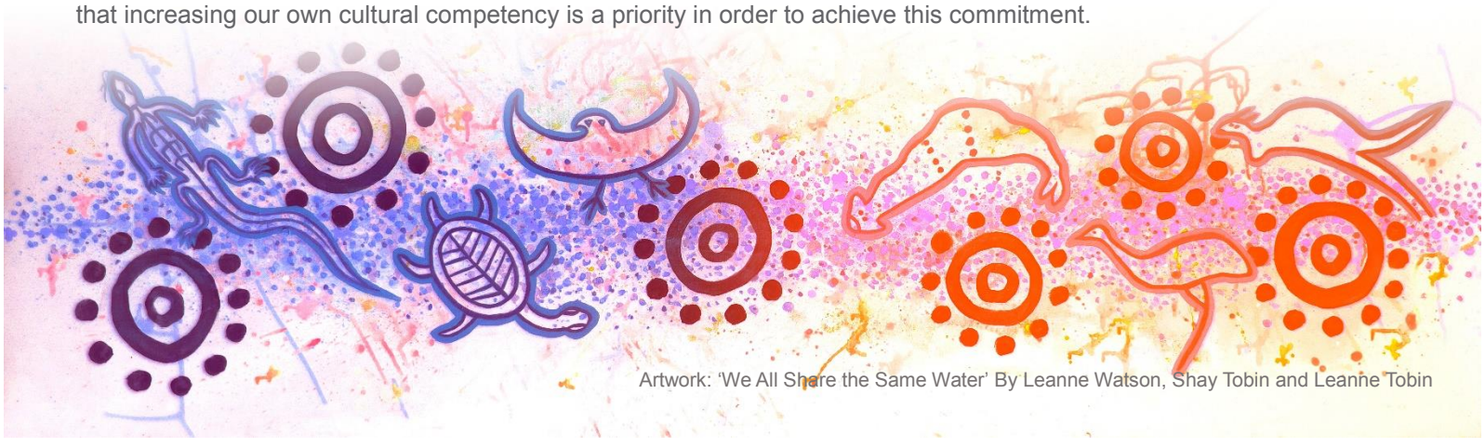
Matthew Daly

December 2021

Acknowledgement of Country

The Nepean Blue Mountains Local Health District would like to acknowledge the Darug, Gundungurra and Wiradjuri people as the traditional custodians of the land that the Local Health District services. We would also like to pay our respects to all Elders both past and present from the many nations we journey through, and communicate with, on a daily basis as employees of the Local Health District.

Nepean Blue Mountains Local Health District is committed to providing culturally appropriate, accessible services that will improve the health status of Aboriginal and Torres Strait Islander people in our communities. We recognise that increasing our own cultural competency is a priority in order to achieve this commitment.



Artwork: 'We All Share the Same Water' By Leanne Watson, Shay Tobin and Leanne Tobin

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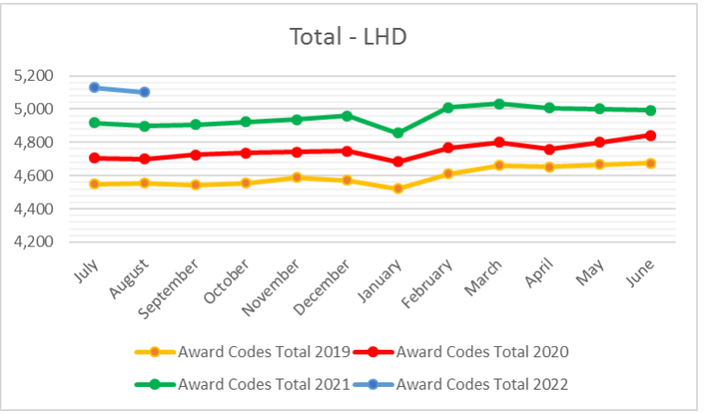
Executive Summary

The Nepean Blue Mountains Local Health District's Strategic Plan 2018-2023 sets the strategic objectives for the Service over a five year period. Under the sub-heading of "Together Achieving Better Health", it was updated in 2020 clearly setting out the District's primary Strategic Directions, supported by a set of strategic objectives outlining, at a high level, how the District will get there, and the issues to be addressed in so doing.

This District aims to deliver its Mission through driving innovation and excellence in its services in order to provide for and respond to the needs of its patients and the community. To continue to meet its Mission, the Local Health District (LHD) also requires achievement of financial sustainability. The District has significant organisational and financial performance issues that is holding it back in meeting the high standards that it, its clinicians, patients and the community expect.

The role of the Financial Recovery Plan (FRP) is to provide a framework populated by a series of transactional strategies, practical and executionable, that will have a net positive impact on the LHD's financial performance of over $20m over three years. The FRP also makes a series of operational and systemic recommendations, some of which are cash releasing not included in the above figure, but most will contribute to improved business processes and decision making. This FRP is not a static document, but needs updating regularly on performance to intended targets, and to be supplemented by the LHD's annual Efficiency Improvement Plan (EIPs), that is required to be submitted to the Ministry of Health on an annual basis. This FRP, supported by annual EIP's, will accelerate the District towards an on budget performance in FY24.

Like most things in Health, it is rarely one casual factor that impacts on an organisations financial performance, hence the breadth of the FRP. Salaries and Wages is nearly always a major factor and is so in this case. The District has experienced unfunded FTE growth over the last three years. The over 10% growth in FTE's exceeds both budget growth and enhancements as well as patient activity growth that has largely flat lined over this period. This plan encompasses expenditure reductions across many facets of a complex health service like Nepean Blue Mountains Local Health District (NBMLHD), there is a clear need to address a degree of FTE reductions, substantially non-clinical, to achieve a balanced budget in 2023/24.



To ensure the Plan establishes a framework across as many activities of the LHD as it was possible for the Review to cover, strategic and operational initiatives and reviews are planned to reduce expenditure across six (6) major headings:

1. Workforce efficiencies and realignments
2. Non-Salary expenditure efficiencies and reduction
3. Structure of Services
4. Revenue Efficiencies
5. Activity Based Management Initiatives
6. Quality Improvement and Model of Care Initiatives

COVID-19

It needs to be acknowledged that the LHD had identified a number of actions and reviews need to be taken in 2020 and it is recognised that the unprecedented pandemic and the District's response consumed many resources and was a major source of distraction in this regards. As the District is now moving from a "response" to "recovery" phase, the focus should now turn to this FRP, although noting that COVID activities are still required. In relation to COVID the Review is confident that only costs incurred by the LHD eligible for reimbursements have to date been claimed, but in part, unearthed costs that were eligible for reimbursements but were not under process for claiming. Finance has responded to those issues as they arose. Further, in this report, FTE data supported by NSW Health COVID funding has been excluded for reporting tables together with Commonwealth and externally funded positions.

1. Introduction

The Financial Recovery Plan (FRP) provides a three (3) year pathway to accelerate NBMLHD towards a balanced budget over three years. The FRP will need to be a living document, supplemented by future Efficiency Improvement Plans (EIPs), to reflect the following:

- One-off and recurrent budget savings measures (workforce and non-salary)
- Immediate actions and structural changes required to prevent further growth in the generating deficit
- Tracking of savings initiatives against cost centres or the General Ledger
- Clarity of decision making and accountability together with recommended management savings
- Issues and Risks in achieving the Plans outcomes as well as mitigation strategies
- Improved activity based management data usage
- Revenue generation opportunities
- Enhancing and allocating clear responsibility for FTE reporting and analysis

Agreed Financial Targets

Whilst the Ministry of Health (MOH) has negotiated flexibility with the LHD, over the delivery of a return to budget over the next three financial years, an exact targeted figure for the end of each year had not be finalised at the time of writing. It would probably be in all parties interest to agree on the end of year result the LHD should be targeting over these three years.

FRP Savings

Through implementing recommendations and workforce efficiency, non-salary efficiency and Activity Based Management strategies outlines in the FRP including EIP initiatives substantiated in the Review, the LHD will be accelerated towards its agreed target over three years.

FRP Year 1			
	Strategic Area	**Target FY22**	**Targeted FTE FY22**
	Workforce Efficiencies	6 009 445	58
	Non-Salary Efficiencies	1 449 000	-
	ABM	267 726	tbc
	Total	**7 726 171**	
FRP Year 2		**Target FY23**	**Targeted FTE FY23**
	Workforce Efficiencies	5 844 966	52
	Non-Salary Efficiencies	2 926 000	-
	ABM	1 207 995	tbc
	Total	**9 978 961**	

FRP Year 3		Target FY24	Targeted FTE FY24
	Workforce Efficiencies	160 000	2
	Non-Salary Efficiencies	Tba	
	ABM	808 080	tbc
	Total	**968 080**	

Whilst the FRP Year 3 figure is significantly lower in target savings than Years 1 and 2, it is anticipated that some strategies from previous years, may as a result of implementation timing, transition into Year 3. Also, a key milestone with Year 2, is for the District to review FRP strategies and implementation progress and identify new opportunities for Year 3 delivery.

In addition, is it expected that further saving opportunities will be gained through:

- Continued focus on increasing controls in the management of FTE;
- Reducing FTE commitments, safely, wherever possible including restricting recruitment
- Restructuring services
- Identifying additional saving opportunities across the organisation.

These strategies are outlined in more detail elsewhere in this Review by way of Recommendations.

2. Workforce Efficiencies and Realignments

By way of anecdotal advice and data interpretation, it is clear that a contributing factor to the LHD's unfavourable budget position, are approvals on increased FTE numbers without a clear means of funding. In health care organisations this is sometimes unavoidable particularly if patient safety is in question. All new positons have a requirement that a business case be developed and forwarded to the Chief Executive for approval. Whilst a number of new positions approved over recent years certainly fall into the above category of ensuring patient safety, the majority of positions identified did not. Business cases attempted in most instances, identified costs offsets or new positons being filled through down grading of others. A detailed review of data showed little evidence of either funding strategy coming to fruition. In some cases, strategies to fund additional permanent FTEs through reduced overtime, in fact both FTE's and the targeted overtime continued to increase. To apply management rigour, the approval of new positions and introduce internal controls the following recommendation follows.

2.1 **RECOMMENDATION:** That a register of new positions approved by the Chief Executive be established by the Director, Finance and Corporate Services, with the identified funding strategy or costs offsets, and these be monitored and reviewed on a monthly basis to ensure the funding stream is being delivered or an alternative funding strategy be developed by the requesting officer.

NBMLHD is typical of most health care organisations, where approximately 75% of budget expenditure is on staffing salaries and wages. As such an understanding of FTE numbers is important to developing a response to a budget challenge. Since FY19, FTE has grown across the LHD by 12%. Table 1 below details the main growth areas:

FTE Growth by major facilities over these years are as follows:

August 2019 – August 2021

NBMLDH	12%
Nepean Hospital	10.4%
Mental Health	9.3%
BMDAMH	17.5%
Springwood	11%

*NB: Excludes COVID and Externally Funded FTE

In looking at inputs it is also important to understand the outputs of the LHD. Table 2 and 3 below graphically demonstrates that activity on most key measures has largely flat lined over the last 4 years however noting that acuity as measured by weighted NWAS has increased by 2.3% since FY19. The impact of COVID cases may have some influence here.

Table 2 - NBMLHD Summary of Activity Parameters

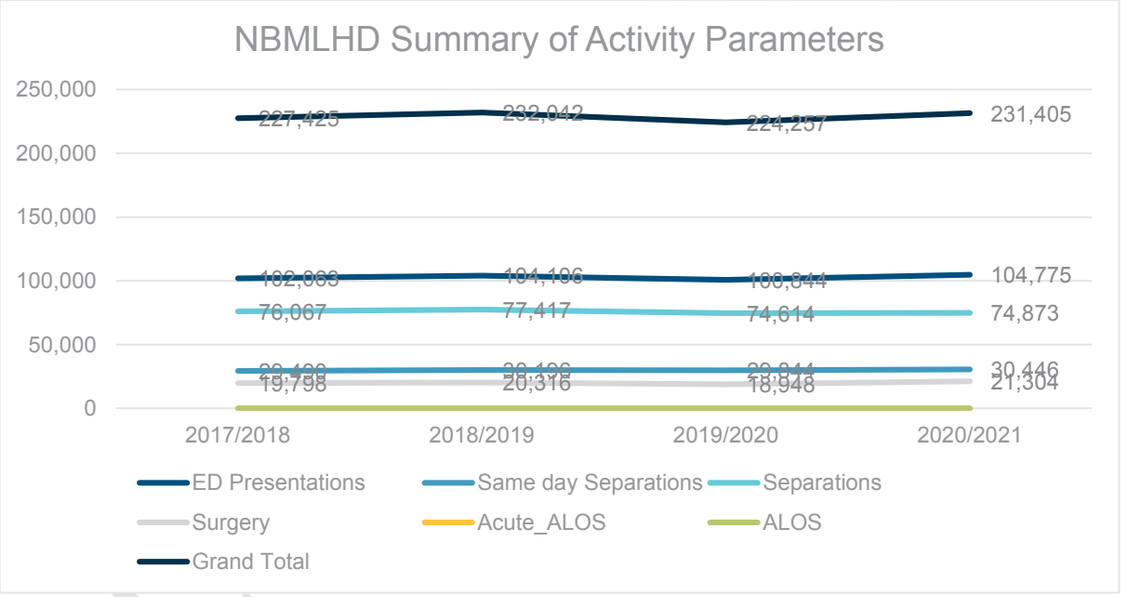
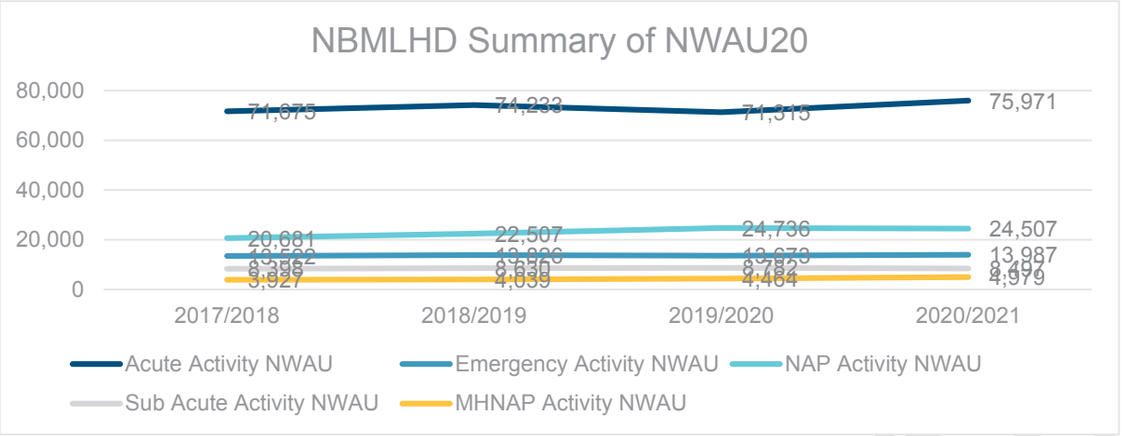


Table 3 - NBMLHD Summary of NWAU



The above FTE table demonstrates, in part, that FTE growth has been erratic across the LHD with the Financial Recovery Plan Summary detailing the actions recommended. Given the mature nature of the organisation, having been in operation for over a decade, growth in most of the Corporate Directorates, but not all, should be addressed by returning those number to FY20 levels. Similarly, a number of non-clinical areas of Nepean Hospital have been identified for FTE correction.

2.2 **RECOMMENDATION**: That the FTE number of identified LHD Corporate Directorate and Non-Clinical areas of Nepean Hospital be returned to FY20 levels commencing this financial year.

Early in the review process the growth in FTE was identified and following discussion with the Chief Executive, all delegations for filling positions were withdrawn and placed under review by a small group, chaired by the Chief Executive. From experience, this practice will challenge the routine replacement of existing FTE's by introducing greater rigour to the alternative of, other than just monitoring the status quo. It will also correct the breach of the LHD's current Delegations where Services/Directorates/Facilities may be replacing positons whilst presently over budget.

2.3 **RECOMMENDATION**: That the withdrawal of all delegations for Services over budget continue to be held by the Chief Executive and in so doing apply a stronger financial rigour to the process that will see FTE reductions in line with the Financial Recovery Plan Summary.

2.4 **RECOMMENDATION**: In order to develop insight and understanding of a cost centres performance, that the "Request to Fill a Vacancy" have mandatory fields documenting the actual financial positon for Salaries and Wages versus budget, as well as documenting the current FTE number compared to the same time in FY20, FY21 and FY22 for that requesting cost centre.

As can be noted from the Financial Recovery Plan Summary Plan, many of the transactional strategies of aligning FTE numbers to budget are in non-clinical and corporate functions both with the Facilities and District directorates. Workforce data indicates a slow movement of these positons exiting the LHD, so to achieve movement within a reasonable time line, a targeted non-clinical staff

redundancy program should be developed with the support of the Ministry of Health to meet the Financial Recovery Plan timetables

2.5 **RECOMMENDATION**: The LHD is encouraged to continue engagement with the Ministry of Health to secure financial support for a non-clinical staff redundancy program targeted at FTE growth in Facility and District Directorate corporate positions.

A common theme in the FY21 and FY22 EIPs were strategies to reduce excessive annual leave balances. Whist this is a prudent approach to better manage the LHD's balance sheet there was not a wide spread appreciation that unless this was managed very carefully, it would not only provide a marginal potential benefit to the LHD's cash unfavourability, but regrettably would most likely increase the cash unfavourability by directing staff to take leave where the organisation would be obligated to back fill the leave, sometimes with premium labour. (Refer also to Recommendation 7.2 under QI & Models of Care Initiative).

2.6 **RECOMMENDATION**: That the execution of leave reduction strategies be carefully overseen by an appropriate senior officer to ensure leave taken is balanced with service demand periods to minimise obligatory back fill and avoid any use of premium labour to enable the leave.

Following widespread interviews and interpretation of data, a small number of cost centres/services were identified as being on or favourable to budget. So as not to exacerbate the current unfavourability, these cost centres should be held to their FY21 expenditure levels.

2.7 **RECOMMENDATION**: That all cost centres/services that were on or favourable to budget at end of FY21 have their expenditure constrained to their FY21 levels to ensure that LHD's unfavourable levels do not increase.

As is not uncommon for a teaching Hospital, new positons can be established and funded via Special Purpose and Trust Funds. As fund balances can vary over time, Services can become dependent on the workforce filled from this source. Whist specifics cannot be identified, the LHD may have realised in the past that the now "essential positons" fall back on the General Fund, thereby creating an unfunded liability.

2.8 **RECOMMENDATION**: That the LHD have tight internal controls on ensuring no positions move from Special Purpose and Trust Funds to the General Fund and that any new positon funded from this source does so in perpetuity or be time limited.

There is an obvious reluctance in the LHD to disrupt the status quo through the non-filling of "discretionary" positons. A big driver of this is at Tier 3 and Tier 4 levels of the organisation uncertain on how they will manage the change required from both a staff and consumer perspective. The skills and experience that exists at both District and Site Executive levels needs to be directly injected into these units and services to facilitate re-engineering to assist with these organisational changes.

2.9 **RECOMMENDATION**: That District and Site Executive staff provide greater and direct hands on assistance to managers in re-engineering their services to balance FTE availability, existing staff capacity and patient/client demands.

Whilst performance to budget is normally the key control on an organisations expenditure, budget figures are so far away from current actual expenditure that most managers seem to pay minimal attention to it as a performance indicator. A secondary, and sometimes, equally effective control, is staffing to a fixed establishment or profile. As the largest single workforce group, Nursing, to its credit, has such a profile in place which is adhered to in quite a disciplined manner throughout the LHD. Whilst the nursing profile is not tied to sustainable budget numbers, it does demand some discipline and controls which can be amended and subsequently supported by accurate budget figures as the LHD progressively moves closer to its budgeted funds. There is a need for the LHD to create the same staffing profile tool across all employment groups and services and for it to be amended on execution of this Financial Recovery Plan and each years EIP's until such time as all staffing profiles are backed by a sustainable and realistic budget. There has clearly been an intention to roll out this profile approach for some years and its delay and subsequent absence is, in the Reviewers opinion, one of the contributors to the LHD's current budget positon, so there is some real urgency to prioritise this as a task across the whole LHD.

2.10 **RECOMMENDATION**: That the LHD urgently prioritise the rolling out of an FTE profiling process, similar to that across Nursing, to introduce greater staff controls, and gradually tie these profiles to approved, sustainable and realistic budgets as the LHD progresses each year towards a balanced budget performance.

Consistent feedback from all the Human Resource (HR) Business Partners (BP) was that the vast majority of their time was absorbed by performance management processes and managing the workload generated by regrading applications and committee processes. Given there are higher priority functions these BP's could be undertaking for the LHD (Refer Recommendation 4.4) the regrading process needs to be reviewed to reduce its onerous workloads on people and to focus those efforts that truly meets the skills sets attending to oversee these applications. Furthermore, the workloads on the BP's and the Regrading Committee would immediately be reduced by passing the delegation to approve new gradings where they are stipulated by the Funder eg Ministry of Health rather than absorb the time of a number of Officers to access to the accede to the funders request/direction. Furthermore, review of the Committee's activities were examined through its minutes that revealed that regrading requests were only infrequently denied and were rarely informed as to how the service or LHD would fund the increased Salaries and Wages burden from an approved regrading application.

2.11 **RECOMMENDATION**: That the Director, People & Culture review the necessity of all current regrading applications being considered by the Committee including where external bodies stipulate the grading or classification and where that Executive position should be given delegations to govern these processes to lessen the workload on a number of roles in largely "rubber stamping" applications.

2.12 **RECOMMENDATION:** It is further recommended that the Regrading Committee either seek advice on, or escalate applications, that have an increased financial cost on how the Service or LHD will fund these changes.

During the Review many Operational and Business Partner managers openly volunteered the lack of consideration of a Cost Centre or Services financial performance as one of the principal determinants in approving a request to replace an existing vacant position. This is in part, relates to the often wide gap between budgets and actuals, the absence of a staff profile or establishment (other than in Nursing) and the fact that salary and wages performance on a YTD basis is not

always sought nor an appraisal of FTE movements over time, for these things to be considered in the approval process. As the budget positon of the LHD did not develop over just one financial year but over a number, data of FTE growth over 3 financial years should be considered when considering to replace a staff vacancy tother with the financial YTD performance of that cost centre.

2.13 RECOMMENDATION: That all requests to fill vacancies be accompanied in a disciplined manner with data on FTE movement for FY 19, 20 and 21 and YTD together with YTD financial performance against budget for an informed approval process to take place. (Refer Recommendation 2.4).

A number of interviews amongst Operational and Business Partner Managers raised anecdotal evidence of non-recording of ADOs and short term periods of annual leave. Whilst no system is perfect, the frequency of this issue being raised with the Reviewer, a need for internal controls to be examined is thought appropriate.

2.14 RECOMMENDATION: That the Director, Internal Audit continues the regular review of internal controls over ADOs and annual leave as part of the Audit Plan and make recommendations, if deemed appropriate, to strength those controls.

Locum medical and specialist staff are a fact of the health system, one that can help services respond to urgent circumstances, but do so at a significant price. This is most felt in NBMLHD at Blue Mountains District ANZAC Hospital (BMDAMH). Whilst hourly rates for locums are appropriately higher than award rates, BMDAMH, not infrequently, finds itself in a bidding war with other parts of the NSW health system. Standards and maximum rates have been determined by NSW health to limit the cannibalisation of its own resources, but local observation is that this is not uniformly adopted across the system.

2.15 RECOMMENDATION: That appropriate NBMLHD Executives re-engage with NSW Ministry of Health to oversee a more effective system of locum engagement that prevents one hospital bidding up for services for a medical locum, above another hospital.

Nursing Hours per Patient Per Day (NHPPD) for the largest workforce in the LHD is a key financial regulator. They are good systems in place operated by skilled managers. Some improvements are recommended to make a good system better. Firstly, whilst Ministry of Health require inclusion of Nursing Specials in reports on NHPPD, they are excluded from the Award definition with which the LHD must comply. This has the effect of current reports clouding whether the LHD is staffing to those stipulated hours. Removal of those Specials highlighted the opportunity to staff more closely to the Award mandated level and is noted in the FPR Summary Plan. Secondly, the financial cost of rostering over the Award NHPPD levels should also be included in standard reports to assist all Nurse Managers in appreciating the dollar implications of not adhering, as close as possible, to the Award mandated by NHPPD.

2.16 RECOMMENDATION: Whilst reporting requirements to Ministry of Health requires inclusion of Nursing Specials in NHPPD, it is recommended that they be removed for purposes of monitoring compliance to the Award stipulated NHPPD.

2.17 **RECOMMENDATION**: That the financial cost of hours rostered/worked be identified above the mandatory NHPPD to develop appreciation of the dollar cost of not complying as closely as possible to those Award hours.

2.18 **RECOMMENDATION**: From a District wide perspective that the District DoNM be responsible to the Chief Executive to support site DoNM's and General Managers in delivering and monitoring rosters to appropriate NHPPD.

2.19 **RECOMMENDATION**: That the District DoNM prioritise the examination of more real time monitoring of costs used elsewhere in NSW Health and assess their demonstrated performance in delivering reductions in NHPPD hours and Specials, with a view to implement that tool and provide education to appropriate nursing managers in their use.

2.20 **RECOMMENDATION**: Whilst the preferred practice is not to roster Nurse Specials on 10 hour night shifts, the District DONM should satisfy herself that this practice is consistently in place across all Units and Facilities in the LHD to avoid the cost penalty of a two hour overlap.

With the adoption of the above Recommendations coupled by escalating after-hours approval for nurse specials and a re-launch and re-education on the Nurse Specials policy, that a long term target from current usage of 2.4% to 0.2%, as delivered by other facilities in NSW Health, be set. To ensure achievability a target for this Financial Recovery Plan is set at 1.2% with resultant savings identified in the Financial Recovery Plan Summary Plan.

2.21 **RECOMMENDATION**: That a long term target of 0.2% (as delivered by other and more acute facilities in NSW Health) be set for all facilities, with the short term target of 1.2% to be delivered by FY23.

Probably the most demonstrable example of committed systems of financial control and accountabilities were found in the Primacy Care and Community Health (PCCH) stream and for that they are commended. They are also one program that receives, not infrequent, additional funding opportunities from external sources, both State and Commonwealth. Whilst work has been commenced in this regards, it should be prioritised in the Service to ensure all overheads supported, both directly and indirectly, by the LHD are resourced from these external funding sources.

2.22 **RECOMMENDATION**: That planned work be finalised to ensure that all overheads are met through external funding sources are carried by those programs and not subsidised, directly or indirectly, by the LHD General Fund.

There was clear commitment from the Drug and Alcohol (D&A) Management Team to its financial obligations as there was to its service commitments. Discussion around their FY22 EIP's showed a reluctance to the non-filling of vacancies as they fell due, but a mere delaying of recruitment may not be sufficient to meet their budget.

2.23 **RECOMMENDATION**: That a review of vacancies currently with the D&A Service together with an opportunistic churn rate be made in order for the D&A Service, to deliver an on budget performance for FY22.

The Review was asked to specifically look at the growth of BMDAMH FTE numbers. Whilst there was an element of COVID staff numbers inflating the core FTE, the biggest source of increase was an inefficient staff model for East Wing that fluctuates and surges between 30 and 41 beds. This Ward needs to be reviewed and established at an appropriate bed number (say 36?) that most generally meets the surge demand of BMDAMH, and the District, to avoid the not irregular inefficient surging, often using premium labour to so do.

2.24 **RECOMMENDATION**: That the East Wing Ward be reviewed, guided by fluctuating surge demand of BMDAMH and the District to settle on a routine bed number (with capacity for planned increases in, say, winter months) in order to have a more efficient staffing profile established to avoid the use of premium labour,

2.25 **RECOMMENDATION**: That the District Executive responsible for Medical Imaging review the current requirement for patients requiring medical imaging services at Nepean Hospital from BMDAMH to be routinely escorted for these trips, including the waiting rooms for medical imaging thereby reducing nursing FTE by 0.5 per week at BMDAMH.

There has been a number of internal and external changes that have impacted upon the District Directorate of Finance and Corporate Services. This has included the maturing of the HealthShare model, evolving procurement changes at Ministry and HealthShare levels, significant new capital assets coming online and the increased need for concise, accurate and reliable information (not data) being provide to the LHD's management at all levels and decision makers. Whilst FTE's in the Directorate have not grown at all over the last 3-4 years, there is a need to ensure investments made are contemporary to the LHD's evolving needs.

2.26 **RECOMMENDATION**: Although there has been no FTE growth over the last 3-4 years, there has been significant service delivery changes, leading to a need to formally review the focus and investments in the Directorate of Finance and Corporate Services to ensure they reflect the LHD's current needs.

Whilst the biggest hurdle in effecting a change program like the Financial Recovery Plan is in execution, a major impediment in a public health system is the management of the people and their industrial bodies. To deliver these changes, structural, systemic and financial, will require a considerable Workforce Management strategy. Two areas in particular are prevalent in this report and appropriate Recommendations follow.

Firstly, the Director, People and Culture needs to have in place a system of effective, the first time, displaced employees into approved funded roles, or where appropriate to a redundancy outcome. Slow moving systems in this regard will heavily impact on the cost reduction strategies in Years 1 and 2, in particular. Secondly, the Director, People and Culture must employ a proactive and timely Industrial Engagement Strategy to ensure the LHD meets its Award obligations on consultation. A poor strategy in this regards will result in the LHD being tied up with endless industrial processes, delaying the execution of staff strategies in the Financial Recovery Plan.

2.27 **RECOMMENDATION**: That the Director, People and Culture commit to ensuring the efficiency of redeployment matching is such to deliver first time, every time direct placement of displaced staff into funded roles.

2.28 **RECOMMENDATION**: That the Director People and Culture urgently establishes a proactive and timely Industrial Engagement Strategy to ensure the LHD meets its Award obligations on consultation which will not delay executing staffing strategies.

3. Non Salary Expenditure Efficiencies and Realignments

Meeting with those responsible for Senior Medical Staff appointments and in particular VMO appointments could not advise that any particular changes were envisaged or how the LHD's Clinical Services Plan may influence the desired outcome of appointments. As quinquennial appointments will restrict the flexibility of the LHD for the medium term to make any major changes, confirmation of mix and numbers, consistent with future planning, both service and population, occur before finalisation in July 2022.

3.1 **RECOMMENDATION**: That VMO workforce numbers and mix be considered in light of this Financial Recovery Plan, Service Planning objectives and population health changes, to ensure quinquennial appointments are best suited to Services and Community needs.

3.2 **RECOMMENDATION**: Similar to SP&TF positions, new FTE's tied to Capital Grants should be held tightly to these capital funds and then be released on completion of the Capital Project to ensure the General Fund does not carry the ongoing unfunded burden.

Interviews with numerous Finance, Procurement and Operational staff raised the opportunities they saw in efficiencies in areas of non-salaries and wages. Whist financial data to cost centre/service levels was of a sound quality, enabling identification of unfavourable trends, there was a consistent belief that Finance Business Partners in particular, were too time poor to prioritise their efforts and investigate further to grasp any efficiency that may be available. (Refer Recommendation 4.4). A further theme in this area was a belief that adoption of HealthShare contracts was not as wide spread or consistently adopted across the LHD as probably should, given the better pricing that HealthShare can secure (although there are exceptions on occasions in this regards). To support improvements in this area a focussed governance group should be established, chaired by the Director, Finance and Corporate Services to consider, guide and support finance, procurement and clinical operations leaders to respond to growth in non-salary line items as well as oversee the works and returns with HealthShare.

3.3 **RECOMMENDATION**: That a non-salaries Working Party be established chaired by the Executive Director, Finance and Corporate Services, to prioritise the correction of goods and services expenditure trends internally, including Pharmacy, review the uniform uptake, of HealthShare contracts across the LHD and be engaged with and ensure traction with HealthShare Savings Program to deliver agreed targeted non-salaries expenditure reductions.

There has been a long standing relationship between Lithgow Hospital and Lithgow Community Private Hospital (LCPH) with the former providing shared surgical facilities. The role institutional facilities play to support more broadly a regional community is acknowledged. A cost sharing model is in place. Details of these costs were reviewed which included both fixed and variable costs. Recovery of these variable costs should continue however, with other private hospital entrants planning to encroach on this market, the viability of the LCPH will be put under pressure as will the viability of the current role of Lithgow Hospital

3.4 **RECOMMENDATON**: That early engagement with Ministry of Health on how Lithgow Hospital should continue to fiscally support LCPH and how these funds should be recognised, but more importantly how the role of the pubic hospital may need to change to support its community and its role in the LHD should changes if the private market unfolds as expected.

A number of interviews expressed concerns about the routine nature of the signing of Intra-Health charges for HealthShare, Pathology etc. Knowledge of the legitimacy of these charges and motivation to control will always be greater where responsibility lies as close as possible to the point of expenditure.

3.5 **RECOMMENDATION**: That the process for Intra Health charges, ie HealthShare (transport, food and linen), Pathology and others be reviewed to ensure the validation of these charges be as close as possible to the point where this expenditure is being incurred.

A review of Patient Transport data over the last 3 financial year, ie, FY19 FY20 and FY21 showed increases over this period of between 13% and 17.5% which is unsustainable. Expenditure for FY22 is also on track to far exceed FY21, however, it was found that current expenditure is heavily impacted by unclaimed COVID incremental costs that should be claimed back through Ministry of Health. There is a need to understand the incremental growth of this major expenditure item that is far above any increase in patient activity. Further, it is acknowledged that whilst, for the majority of patient transports, the District is contractually obligated to use Patient Transport Services (PTS), there are a number of patients for which alternative transport options can be explored. There is further opportunity to reduce patient transport services through maximising pre-day of discharge bookings. A very conservative target of savings of $160,000 pa has been identified in part, based on the experience of the LHD benchmarking partner, but additional savings should also be targeted for out years.

3.6 **RECOMMENDATION**: That the District understands the exponential increased in PTS charges well above increases in patient activity and introduce a range of initiatives to reduce these costs. This initiative should include maximising the use of taxi or non-patient transport services for the transport of Category E Type patients and the uniform adoption of the HealthShare initiatives to reduce patient cancellation fees. It is further recommended that this strategy should be overseen by the Working Party chaired by the Director Finance and Corporate Services as noted in Recommendation 3.3.

4. Structure of Services

A number of senior staff interviews as part of the Review, felt that single point accountability and hence responsibility was too opaque and that often committees and groups of people were deemed, or perceived to be responsible for actions or tasks. Given the importance in executing recommendations in the Financial Recovery Plan, District Executives have been named for two reasons. Firstly, to ensure they engage more closely with Operational and Clinical Leaders and secondly to ensure that the Chief Executive has direct line of site for every action required as they are her direct reports, so there can be no uncertainty as to who is responsible for what.

4.1 **RECOMMENDATION**: That each of the District Executive members, amend their Performance Agreements to reflect each of their responsibilities documented in the Financial Recovery Plan.

A further theme amongst Operational and Business Partner managers was a lack of clarity for financial accountability amongst and between the "triumverate" Leadership of Clinical Divisions and how each of the three specialist Business Partners interact. The Reviewer provide some feedback to the Director, Hospital Services on a framework document of accountabilities that was soon to be released.

4.2 **RECOMMENDATION:** That the framework document clarifying accountabilities of Leaders in Clinical Directorates be released as soon as possible, that sign off from each of these three leaders be obtained, and the expectations of how each of the specialists Business partners interact with these positions be made clearly known.

There are two aspects that the Director, Finance and Corporate Services needs to give some consideration of, and subsequent advice to, the Chief Executive as it relates to Finance Business Partners. Firstly, is their role merely to be messengers with the provision and analysis of data, or to play an active role giving advice on affordability to budget, alternatives to routinely replacing positons and exploring other means to finance Service priorities? The majority of current incumbents perform their role to the former. If the latter is preferred for the LHD, they will need clear direction and support to do so as they presently do not feel empowered. The second question is whether the Business Partner model is right for Nepean Blue Mountains. All Finance Business Partners interviewed were very new to their roles and many clinical and operational leaders observed that there had been constant turnover so no one Business Partner was ever in the job long enough to understand the nature of the services they were meant to be partnering. The LHD needs to consider if this model is right for the LHD given the constant turnover (a question given more consideration later in this section as it related to Human Resource Business Partners).

4.3 **RECOMMENDATION**: That the Director, Finance and Corporate Services consider and give advice to the Chief Executive that due to repetitive turnover of occupancy of the Finance Business Partner roles whether this model is the right one for NBMLHD. Further, if the Business Partner model is considered correct for the LHD, and given the gradings of these positions, that they be supported and empowered to contribute more to financial management of the services they support than by merely producing reports.

Whilst the nature of the Human Resources Business Partner model is considered elsewhere in this section of the Review, should this model continue, there is a need to broaden the breadth and depth of financial related analysis to Operational and Clinical Leaders. A constant theme for Finance Business Partner's was their shortage of time to provide detailed analysis across the range of cost drivers in a health organisation. Conversely, it was observed that Human Resources Business Partners have responsibility to provide data and analysis on all the key Human Resources KPI's with the exception of the most important one, FTE movements. By focusing on Human Resources Business Partner's providing historical, current and projected FTE activity, in collaboration with Finance Business Partner's, to Operational and Clinical Leaders, will free up time for Finance Business Partner's to do deeper research into unfavourable trends associated with goods and services and contract expenditure.

4.4 **RECOMMENDATION**: That by simplifying regrading process (refer Recommendation: 2.12) and prioritising workloads, that Human Resources Business Partner's take over the analysis on FTE movements for their respective cost centres in collaboration with Finance Business Partner's in order to overall enhance the quality of financial analysis to Operational and Clinical Leaders.

Data reviewed over recent financial years demonstrated a significant growth in both JMO FTE's and JMO overtime. Rationale for the growth in FTE's was often to meet College/Training requirements or for patient safety reasons. A similar number were also approved as an efficiency strategy to be self or surplus funding. The data clearly demonstrates that this has not been achieved. The model for both a decentralised JMO rostering function (above PGY 1 & 2) and the organisational placement of this activity under a District Directorate, ie People & Culture, and not in the remit of professional medical administrators reporting to the facility General Manager is unique in NSW Health to the knowledge of the Reviewer. JMO rosters are both a key lever of both expenditure control and service/patient flow and not to have this professionally managed by the Director Medical Services reporting to the General Manager detracts from their ability to manage the entirety of the facility.

4.5 **RECOMMENDATION**: That the JMO Unit and rostering function be moved under the stewardship of the Director Medical Services and General Manager, Nepean Hospital to facilitate it being closer to the workforce and under the direction of those senior officers that have "skin in the game" for finance, patient flow, and safety and quality.

Discussions with senior staff of the District's smaller facilities reflected on the difficulties in obtaining support and even data from the Corporate Directorates, particularly Human Resources and Finance. Recommendations elsewhere pose questions about the Business Partner model going forward especially for these two directorates, and so in responding to those recommendations, the appropriate Executive should give consideration as to how to turn around this perception/belief.

4.6 **RECOMMENDATION**: That in responding to Recommendation 2.12 and 4.3 that the appropriate District Executive consider how to better support small facilities for the key services of workforce and finance.

Discussions with the three District Executives who have responsibility for Allied Health Professionals (AHP) and/or their services, saw an interest to streamlining the current arrangements that has

structures in place for hospital, community and professional leadership. It is proposed for consideration that only one structure exists, replacing the current three, to have the leadership responsibility for resource distribution across both community and facility services and also for professional purposes. Health Services often espouse the benefits to the patient journey and outcomes through a “continuum of care”, however they continue to support siloed structures in the community and facilities. The benefits of such a change would give enormous flexibility to Operational Leaders to readily flex resources for areas of greatest need by breaking these silos down, broadens career paths for AHP’s into community settings and services, or conversely acute or sub-acute services, whilst also reducing management overheads and professional bureaucracy.

4.7 **RECOMMENDATION**: That the Directors of Hospital Services, Community and Integration and Allied Health, Research and Strategic Partnerships continue their work to recommend to the Chief Executive a single allied structure to oversee community, facility and professional leadership. This structure should be focused on providing flexibility of resource distribution between facilities and community settings, broaden career paths for AHPs across the remit of all Services in the District and reduce management overheads in the process.

From the many conversations conducted during the Review, it is widely held that the HR Business Partner model is not delivering support to its “customers” or the strategic value, for their senior investment, in line with the LHD’s needs. Whilst an intensive review of this model was conducted by the “People Strengths” Report, with the report being delivered over 12 months ago, COVID appears to have interrupted the Director People & Culture to progressing the required changes. Given the current impetus, action should be taken to adopt one of three approaches. 1. Accept that the HRPB model does not suit NBMLHD and centralise the services thereby releasing FTE. 2. Maintain the model but expand the analytical role provided to Operational Leaders to include FTE management, trends and alternatives to routine replacements. Or 3, following discussion with the Chief Executive, a hybrid of the above but a model that is financially more effective and contributing to the LHD’s strategic objectives given the significant investment in these positions.

4.8 **RECOMMENDATION**: That the Director, People and Culture use this Review as impetus to act on the above issues and the detailed Review by “People Strengths” to deliver an HR support model that meets operational managers and clinical leaders needs, provides greater analytical capacity on the most important of workforce KPI’s, FTE’s, and is more financially sustainable.

5. Revenue Efficiencies

It is noted that Salary Packaging revenues have significantly declined since the onset of COVID, primarily due to providers not being on site to educate and sign up staff of the LHD. As sites open up, a strong commercial conversation should be had to commit them to deliver participation rates that were being achieved by some LHD's prior to COVID that should increase revenues, in the worst case scenario, above the LHD's current contracts which ends in FY24.

5.1 **RECOMMENDATION:** That should the current Salary Packaging contract not be able to be amended, that a future or new contract be negotiated to set the Living Expenses participation target at 83% for Year 1 increasing to 85%, that has been achieved by other LHD's, prior to COVID. Similarly, Meal Expenses participation should be increased to 42% for Year 1, increasing to 45%.

5.2 **RECOMMENDATION**: That review work be finalised within PC&CH to advise the Director, Finance and Corporate Services, if new revenue streams are possible through Private Health Insurance (PHI) funding by partnering with General Practitioners to bundle services and other potential government agencies in purchasing health inputs.

The onset of COVID has seen many functions turn to digital solutions for safety and efficiency reasons. Nepean ICU appears to have developed a unique response to continue the education and development of this critical workforce through digital ICU courses.

5.3 **RECOMMENDATION**: That the Revenue Manager (or other appropriate Commercial Officer) work with Nepean ICU to assess the delivery of ICU Courses to both the public and private sectors. If successful new revenue streams could offset existing costs whilst enhancing the reputation of this Unit.

A review of Outpatient activity at BMDAMH showed a real potential for a number of these clinics to be converted to Privately Referred Non Inpatients.

5.4 **RECOMMENDATON**: That the Revenue Manager in conjunction with the General Manager BMDAMH review the operation of outpatient clinics with a view to operate as Privately Referred Non-Inpatients.

Improvements in patient fee revenues are driven at the facility level, for local initiatives, and at District level for high level delivery of In-Patient and Non-Inpatient fees. The Revenue Manager, recently appointed, no doubt has expertise in this area, but the Review was advised that this position does not always have line of sight of these local initiatives. This is problematic for two reasons. Firstly, the Revenue Manager should have skills and experience that can assist facility operational staff more easily achieve their objectives. Secondly, given the compliance obligation around billing for Inpatients and Non-Inpatient fees, that this position, on behalf of the Director, Finance and Corporate Services, should have oversight to give organisational comfort to the billing practices and environments.

5.5 **RECOMMENDATION**: That whilst local revenue initiatives should be encouraged, the District Revenue Manager should have oversight of all patient fee developments to assist in

their implementation, and ensure the LHD meets all its compliance obligations in this regards.

6. Activity Based Management Initiatives

Improving the District Activity Based Management (ABM) performance will provide long term budget relief and improved financial performance. Whilst the District as a whole would be judged a good performer amongst many peer LHD's and State averages, there are stand outs that are well above average costs within NSW Health. To the District's credit, these outliers have been clearly identified together with the financial opportunity for even a conservative performance improvement. The table below (NBMLHD Activity Cost & Price Variations - Suggested Focus Areas) summaries the improvement opportunity over the next 2-3 years *.

NBMLHD Activity Cost & Price Variations - Suggested Focus Areas

Time Period - July 2019 - March 2020 data (9 months excludes COVID affected 3 months)

Source - Rnd 24.3 DNR

Note: Jul 19 to Mar 20 data has been recalibrated in Ministry ABM Portal from NWAU (20) to NWAU(21) - both figures are provided as some ABM Portal extracts on separate tabs per focus area are in NWAU(21)

Focus Area	Rationale for Priority	Average Cost Per NWAU (NWAU20) ($)	Total Variance to (above) State Price (NWAU20) ($)	Average Cost Per NWAU (NWAU21) ($)	Total Variance to (above) State Price (NWAU21) ($)	RSI	RCI	25% Improvement Target
PCCH Activity	PCCH had the highest average cost per NWAU(20) of all NBMLHD facilities in 2019/20 Compared to Peer Groups (F8 Other Ungrouped) also PPCH has highest Avgas/Cost per NWAU(21).	$6,841	$8,632,553	$6,587	$5,354,530			**$1,338,633**
Blue Mountains Hospital - Acute Activity	Average Cost per NWAU20 across **all** streams for Blue Mountains is $5,328 with total variance to price being $6,970,076.	$5,974	$4,725,155	$5,911	$3,114,017	1.00	0.96	**$778,504**
Nepean Hospital - Geriatric Medicine Specialty	Geriatric Medicine (based on discharging specialty) has a higher average cost per NWAU(20).	$5,579	$1,908,281	$5,677	$1,860,295	1.12	1.01	**$465,074**
Nepean Hospital - Urology Specialty	Urology (based on discharging specialty) has a higher average cost per NWAU(20).	$5,785	$1,995,240	$5,785	$1,806,166	0.85	0.99	**$451,542**

6.1 **RECOMMENDATION**: That the Information Management and Organisational Performance Unit's (IMOPU) resources are realigned to support delivering these strategic improvements in the identified ABM priorities. Further, a review is conducted to ensure all IMOPU resources are supporting these Financial Recovery Plan initiatives, focusing on high cost/high volume areas by supporting key innovations and education strategies.

6.2 **RECOMMENDATION**: Conscious of data imperfections it is recommended that the IMOPU be guided by the above tables and working with Operational and Clinical Leaders to deliver, in the first instance, improvement to State average of 25%. It is further recommended that these reviews focus initially on the Salaries and Wages component of these cost "buckets" and not be distracted on indicators around Length of Stay and Goods and services expenses at this time.

6.3 **RECOMMENDATION**: That the District establish a system of Activity Based Management performances reviews, costs and activity volumes for all high level clinical groups/specialities against State averages circulating these to all Clinical Leaders in order to recognise good performers and encourage interest in understanding the opportunities in the LHD against these system averages.

It was observed that the LHD's limited resources in Episode Funding and Activity Based Management were stretched and distracted by numerous stakeholders from across the LHD. One off requests and the desire to meet their "customers' needs distracted from the capacity of this important group to contribute strategically to the needs of the LHD. A primary focus of the group was to work on data quality and ensuring that all appropriate factors for each patient were recorded and coded appropriately. Whilst this will result in more accurate recognition of patients presenting, it does little to address the current budget position of the LHD.

6.4 **RECOMMENDATION**: That the efforts invested in improving Data Quality and Capture be addressed by a Quality Improvement Program and viewed as "Business as Usual", that the IMOPU prioritise targeted strategic reviews (Refer to Recommendation 6.2) and that one off requests be vetted by the Director Finance and Corporate Services to enable the strategic reviews to be completed in accordance with the Financial Recovery Plan timetable.

Discussions with various stakeholders across the LHD has indicated some confusion around the funding model for Portland Tabulam Health Centre that is impacting the capacity to effectively manage a diverse but small facility.

6.5 **RECOMMENDATION**: That clarity be sought through engagement with Ministry of Health officers around the optimal and appropriate funding model for Portland so as services can be structured to suit both the needs of the community whilst maximising funding from various tiers of government.

Whilst acknowledged elsewhere in this section the demands placed on the LHD's ABM resources, a source of observation/complaint was a lack of learnings being shared across all services and especially the smaller facilities from the engagement of coding services with clinicians. The coding improvement secured from one Service Audit/Review could be multiplied through appropriate dissemination of these outcomes across the LHD.

6.6 **RECOMMENDATION**: That the IMOPU give consideration as to how they could share learnings from their QA and Audit activities to all appropriate Operational Managers in order to roll out these benefits across the LHD.

7. Quality Improvements and Model of Care Initiatives

Supporting research activities and conducting and participating in Clinical Trials is an important function of a Teaching Hospital. Whilst recent organisational changes have clearly identified a LHD Executive as having carriage of these important functions, it is unclear (from feedback from key stakeholders), as to the efficacy of how this is done, how governance is achieved in terms of oversight and grant applications and supporting the prevention of grant leakage to other organisations. It has been identified that not all research activity, especially clinical trials, is conducted at a cost neutral or cost recovery basis resulting in the general fund budget supporting unfunded expense. A detailed review is required to ensure that all clinical trial agreements, both with the funder and internally contracted services (ie Pharmacy) operate at a minimum of cost neutral basis.

7.1 **RECOMMENDATION**: A review of clinical trials costings and revenue should be undertaken to ensure that all such trial activity is performed at a minimum, cost neutral to the LHD. Expenses for positions supporting trial activity should be fully off-set by relevant grants, project funds and/or trust funds supporting the trial. This includes internal charges for services such as pharmacy.

It is noted that the Ministry of Health has requested Efficiency Improvement Plans (EIPs) from LHD's for some years. A review conducted of the EIP submitted by NBMLHD for FY21, early in this Review process, indicated that up to half of the strategies submitted fell well short of their savings targets with may in fact increasing their costs. Interviews with most, if not all the stakeholders responsible for developing these EIPs advised that little centralised guidance was provided as to how these were to be developed, and in most cases no targets were given for Facilities/Services/ Directorates to aim their set of strategies towards. It is unclear how robust these submitted strategies were interrogated prior to forwarding to the Ministry of Health but as an EIP, it fell well short of the intended target. The process undertaken for EIP's development for FY22 is much improved where clearer direction from finance was provided including targets however it can be further improved by identifying meaningful KPI's, eg, FTE reduction numbers, cost centres to be measured, general ledger account codes to be impacted, so as movement towards these cost reductions can be monitored transparently with early indicators if strategies are not to meet their targets. To this end, relevant KPI's have now been added to all strategies accepted by this Review and included in the Summary of the Financial Recovery Plan.

Furthermore, the fact that a number of senior managers put forward strategies believing that they would improve the financial performance of their service indicated enormous variances in understanding the nature of health finances and expenditure.

7.2 **RECOMMENDATION**: That Facilities/Services/Directorates be given a clear pro-forma of advice as to how EIPs should be developed, meaningful KPIs to monitor be identified together with financial targets to support the LHD's financial management plan.

7.3 **RECOMMENDATION**: That these EIP strategies be robustly challenged to ensure authenticity before submission to the Chief Executive for approval and subsequent to them going to the Ministry of Health.

7.4 **RECOMMENDATION**: It is recommended that the District introduce a compulsory Strategic Financial Management education program for all Executive, Managers and Leaders to raise the overall knowledge base of the LHD and develop a consistency of language across this group.

Like a number of LHD's in the NSW Health System, NBM experiences far less staff churn particularly compared to LHDs closer to the CBD. This has its positives and negatives. One negative is a lesser impact of staff from other LHDs or even other Health Systems entering the NBM workforce and bringing with them fresh ideas on practices, models of care and approaches to problems that are not dissimilar to those the District experiences. The Chief Executive is commended for her active engagement with the Austrian Institute of Health Service Management (AIHSM) and encourages staff participation in the variety of Masters and Doctorate programs on offer to broaden participant's exposure to develop their careers.

7.5 **RECOMMENDATION:** That the District continue to promote staff take up of education programs like those offered by AIHSM to keep aspiring future leaders contemporary on Health issues and management, and support a leadership culture of continuous learning.

The philosophy behind Business Partner models is about embedding an understanding of the core services they are supporting. A number of recommendations will be made in this Review to enhance that objective and hence these roles. Clinical Governance business partners are uniformly highly valued throughout the LHD. An even greater contribution and engagement with the core business of the LHD would be for these Business Partners to periodically attend Morbidity and Mortality meetings (however titled) to maintain and further develop their understanding of core clinical services and continue to develop supportive relationships.

7.6 **RECOMMENDATION**: That the Director, Clinical Governance consult with key Clinical Directors to seek guidance on what key patient safety and quality forums, eg, M&M, Clinical Governance Business Partners would benefit from attending and where they could offer greater contribution and support.

The commissioning of a new build brings with it both financial and service opportunities and risks. A strict program overseeing the commissioning process has been set up, but it should also have a focus on delivering the efficiency improvements any new capital facility should have been designed to improve, funding firstly the fixed costs associated with an increase in floor space and only increasing capacity where formal agreement has been reached with Ministry of Health to fund an identified uplift in outputs.

7.7 **RECOMMENDATION**: That any additional costs incurred by the opening of additional floor space strictly falls within the commissioning funds allocated by Ministry of Health, and that no additional capacity be opened unless it is funded by these Commissioning funds or by way of a corresponding service agreement confirming funding.

Numerous stakeholders interviewed and data sources reviewed, supported the long term view of efficiency opportunities residing within the Medical Imaging Service. Recent Executive changes and appointment of a new Manager to the service, together with this Review creates the opportunity to re-evaluate the operating model using "customer" input, benchmarking data and especially ABM data to re-create a service that is responsive to patient and clinician needs whilst operating closer to peer levels of expenditure.

7.8 **RECOMMENDATION**: That using the catalyst of this Review, user input, benchmarking and ABM data complete with Executive and management changes, this "Service" operating model be re-aligned to continue to meet patient and clinician demands whilst operating closer to peer levels of utilisation and expenditure.

The nature of health services are a complex dependency across many units and services. Many interviews reflected on the relationship across non-clinical units, and between clinical and non-clinical units being process driven and at times tense. Culture takes time to change and it must be driven from the top, in this case to develop a customer service mentality between units, not one that is process orientated.

7.9 **RECOMMENDATION**: That the Director, People and Culture give consideration on how to start an evolution of adopting and delivering an internal customer service approach by all services to each other across the LHD.

The Review was advised of plans and desires to increase the volume of planned surgery at BMDAMH. From a Clinical Services Planning perspective this may be of value and would probably be at a lower unit price, but would only be of financial benefit to the LHD if any increase in activity were supported by the Ministry of Health through the Service Agreement.

7.10 **RECOMMENDATION:** That any move to expand surgical activity at BMDMAH be financially supported by cost offsets elsewhere in the LHD or accommodated in an expanded Service Agreement with the Ministry of Health.

As the main conduit to operationalising and managing the budget below Executives are the Divisional Managers, Nurse Manager and Finance Business Partners. There is strong disquiet amongst this group around a lack of transparency in changes to budget, approvals of new positions at Executive level with no advice on funding arrangements and a feeling that particularly Divisional Managers are held accountable for the budget but have no inclusion or engagement in building that budget up. Whilst understanding that budget availability does not presently meet current expenditure levels, this group's inclusion in the process, even to only understand the constraints and principles around the development of budgets will foster greater engagement and commitment from a group the LHD appears to depend upon for budget management.

7.11 **RECOMMENDATION**: That the budget building and distribution process embrace inputs from Divisional Managers to assist that group understand more clearly the constraints and principals around annual budget building ups.

A key driver of expense at Lithgow Hospital is its length of stay challenges. Management have commenced work on initiatives to address this issue however there will be a need for discipline in ensuring that as length of stay decreases that their unused bed days are closed behind them.

7.12 **RECOMMENDATION**: That a clear program of bed day reductions facilitated by reduced length of stay also have a program of bed closures supporting them, the financial savings can be directed towards its budget sustainability of other supporting service needs for the Lithgow community.

Review of staffing data pointed to the establishment of “The Hub” as a source of increased FTE within Nepean Hospital. Those close to managing patient flow for the District and a number of senior clinicians were sceptical of whether it had achieved is objective on improving patient flow. Discussions with the Director, Hospital Services indicated a similar sense of uncertainty in this regards.

7.13 **RECOMMENDATION**: That the Review by the Director, Hospital Services into how and if “The Hub” has contributed to improved patient flow outcomes be expedited to give confidence to the CE that this was a sound investment or immediately reduce FTE numbers if not. This Review should also include input from the smaller facilities.

Feedback was received from a number of nurse managers that the intended roles in establishing a number of Nurse Practitioner positons had lost their way and were now largely just part of the “roster workforce” but were in addition to NHPPD numbers.

7.14 **RECOMMENDATION**: That District DoNM review all Nurse Practitioner positons and how they contributed to direct patient care and outcomes to give the Chief Executive confidence that all those roles should remain as structured.

There was a broad range of opinions as to the quality and appropriateness of Management Information that was provided. A constant theme was that the relevance was largely dependent on the view of the Finance Business Partner, their capacity and skill set and whether Operational Units asked the right question. Performance information at peak forums like the Service Performance Meeting is comprehensive to say the least. Conscious that sometimes “less is best” the District should give consideration to focusing the key reports to those KPI’s that we know make a difference, be it finance, workforce or Quality and Safety. This way the District can focus its key Operational Leader’s attention and responsiveness to the key strategic and operational priorities of the LHD.

7.15 **RECOMMENDATION**: That a more succinct and standard suite of reporting be prepared in consultation with stakeholders to allow the District to guide Operational Leaders and their supports to the key strategic and operational objectives of the LHD.

There was a clear sense that in terms of financial management accountability, that this was seen as the domain of the Director Hospital Services, General Managers of Facilities and Divisional Managers. To hold all senior officers to account, performance agreements with the appropriate targets, applied and be incorporated in the Agreement for Nurse Managers, Clinical Directors and the three specialist Business Partners.

7.16 **RECOMMENDATION**: That in addition to the Director Hospital Services, General Managers and Divisional Managers, financial and operational KPI’s be included in the Performance Agreement of Nurse Managers, Clinical Directors and the three specialist Business Partners (however the model going forward for these roles will be).

If the District Executive proceed with implementation of Recommendation 7.4 under the Section "Structure of Services" which will create capacity building and flexibility, the opportunity arises to turn the traditional discharge model on its head. Instead of inpatient units looking to "push" patient discharges to the appropriate community or residential setting, the appropriate community services should be realigned, incentivised and KPI'd to reach into inpatient settings to "pull" patients to the appropriate discharge location together with appropriate supports. Once this model is finalised, focussed on appropriate patient cohorts, a virtual bed capacity can be identified and factored into the facilities effective bed base for patient flow management.

7.17 **RECOMMENDATON**: Following discussions with the Director, Hospital Services and Director, Community and Integration, that the District turn the discharge model around for appropriate patient groups from facilities "pushing" patients out, to community services reaching in to "pull" patients into appropriate earlier discharge supports.

8. Benchmarking Initiatives

The Chief Executive together with the Chief Executives of Central Coat and Illawarra Shoalhaven LHDs are to be commended on their initiative to establish a three-way benchmarking process in 2020. High level and even more detailed data show significant opportunities for all three. Understandably, execution of these outcomes and development of further opportunities have been hampered with the onset of COVID-19 on the health system. Nonetheless workforce efficiencies and realignments highlighted by the benchmarking work to date should be urgently resurrected and executed upon. There will be natural organisational reluctance, however the quality of the data from very similar organisations, with very similar demographics, is quite powerful and a rigorous process should be undertaken to challenge why any leader feels that opportunities highlight by the benchmark data should not be adopted by NBMLHD.

8.1 **RECOMMENDATION**: That the Chief Executive reconvene a governance process to ensure all opportunities identified by the benchmarking group of the NSW LHD's are pursued through to adoption and only dismissed after rigorous review.

Whilst comments will be made elsewhere in this section regarding benchmarking there is a real need to understand the large variances in the Health Services Manger workforce compared with benchmarking partners Central Coast LHD and Illawarra Shoalhaven LHD. In particular, the 27% higher usage of these classifications to the next highest, Illawarra Shoalhaven LHD, and the much higher numbers graded at HSM 4 and 6.

8.2 **RECOMMENDATION**: That no HSM positon be appointed until an urgent review is undertaken to understand the 27% higher usage of HSM classifications and the much higher grading numbers than benchmarking partners, Central Coast LHD and Illawarra Shoalhaven LHD.

9. Risks and Issues

Risk Title	Risk Description	Mitigation
COVID-19	Expenditure on COVID-19 Is not reimbursed by Ministry of Health	• Review completed to ensure expenditure is in accordance with the Ministry Guidance Paper 01-GP172020 (since Revised). • Ensure the District maximises the flexibility of the COVID-19 response to ensure that it can approximately flex up and flex down resources (and therefore costs) as is appropriate. • That the Director, Finance & Corporate Services, coordinate all Finance Business Partners and Divisional Managers to review their services to ensure no further incremental costs are failing to be claimed back through the Ministry of Health
Patient Quality Safety and Access	Impact of organisational changes incur unacceptable outcomes on patient quality, safety and access	• CE oversight on appropriateness of staff reductions • Targeted mapping of Quality and Safety indicators to areas of FTE reductions • Develop an organisational appetite on waiting lists and quality variances • Monitor Service Agreements at LHD and Site levels for agreed outcomes • Monitor outcomes of Patient Experience Survey
Workforce Changes	The District fails to meet its industrial obligations to improve efficiency and realistic FTE.	• Proactively engage appropriate staff, Ministry of Health and Union stakeholders • Accelerate Workforce processes to document changes.
FTE Reductions	Inability of Managers to amend workflows and patient access in response to reduced FTE numbers	• Chief Executive oversight of all vacancy recruitment on achievability of staff reductions.

		• Executive and Workforce support to Managers in implementing FTE reductions • Implementation of AHP management structure. • Implementation of District and Nepean corporate FTE numbers to FY20 levels. • Continued reviews on all temporary contracts. • Qualitative review of Nurse Practitioner positions. • Targeted voluntary redundancy strategy developed (subject to Ministry of Health approvals). • Benchmarking FTE against comparable LHDs and Professional guidelines and acting on outcomes. •
Nepean Hospital Redevelopment	Commission of Nepean Hospital redevelopment negatively impacts the District budget.	• Commissioning costs recognised and approved by Ministry of Health. • Review and minimise commissioning costs to those approved by Ministry of Health • Commitment to occupy the new build at current profile and activity levels. • Expand current activity only where Service Agreements are agreed to be funded by Ministry of Health.
Expenditure Controls	Controls not in place or not effective for preventing over expenditure	• CE approval to continue to be required for all recruitment for cost centres and Services over budget in accordance with current Delegations Manual. • Updating recruitment requests to include all relevant financial and FTE information recommended. • Senior Working party formed to review and oversee all non-salary expenditure recommendations.

		• Internal and external obligatory reporting on metrics establish for the FRP to the Board, Ministry of Health and Executive.
Savings Governance	Lack of governance and Executive ownership and savings implementation and achievement	• Establish a Governance model to monitor and review savings and FRP implementation and empower it to respond if strategies fail. • The Chief Executive be appointed Executive Sponsor of FRP implementation • Dedicated Project Manager allocated to oversee FRP implementation reporting directly to the Chief Executive. • Each Executives Performance Agreement should be amended to reflect each of their respective accountabilities` in the FRP.
New unfunded expenditures incurred	Funding is approved for services or initiatives over and above approved budget thereby off-setting savings	• CE approval required • Ensure these new expenditures are captured as part of FRP reporting and monitoring. • This information be provided to the FRP governance model in order to identify additional savings strategies before approval to proceed
TESL expenditure accruals	Accrual of TESL entitlements if taken, creates a clear financial risk of doubling up in Year 2 of the FRP, together with potential impacts on services should Staff Specialists proceed to make greater use of their entitlements.	• Some requests for TESL leave may need to be deferred if a doubling up occurs as this may impact on clinical service capacity to meet demands. • Proactive industrial consultation to establish the LHD's capacity to meet requests for utilisation of TESL.

10. Milestones and Dashboard

Financial Recovery Plan – Dashboard (MOCR)

Provided directly to the Director, Finance and Corporate Services

		2021			2022			2022			2022			2022			2023			2023		
Key Task	**Lead**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
CE approver of all vacancy & recruitment	CE	*																				
Decision on AHP and JMO Changes	CE					*																
Inclusion of FRP targets in Exec & SES Performance Agreements	CE			*						*												*
Quarterly review of temporary contracts	CE	*			*			*			*			*			*			*		
Regular monitoring of FTE at Executive	D,F&CS	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Monitoring FTE against Targeted Reductions	CE						*			*			*			*			*			*
Benchmark Reviews against other LHDs	CE						*		*													
Matching of displaced staff	D,PC				*			*			*			*			*			*		
Review of clinical trials cost recovery	D,F&CS					*																
Review of outpatient clinics for new revenues	D,HS					*			*													
Correct Pathology costing and billing	D,HS					*			*			*			*			*				
Nepean Reduction security usage	D,HS						*		*			*			*			*			*	
Voluntary redundancy program	D,P&C						*			*												

		2021			2022			2022			2022			2022			2023			2023		
Key Task	**Lead**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Transition to award NHPPD	DDN&M			*			*			*			*			*			*			*
Achieve Nursing Specials targets	DDN&M			*			*			*			*			*			*			*
Reduction Nepean Nursing casual usage	DDN&M				*		*			*												
NRM Implement real time monitoring tool (NHPPD, Specials)	DDN&M					*																
Non-Salary Efficiencies report to targets	D,F&CS						*			*			*			*			*			*
JMO overtime reduction	D,HS						*			*			*			*			*			*
ABM cost reduction Priority 1	D,C&I							*														
Review of FRP Y2 Targets	D,F&CS						*			*												
ABM cost reduction Priority 2	D,HS									*			*			*			*			
ABM cost reduction Priority 3	D,HS													*		*						*
Review and Revise FRP Plan & targets	D,F&CS									*												*

Key	
Chief Executive	CE
Director, Finance & Corporate Services	D,F&C
District Director, Nursing & Midwifery	DDN&M
Director, Hospital Services	D,HS
Director, People & Culture	D,P&C
Director, Community & Integration	D,C&I

11. Summary of Recommendations

2. WORKFORCE EFFICIENCIES AND REALIGNMENTS

2.1 That a register of new positions approved by the Chief Executive be established by the Director, Finance and Corporate Services, with the identified funding strategy or costs offsets, and these be monitored and reviewed on a monthly basis to ensure the funding stream is being delivered or an alternative funding strategy be developed by the requesting officer.

2.2 That the FTE number of identified LHD Corporate Directorate and Non-Clinical areas of Nepean Hospital be returned to FY20 levels commencing this financial year.

2.3 That the withdrawal of all delegations for Services over budget continue to be held by the Chief Executive and in so doing apply a stronger financial rigour to the process that will see FTE reductions in line with the Financial Recovery Plan Summary.

2.4 In order to develop insight and understanding of a cost centres performance, that the “Request to Fill a Vacancy” have mandatory fields documenting the actual financial positon for Salaries and Wages versus budget, as well as documenting the current RTE number compared to the same time in FY20, FY21 and FY22 for that requesting cost centre.

2.5 The LHD is encouraged to continue encouragement with the Ministry of Health to secure financial support for a non-clinical staff redundancy program targeted at FTE growth in Facility and District Directorate corporate positions.

2.6 That the execution of leave reduction strategies be carefully overseen by an appropriate senior officer to ensure leave taken is balanced with service demand periods to minimise obligatory back fill and avoid any use of premium labour to enable the leave.

2.7 That all cost centres/services that were on or favourable to budget at end of FY21 have their expenditure constrained to their FY21 levels to ensure that LHD’s unfavourable levels do not increase.

2.8 That the LHD have tight internal controls on ensuring no positions move from Special Purpose and Trust Funds to the General Fund and that any new positon funded from this source does so in perpetuity or be time limited.

2.9 That District and Site Executive staff provide greater and direct hands on assistance to managers in re-engineering their services to balance FTE availability, existing staff capacity and patient/client demands.

2.10 That the LHD urgently prioritise the rolling out of an FTE profiling process, similar to that across Nursing, to introduce greater staff controls, and gradually tie these profiles to approved, sustainable and realistic budgets as the LHD progresses each year towards a balanced budget performance.

2.11 That the Director, People & Culture review the necessity of all current regrading applications being considered by the Committee including where external bodies stipulate the grading or classification and where that Executive

position should be given delegations to govern these processes to lessen the workload on a number of roles in largely “rubber stamping” applications.

2.12 It is further recommended that the Regrading Committee either seek advice on, or escalate applications, that have an increased financial cost on how the Service or LHD will fund these changes.

2.13 That all requests to fill vacancies be accompanied in a disciplined manner with data on FTE movement for FY 19, 20 and 21 and YTD together with YTD financial performance against budget for an informed approval process to take place. (Refer Recommendation 2.4).

2.14 That the Director, Internal Audit continues the regular review of internal controls over ADOs and annual leave as part of the Audit Plan and make recommendations, if deemed appropriate, to strength those controls.

2.15 That appropriate NBMLHD Executives re-engage with NSW Ministry of Health to oversee a more effective system of locum engagement that prevents one hospital bidding up for services for a medical locum, above another hospital.

2.16 Whilst reporting requirements to Ministry of Health requires inclusion of Nursing Specials in NHPPD, it is recommended that they be removed for purposed of monitoring compliance to the Award stipulated NHPPD.

2.17 That the financial cost of hours rostered/worked be identified above the mandatory NHPPD to develop appreciation of the dollar cost of not complying as closely as possible to those Award hours.

2.18 From a District wide perspective that the District DoNM be responsible to the Chief Executive to support site DoNM’s and General Managers in delivering and monitoring rosters to appropriate NHPPD.

2.19 That the District DoNM prioritise the examination of more real time monitoring of costs used elsewhere in NSW Health and assess their demonstrated performance in delivering reductions in NHPPD hours and Specials, with a view to implement that tool and provide education to appropriate nursing managers in their use.

2.20 Whilst the preferred practice is not to roster Nurse Specials on 10 hour night shifts, the District DONM should satisfy herself that this practice is consistently in place across all Units and Facilities in the LHD to avoid the cost penalty of a two hour overlap.

2.21 That a long term target of 0.2% (as delivered by other and more acute facilities in NSW Health be set for all facilities, with the short term target of 1.2% to be delivered by FY23.

2.22 That planned work be finalised to ensure that all overheads are met through external funding sources are carried by those programs and not subsidised, directly or indirectly, by the LHD General Fund.

2.23 That a review of vacancies currently with the D&A Service together with an opportunistic churn rate be made in order for the D&A Service, to deliver an on budget performance for FY22.

2.24 That the East Wing Ward be reviewed, guided by fluctuating surge demand of BMDAMH and the District to settle on a routine bed number (with capacity for planned increases in, say, winter months) in order to have a more efficient staffing profile established to avoid the use of premium labour,

2.25 That the District Executive responsible for Medical Imaging review the current requirement for patients requiring medical imaging services at Nepean Hospital from BMDAMH to be permanently escorted for these trips, including the waiting rooms for medical imaging thereby reducing nursing FTE by 0.5 per week at BMDAMH.

2.26 Although there has been no FTE growth over the last 3-4 years, there has been significant service delivery changes, leading to a need to formally review the focus and investments in the Directorate of Finance and Corporate Services to ensure they reflect the LHD's current needs.

2.27 That the Director, People and Culture commit to ensuring the efficiency of redeployment matching is such to deliver first time, every time direct placement of displaced staff into funded roles.

2.28 That the Director People and Culture urgently establishes a proactive and timely Industrial Engagement Strategy to ensure the LHD meets its Award obligations on consultation which will not delay executing staffing strategies.

3. NON SALARY EXPENDITURE EFFICIENCIES AND REALIGNMENTS

3.1 That VMO workforce numbers and mix be considered in light of this Financial Recovery Plan, Service Planning objectives and population health changes, to ensure quinquennial appointments are best suited to Services and Community needs.

3.2 Similar to SP&TF positions, new FTE's tied to Capital Grants should be held tightly to these capital funds and then be released on completion of the Capital Project to ensure the General Fund does not carry the ongoing unfunded burden.

3.3 That a non-salaries Working Party be established chaired by the Executive Director, Finance and Corporate Services, to prioritise the correction of goods and services expenditure trends internally, including Pharmacy, review the uniform uptake, of HealthShare contracts across the LHD and be engaged with and ensure traction with HealthShare Savings Program to deliver agreed targeted non-salaries expenditure reductions.

3.4 That early engagement with Ministry of Health on how Lithgow Hospital should continue to fiscally support LCPH and how these funds should be recognised, but more importantly how the role of the pubic hospital may need to change to support its community and its role in the LHD should changes if the private market unfolds as expected.

3.5 That the process for Intra Health charges, ie HealthShare (transport, food and linen), Pathology and others be reviewed to ensure the validation of these charges be as close as possible to the point where this expenditure is being incurred.

3.6 That the District understands the exponential increased in Patient Transport Service charges well above increases in patient activity and introduce a range of initiatives to reduce these costs. These initiative should include maximising the use of taxi or non-patient transport services for the transport of Category E Type patients and the uniform adoption of the HealthShare initiatives to reduce patient cancellation fees. It is further recommended that this strategy should be overseen by the Working Party chaired by the Director Finance and Corporate Services as noted in Recommendation 3.3.

4. STRUCTURE OF SERVICES

4.1 That each of the District Executive members, amend their Performance Agreements to reflect each of their responsibilities documented in the Financial Recovery Plan.

4.2 That the framework document clarifying accountabilities of Leaders in Clinical Directorates be released as soon as possible, that sign off from each of these three leaders be obtained, and the expectations of how each of the specialists Business partners interact with these positions be made clearly known.

4.3 That the Director, Finance and Corporate Services consider and give advice to the Chief Executive that due to repetitive turnover of occupancy of the Finance Business Partner roles whether this model is the right one for NBMLHD. Further, if the Business Partner model is considered correct for the LHD, and given the gradings of these positions, that they be supported and empowered to contribute more to financial management of the services they support than by merely producing reports.

4.4 That by simplifying regrading process (refer Recommendation: 2.12) and prioritising workloads, that Human Resources Business Partner's take over the analysis on FTE movements for their respective cost centres in collaboration with Finance Business Partner's in order to overall enhance the quality of financial analysis to Operational and Clinical Leaders.

4.5 That the JMO Unit and rostering function be moved under the stewardship of the Director Medical Services and General Manager, Nepean Hospital to facilitate it being closer to the workforce and under the direction of those senior officers that have "skin in the game" for finance, patient flow, and safety and quality.

4.6 That in responding to Recommendation 2.12 and 4.3 that the appropriate District Executive consider how to better support small facilities for the key services of workforce and finance.

4.7 That the Directors of Hospital Services, Community and Integration and Allied Health, Research and Strategic Partnerships continue their work to recommend to the Chief Executive a single allied structure to oversee community, facility and professional leadership. This structure should be focused on providing flexibility of resource distribution between facilities and community settings, broaden career paths for AHPs across the remit of all Services in the District and reduce management overheads in the process.

4.8 That the Director, People and Culture use this Review as impetus to act on the above issues and the detailed Review by "People Strengths" to deliver an HR support model that meets operational managers and clinical leaders needs, provides greater analytical capacity on the most important of workforce KPI's, FTE's, and is more financially sustainable.

5. REVENUE EFFICIENCIES

5.1 That should the current Salary Packaging contract not be able to be amended, that a future or new contract be negotiated to set the Living Expenses participation target at 83% for Year 1 increasing to 85%, that has been achieved by other LHD's, prior to COVID. Similarly, Meal Expenses participation should be increased to 42% for Year 1, increasing to 45%.

5.2 That review work be finalised within PC&CH to advise the Director, Finance and Corporate Services, if new revenue streams are possible through Private Health Insurance (PHI) funding by partnering with General Practitioners to bundle services and other potential government agencies in purchasing health inputs.

5.3 That the Revenue Manager (or other appropriate Commercial Officer) work with Nepean ICU to assess the delivery of ICU Courses to both the public and private sectors. If successful new revenue streams could offset existing costs whilst enhancing the reputation of this Unit.

5.4 That the Revenue Manager in conjunction with the General Manager BMDAMH review the operation of outpatient clinics with a view to operate as Privately Referred Non-Inpatients.

5.5 That whilst local revenue initiatives should be encouraged, the District Revenue Manager should have oversight of all patient fee developments to assist in their implementation, and ensure the LHD meets all its compliance obligations in this regards.

6. ACTIVTY BASED MANAGEMENT INITIATIVES

6.1 That the Information Management and Organisational Performance Unit's (IMOPU) resources are realigned to support delivering these strategic improvements in the identified ABM priorities. Further, a review is conducted to ensure all IMOPU resources are supporting these Financial Recovery Plan initiatives, focusing on high cost/high volume areas by supporting key innovations and education strategies.

6.2 Conscious of data imperfections it is recommended that the IMOPU be guided by the above tables and working with Operational and Clinical Leaders to deliver, in the first instance, improvement to State average of 25%. It is further recommended that these reviews focus initially on the Salaries and Wages component of these cost "buckets" and not be distracted on indicators around Length of Stay and Goods and services expenses at this time.

6.3 That the District establish a system of Activity Based Management performances reviews, costs and activity volumes for all high level clinical groups/specialities against State averages circulating these to all being Clinical Leaders in order to recognise good performers and encourage interest in understanding the opportunities in the LHD against these system averages.

6.4 That the efforts invested in improving Data Quality and Capture be addressed by a Quality Improvement Program and viewed as "Business as Usual", that the IMOPU prioritise targeted strategic reviews (Refer to Recommendation 6.2) and that one off requests be vetted by the Director Finance and Corporate Services to enable the strategic reviews to be completed in accordance with the Financial Recovery Plan timetable.

6.5 That clarity be sought through engagement with Ministry of Health officers around the optimal and appropriate funding model for Portland so as services can be structured to suit both the needs of the community whilst maximising funding from various tiers of government.

6.6 That the IMOPU give consideration as to how they could share learnings from their QA and Audit activities to all appropriate Operational Managers in order to roll out these benefits across the LHD.

7. QUALITY IMPROVEMENTS AND MODEL OF CARE INITIATIVES

7.1 A review of clinical trials costings and revenue should be undertaken to ensure that all such trial activity is performed at a minimum, cost neutral to the LHD. Expenses for positions supporting trial activity should be fully off-set by relevant grants, project funds and/or trust funds supporting the trial. This includes internal charges for services such as pharmacy.

7.2 That Facilities/Services/Directorates be given a clear pro-former of advice as to how EIPs should be developed, meaningful KPI's to monitor be identified together with financial targets to support the LHD's financial management plan.

7.3 That these EIP strategies be robustly challenged to ensure authenticity before submission to the Chief Executive for approval and subsequent to them going to the Ministry of Health.

7.4 It is recommended that the District introduce a compulsory Strategic Financial Management education program for all Executive, Managers and Leaders to raise the overall knowledge base of the LHD and develop a consistency of language across this group.

7.5 That the District continue to promote staff take up of education programs like those offered by AIHSM to keep aspiring future leaders contemporary on Health issues and management, and support a leadership culture of continuous learning.

7.6 That the Director, Clinical Governance consult with key Clinical Directors to seek guidance on what key patient safety and quality forums, eg, M&M, Clinical Governance Business Partners would benefit from attending and where they could offer greater contribution and support.

7.7 That any additional costs incurred by the opening of additional floor space strictly falls within the commissioning funds allocated by Ministry of Health, and that no additional capacity be opened unless it is funded by these Commissioning funds or by way of a corresponding service agreement confirming funding.

7.8 That using the catalyst of this Review, user input, benchmarking and ABM data complete with Executive and management changes, this “Service” operating model be re-aligned to continue to meet patient and clinician demands whilst operating closer to peer levels of utilisation and expenditure.

7.9 That the Director, People and Culture give consideration on how to start an evolution of adopting and delivering an internal customer service approach by all services to each other across the LHD.

7.10 That any move to expand surgical activity at BMDMAH be financially supported by cost offsets elsewhere in the LHD or accommodated in an expanded Service Agreement with the Ministry of Health.

7.11 That the budget building and distribution process embrace inputs from Divisional Managers to assist that group understand more clearly the constraints and principals around annual budget building ups.

7.12 That a clear program of bed day reductions facilitated by reduced length of stay also have a program of bed closures supporting them, the financial savings can be directed towards its budget sustainability of other supporting service needs for the Lithgow community.

7.13 That the Review by the Director, Hospital Services into how and if “The Hub” has contributed to improved patient flow outcomes be expedited to give confidence to the CE that this was a sound investment or immediately reduce FTE numbers if not. This Review should also include input from the smaller facilities.

7.14 That District DoNM review all Nurse Practitioner positons and how they contributed to direct patient care and outcomes to give the Chief Executive confidence that all those roles should remain as structured.

7.15 That a more succinct and standard suite of reporting be prepared in consultation with stakeholders to allow the District to guide Operational Leaders and their supports to the key strategic and operational objectives of the LHD.

7.16 That in addition to the Director Hospital Services, General Managers and Divisional Managers, financial and operational KPI’s be included in the Performance Agreement of Nurse Managers, Clinical Directors and the three specialist Business Partners (however the model going forward for these roles will be).

7.17 Following discussions with the Director, Hospital Services and Director, Community and Integration, that the District turn the discharge model around for appropriate patient groups from facilities “pushing” patient out, to community services reaching in to “pull” patients into appropriate earlier discharge supports.

8. BECHMARKING INITIATIVES

8.1 That the Chief Executive reconvene a governance process to ensure all opportunities identified by the benchmarking group of the NSW LHD's are pursued through to adoption and only dismissed after rigorous review.

8.2 That no HSM positon be appointed until an urgent review is undertaken to understand the 27% higher usage of HSM classifications and the much higher grading numbers than benchmarking partners, Central Coast LHD and Illawarra Shoalhaven LHD.

12. Summary of Financial Recover Plan Saving Strategies

NBMLHD FINANCIAL RECOVERY PLAN SUMMARY

PART 1

FRP No.	CATEGORY/ LOCATION	INITIATIVE	DESCRIPTION OF INITIATIVE	ANNUALISED TARGET	FY22 TARGET	FY23 TARGET	FY24 TARGET	EXECUTIVE OWNER	KPIs
EXPENSES INITIATIVES									
1	Workforce District	**Sick Leave Reduction Nursing**	Reduce backfill on reduced Sick Leave activity	144,000	72,000	72,000		Julie Williams	FY21 Sick Leave baseline FY22 Sick Leave to Date FY21 O/T, Casual and Agency actual FY22 O/T, Casual and Agency YTD
2	Workforce District	**Workforce attrition via centralisation of approvals**	Withdraw all workforce approval delegations from Cost Centres over Budget and reduce approvals via target of 36 FTEs	3,240,000	2,160,000	1,080,000		Kay Hyman	Capture position request not approved and those not submitted by relevant Tier2 Executive in each financial year
3	Workforce Nepean	**JMO Overtime Reduction**	Centralised improved rostering for All JMOs, following increased JMO workforce in the last 4 financial years facilitating reduction in overtime.	600,000	400,000	200,000		Brett Williams	FY21 JMO FTE and O/T Hours baseline FY22 JMO FTE and O/T Hours YTD

4	Workforce Nepean	**Reduction Nursing Casual Usage**	Premium labour costs have been significant in recent years, increasing at a rate greater than the growth in activity. The increase in premium labour costs have largely been driven by covering for staff vacancies and sick leave. New Nursing Staffing models identified to reduce Casual and Premium Labour costs.	350,000	120,000	230,000		Julie Williams	FY21 Nursing O/T, Casual, Agency Baseline FY22 Nursing O/T Casual, Agency YTD
5	Workforce Nursing District	**Reduction Nursing Specials and process compliance**	The process around monitoring and approving nursing specials will change. Current usage at 2.4%. FY23 target of 1.2%. Long term target at system benchmark of 0.2%.	307,335	102,445	204,980		Julie Williams	FY21 Nursing Specials for Baseline FY22 Nursing Specials Actuals YTD
6	Workforce Nepean	**Reduction Nursing Agency Fees**	Reduction and better management of agency nursing usage, including a reduction in the number of nursing agencies being utilised has seen a progressive reduction in the use of agency nursing and dollar savings through the management of this	110,000	45,000	65,000		Julie Williams	FY21 Agency Fees as Baseline FY22 Agency Fees Actuals YTD

			aspect of the service by one central person (Nursing Workforce Manager).						
7	Workforce Nepean	**Nursing Hours to reflect award obligations**	Stronger compliance to Award obligation on HPPD. Currently staffing 32 FTE above Award requirements, 50% reduction to be targeted.	2,880,000	1,200,000	1,680,000		Julie Williams	FY21 NHPPD Baseline FY22 NHPPD Actuals
8	Workforce Nepean	**Reduction Nursing Overtime - excl. Medicine Division**	This strategy aims to reduce the nursing overtime occurring across Nepean Hospital Divisions by recruiting and strengthening the Nurse Casual Pool / Permanent Nurse Pool. The aim is to initially replace 5% of the overtime, whilst quantifying other savings from initiatives.	430,000	180,000	250,000		Julie Williams	To be monitored with same KPIs in conjunction with strategies (FRP No.4 and FRP No.6)
9	Goods & Services	**Security Usage**	This strategy aims to reduce agency security costs at Nepean Hospital by establishing a team consisting of RNs, AINs and Health & Security Assistants (HSAs) to "special"	900,000	300,000	600,000		Brett Williams	FY21 Security Specials expenditure baseline FY22 Security Specials expenditure YTD Await Business Case to confirm

			MH patients in ED at Nepean rather than using agency security staff.						
10	Goods & Services	**Pathology**	Nepean Hospital and NSW Health Pathology will undertake a process of reviewing public pathology usage with clinicians to reduce pathology ordering within the district. An agreement will be made between Nepean and NSW Health Pathology to reduce pathology by 5%.	450,000	-	450,000		Brett Williams	FY21 Payments to NSW Pathology baseline FY22 Payments to NSW Pathology YTD
11	Goods & Services District	**Pathology Error Corrections (Cost Avoidance)**	Nepean Blue Mountains LHD and NSW Health Pathology will review our Pathology Outpatients pathology requests that are non-compliant for Medicare billing. Retrospective last 2 years.	500,000	160,000	340,000		Brett Williams	Total of all Pathology requests converted to Medicare funding during FY22 and FY23
12	Goods & Services District	**Procurement (multiple initiatives)**	Establish non-salaries efficiencies "Working Party", chaired by Director of Finance Corporate Services	1,600,000	600,000	1,000,000		Luke Bellman	FY21 G&S Expenditure baseline FY22 G&S Expenditure Actual discounted by CPI

			to deliver reduced non-salaries expenditure reductions and greater and uniformed adoption of HealthShare contracts.						
13	Workforce District	**Corporate FTE Corrections**	Return Corporate FTE to FY20 numbers (equivalent to 15 FTEs) covering Planning, N&M Exec, CGU, WP&C, Hospital Exec Services & AHP Exec.	1,300,000	650,000	650,000		Luke Bellman	FY22 FTE to be monitored against FY20 Actuals for each of the District Directorates
14	Workforce Nepean	**Nepean Hospital FTE Corrections**	Return targeted areas FTE to FY20 numbers (equivalent to 19 FTEs)	1,710,000	855,000	855,000		Brett Williams	FY22 FTE to be monitored against FY20 Actuals for Non Clinical groupings ie (Not Medical, Nursing, Allied Health)
			PART 1 TOTAL	**14,521,335**	**6,844,445**	**7,676,980**	**-**		

PART 2

FRP No.	CATEGORY/ LOCATION	INITIATIVE	DESCRIPTION OF INITIATIVE	ANNUALISED TARGET	FY22 TARGET	FY23 Target	FY24 Target	Executive Owner	KPIs
15	Workforce Oral Health	**Oral Health Cessation of Agency Staff**	Changed rostering practices to remove need for engagement of external agency dental assistance	38,000	19,000	19,000		Cathy Crowe	FY21 expense in CC362440. FY22 actual expense.

16	Goods and Services Oral Health	**Reduction of Oral Health Vouchers**	Decreased use of Oral Health Vouchers facilitated by increased Student Placement	170,000	85,000	85,000		Cathy Crowe	FY21 baseline in CC362440 established to compare with FY22 actual.
17	Goods and Services Blue Mountains	**Private Security Reduction**	New contractual and approval arrangements to facilitate reduction in private security usage	72,000	30,000	42,000		Brett Williams	FY21 baseline of CC355564 vs FY22 actual.
18	Workforce Blue Mountains	**Targeted Overtime Reduction**	Targeted reduction in Overtime for Non-Clinical Staff e.g. Security, Admin, Food Services etc.	51,000	20,000	31,000		Brett Williams	FY21 cost baseline $133K. FY21 baseline vs FY22 actual.
19	Workforce Blue Mountains	**Agency Medical Cost**	Reduction in agency medical cost through changed staffing structure	100,000	40,000	60,000		Brett Williams	FY21 baseline for Cost Centres CC355889, CC355870, CC355861, CC355825. FY22 Actual comparison.
20	Goods and Services Drug and Alcohol	**Reduction in archiving cost**	Reduction in archiving cost	45,000	20,000	25,000		Cathy Crowe	$60,000 established as FY21 baseline. FY22 actual comparison.
21	Goods and Services Drug and Alcohol	**Reduction in Imaging and Pathology Costs**	Reduction in Imaging and Pathology Costs	60,000	20,000	40,000		Cathy Crowe	Cost Centres CC362140 and CC362901 for FY21 baseline. FY22 actual comparison.
22	Goods and Services Drug and Alcohol	**Reduction in Pharmacy Cost**	Changed pharmacy requisition practices	30,000	10,000	20,000		Cathy Crowe	CC362140 for FY21 baseline. FY22 actual comparison.

23	Workforce Mental Health	**Reduce Administration Overtime**	Targeted efficiencies to reduce Overtime amongst Administration Staff	25,000	10,000	15,000		Cathy Crowe	FY21 Admin Overtime as baseline. FY22 Admin actual.
24	Workforce Nepean Hospital	**ABM Priority Geriatric Medicine**	Focused ABM efficiencies in Salaries and Wages for Nepean geriatric Medicine. Priority 3. Refer recommendation 6.2	372,059	-	93,014	279,045	Brett Williams	Priority 3. 1 Quarter only for FY23. Total Nepean Geriatric Medicine costs FY22 vs FY23 and then FY24
25	Workforce Primary Care Community Health	**ABM Priority PCCH**	Focused ABM efficiencies in Salaries and Wages for PCCH. Priority 1. Refer recommendation 6.2	1,070,906	267,726	803,180		Cathy Crowe	First priority, 1 Quarter only for FY22.Total PC&CH costs FY21 vs FY22, then FY23
26	Workforce Nepean Hospital	**ABM Priority for Urology**	Focused ABM efficiencies in Salaries and Wages for Nepean for Urology. Refer recommendation 6.2	217,233	-	-	217,233	Brett Williams	Priority 4. Full year effect to be seen FY24. Total Nepean Urology Specialty costs FY23 vs FY24
27	Workforce Blue Mountains	**ABM Priority for Blue Mountains Acute Activity**	Focused ABM efficiencies in Salaries and Wages for Blue Mountains Acute. Priority 2. Refer recommendation 6.2	623,603	-	311,801	311,802	Brett Williams	Priority 2. Half rear only for FY23. Total BM Hospital Acute activity costs FY22 vs FY23 and then FY24
28	Medical Imaging	**Medical Imaging vacancy management**	Targeted vacancy management resulting in FTE reduction of 1.4	130,000	60,000	70,000		Karen Arblaster	Comparison of FY21 FTE's vs FY22 then FY23 actual FTE's

29	Medical Imaging	**Reduction in Radiographer Agency usage**	Reduction of Agency usage through FTE strateby for Lithgow and Blue Mountains Hospitals	300,000	120,000	180,000		Karen Arblaster	Comparison of R'grapher Agency costs FY21 vs FY22 then FY23 nett of FTE increases.
30	Workforce District Allied Health	**Streamlining of AHP Leadership and Management**	Streamlining of management and professional leadership roles across acute and community settings	400,000	-	240,000		Karen Arblaster	Net savings of AHP management positions. Management allowances and backfill reductions. FY23 vs FY24.
31	Workforce District	**ICT Corporate FTE Correction**	Return Corporate ICT FTE to FY20 numbers (equivalent to 6 FTE's) covering ICT & Hospital Exec Services	540,000	180,000	360,000		Luke Bellman	ICT FTE numbers FY20 vs FY22. Alternative is to transfer from other Corporate Directorates
			PART 2 TOTAL	**4,244,801**	**881,726**	**2,301,981**	**808,080**		
			TOTAL COST REDUCTIONS	**18,766,136**	**7,726,171**	**9,978,961**	**808,080**		

REVENUE INITIATIVES

FRP No.	CATEGORY/ LOCATION	INITIATIVE	DESCRIPTION OF INITIATIVE	ANNUALISED TARGET	FY22 TARGET	FY23 Target	FY24 Target	Executive Owner	KPIs
32	Revenue District	**Revenue increases through Pharmacy Discounts Received**		TBA					
33	Revenue District	**Salary Packaging Revenue Increase**		1,429,320	-	-	120,000	Luke Bellman	SP shared revenue FY24 compared to FY23

34	Revenue District	**Patient Fees - Inpatient Increase**		Awaiting final data from Christine McCain				Luke Bellman	IP fee revenue FY21 vs FY22 then FY23
35	Revenue District	**Patient Fees - Outpatient Increase**		Awaiting final data from Christine McCain				Luke Bellman	IP fee revenue FY21 vs FY22 then FY23
36	Revenue District	**Commercial Revenue Increase**		TBA					
			REVENUE TOTAL	**1,429,320**	**-**	**-**	**120,000**		

Appendix/ces

NBMLHD FTE Total

Treasury Codes	FY	July	August	September	October	November	December	January	February	March	April	May	June
Medical	2019	600.7	610.5	601.1	593.1	598.3	597.8	590.0	651.1	633.2	622.5	622.8	622.0
Allied Health	2019	490.9	493.8	489.5	487.9	487.3	478.3	481.1	489.0	494.0	491.9	499.1	497.5
Nursing	2019	2,082.2	2,071.3	2,066.4	2,076.7	2,102.8	2,090.1	2,052.3	2,079.1	2,131.3	2,133.9	2,126.6	2,141.9
Corporate Services	2019	771.6	779.5	777.1	783.0	775.1	785.5	784.4	783.4	788.4	791.0	802.9	796.1
Other	2019	576.1	573.1	581.6	586.9	599.3	597.0	586.1	583.1	586.7	591.8	591.9	593.5
Award Codes Total	**2019**	**4,548.0**	**4,554.6**	**4,543.3**	**4,555.5**	**4,589.7**	**4,572.7**	**4,520.1**	**4,609.9**	**4,660.7**	**4,652.5**	**4,666.0**	**4,673.7**
Medical	2020	632.0	618.6	627.3	626.2	625.0	624.1	610.0	642.5	638.7	640.3	628.6	635.0
Allied Health	2020	499.0	501.3	505.5	510.5	514.5	507.4	500.6	518.1	508.8	514.1	523.0	526.5
Nursing	2020	2,149.3	2,152.8	2,156.6	2,161.9	2,149.6	2,163.2	2,126.8	2,149.4	2,192.5	2,138.3	2,164.2	2,194.3
Corporate Services	2020	801.6	801.8	803.2	798.7	808.8	809.1	801.3	811.7	814.1	813.6	825.7	825.9
Others	2020	600.2	603.2	609.5	615.7	618.0	616.4	619.7	618.8	618.1	622.5	627.0	628.1
Award Codes Total	**2020**	**4,706.6**	**4,701.0**	**4,725.0**	**4,737.1**	**4,740.9**	**4,746.7**	**4,682.6**	**4,766.4**	**4,799.1**	**4,758.1**	**4,799.2**	**4,841.0**
Medical	2021	643.7	641.2	646.5	649.9	646.3	647.1	624.3	689.4	653.5	661.9	667.8	663.3
Allied Health	2021	533.1	537.7	531.9	535.5	534.7	533.0	517.6	538.2	538.4	537.6	527.9	528.4
Nursing	2021	2,256.2	2,239.4	2,238.3	2,235.1	2,241.0	2,247.9	2,204.1	2,254.7	2,300.9	2,267.7	2,269.9	2,269.1
Corporate Services	2021	822.0	825.4	838.6	846.5	861.6	880.6	871.7	874.0	884.1	881.8	888.5	889.0
Others	2021	631.5	623.7	622.9	627.0	622.5	620.9	611.6	623.9	628.7	631.4	624.6	618.5
Award Codes Total	**2021**	**4,916.1**	**4,897.0**	**4,907.5**	**4,923.7**	**4,936.2**	**4,958.7**	**4,857.4**	**5,009.0**	**5,032.8**	**5,006.0**	**5,002.4**	**4,992.7**
Medical	2022	665.5	673.4										
Allied Health	2022	540.2	545.4										
Nursing	2022	2,377.9	2,325.7										
Corporate Services	2022	897.4	899.3										
Others	2022	623.5	632.3										
Award Codes Total	**2022**	**5,130.5**	**5,101.1**										