Shoalhaven Financial Recovery Plan Recommendations April 2023

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EXECUTIVE SUMMARY

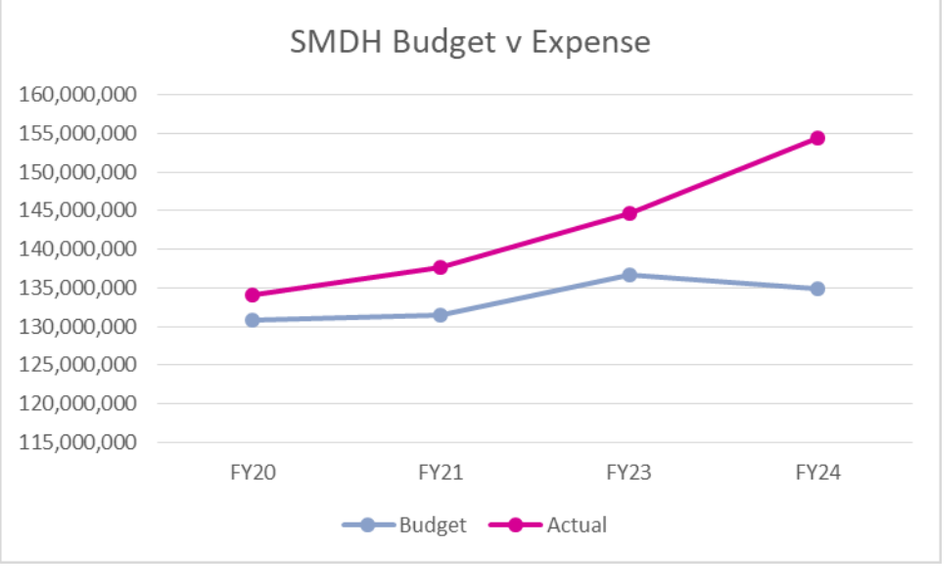
The Illawarra Shoalhaven Local Health District (ISLHD) has responsibility for health services in the Illawarra Shoalhaven region – a catchment area extending along the coastline from Helensburgh in the north to North Durras in the south with over 400,000 residents. This catchment covers four Local Government Areas (LGAs): Wollongong, Kiama, Shellharbour and Shoalhaven. ISLHD operates eight hospital sites in Coledale, Bulli, Wollongong, Port Kembla, Shellharbour, Berry, Shoalhaven and Milton Ulladulla, and community health services operating from approximately 58 locations across the region.

The ISLHD vision is to provide excellent services, quality partnerships and healthy communities. To meet this vision the key strategic priorities of the District are:

1. Excellence in models of care, health programs and health services,
2. An engaged and high performing workforce for the future,
3. Innovation, agility and learning for continuous improvement,
4. Efficient, effective, sustainable financial operations.

Like all health services, ISLHD faces cost pressures to deliver services within the funding provided. ISLHD must make choices that result in high quality care being equitably accessible across the Illawarra Shoalhaven. An emerging issue in achieving the District vision is the financial performance of the Shoalhaven District Memorial Hospital (SDMH) and Hub. SDMH is the main acute care hospital for the Shoalhaven region, providing emergency care, medical, surgical and orthopaedic services. Across the Hub (Berry, Shoalhaven and Milton Ulladulla) there is approximately 190 beds and 1,020 FTE of staff. Critically the Shoalhaven Hub is currently forecasting a $19.447M end-of-year unfavourability.

Graph 1: SDMH Budget v Expense



Note FY24 is based on a provisional forecast of $19.447M unfavourable.

A further risk to the financial sustainability is that a $438M redevelopment of SDMH is planned for 2026 and will provide a wide range of new and enhanced services. Historically, unforeseen costs can emerge with such large redevelopments and could compound the financial sustainability issue of SDMH if not adequately addressed prior.

In order to address this financial suitability issue a SDMH Financial Recovery Plan (FRP) has been developed which outlines key opportunities in governance, savings and efficiencies strategies that will assist in returning the service to a favourable budget position.

It is recommended that the Hub approach achieving an on-budget position over a three year plan. The required savings proposed for the FRP over three-years could be as follows:

Table 1: SDMH FRP Targets

Financial Year	Required Savings	Worst Case Scenario
2023/24	7.0m	12.5m UF
2024/25	7.0m	5.5m UF
2025/26	5.5m	Balanced Budget

The most significant contributor to the unfavourability has been through not insignificant unfunded FTE growth. Compounding this further has been the utilisation of FTE profiles for services which does not meet budget available, rostering inefficiencies which contribute to FTE growth, above NHPPD target results and premium labour costs and access and flow challenges.

The key driver to financial recovery will be for SDMH to return to an 'affordable' FTE profile. Affordable FTE profile is aligned to the budget allocation less required goods and services expense. Whilst this Plan, encompasses expenditure reductions across the many facets of a complex health service like SDMH, there is a clear dependence on FTE reductions, the primary contributor to the current unfavourable position, in order to reach a balanced budget in 2025/26. Note these reductions can be off-set by utilising any transition funding within the SDMH redevelopment and/or from growth funding received to off-set existing FTE.

Table 2: Affordable FTE

Financial Year	Existing FTE Profile	Estimated Affordable FTE	Required FTE Reduction Target
2023/24	1,012	976 FTE	108 FTE
2024/25	976 FTE	940 FTE	76 FTE
2025/26	940 FTE	904 FTE	36 FTE

Although the primary driver of sustainability will be salary and wage expense reduction a goods and services expense reduction target is also required. If this target is not achieved then the gap will need to be found through additional FTE reduction targets.

To ensure this Plan establishes a framework across the activities of the SDMH, strategies and reviews are planned to reduce expenditure across six (6) major headings:

1. Workforce efficiencies and reductions,
2. Non-salary expenditure efficiencies and cost savings,
3. Structural
4. Revenue efficiencies
5. ABF initiatives
6. Models of care initiatives

Review Team

Key staff of CCLHD were invited to undertake the review and share experience from implementing and efficiency program which enabled the District to recover from a $62M unfavourable position in 18-months. The CCLHD Review team comprised of:

- Jacqui Edgley – 20+ years of senior nursing operation and strategy experience across a number of NSW Health District and the UK National Health Service.
- Justin English – 17 years of senior management and leadership experience in operational and Ministry roles in NSW Health and South Australian Health.

GOVERNANCE AND LEADERSHIP

A key to the delivery of savings and efficiencies is ensuring appropriate governance is in place. A challenge for organisations and services is that the focus on other BAU activity dilutes the needed approach on delivering cash savings as frequently these discussions are incorporated into existing meetings and compete against other agenda items i.e. access and flow, clinical risk and productivity initiatives, and general finance.

Key Observation

The following key observations were made:

1. Whilst it is evident senior management are all wanting to address the financial situation there is a general lack of understanding of the approach and a lack of 'sense of urgency' to do so when hospital demand and flow issues require attention.
2. Until recently there is no dedicated resource to support the savings program. As a result the coordination, monitoring and reporting of savings is inconsistent.
3. A governance meeting group had been established to focus on recovery activities but has inconsistently met. This has contributed to the lack of urgency. The GM has since reconvened this in-line with recommendations below.
4. Ministry of Health priorities at times on access and flow have also contributed to a mixed-message on the urgency of addressing the financial pressure.
5. Financial literacy of leaders and managers is at variable levels.

Recommendations

The following recommendations are made:

1. Recovery Plan Sponsorship

Reaffirm the recovery Executive Sponsor between either the Chief Executive or the Executive Director Clinical Operations

2. Recovery Plan Lead

The General Manager SDMH should be the Recovery Plan lead.

3. Financial Recovery Committee

It is recommended that the peak committee be re-established and maintained. The purpose of this committee is to focus only on cash expense initiative development and performance:

- Chaired by the GM,
- Membership is SDMH executive and nominated senior leaders
- Meeting frequency is to be fortnightly – 1 hour duration.
- Update from recovery (savings) project manager on:
    - Verified savings v target performance
    - Number of new savings verified since last meeting
    - New issues and risks (for sustainability risk log)
- Update from members on initiatives that they are sponsoring and/or leading (including any working groups being chaired – i.e. pathology, discretionary food etc.)
- Update from service Managers/Leaders, where unfavourability is greater than 2% of budget, on what mitigations they are putting in place. As an example the following budget performance framework was used by CCLHD during recovery. A similar approach can be adopted for SDMH hub at a service or ward level.

Level	KPI (expenditure / revenue)	Description	Action (CE Discretion)
0	On Budget or favourable	Performing	Business as Usual
1	≤ 2% UF to budget	Under Performing	Review of Performance at OSP
2	≤ 4% UF to budget	Not Performing	Formal Recovery Plan to CE
3	> 4% UF to budget	Critical	Recovery Plan submitted to Board F&P

- Identification of initiatives not progressing and mitigation actions
- Committee identification of new savings concept ideas for investigation.

4. Recovery Plan Project Manager

It is recommended a dedicated resource be assigned to support the plan. Reporting weekly to the GM key functions of the role include:

- Developing, maintaining and reporting on verified savings (verified against the GL)
- Maintain a log of savings ideas/concepts which are being explored and work with the key sponsor and Finance to work this initiative up. Concepts can be worked up initially by the project manager on a simple template for the governance committee and sponsor to review (see example CCLHD Project on a Page template in appendices)
- Upon completion of a due diligence process the concept will either transition into a 'verified' savings initiative, be identified as not delivering a cash benefit and therefore not currently pursued (closed), or identified due to timing for consideration at a later date (on hold).
- Meet with executive, initiative sponsors and senior managers 1:1 once per month to update initiative progress, share savings ideas, identify issues for mitigation including lack of progress.
- Liaise with other LHDs and MoH Project Management Office (PMO) to obtain savings ideas that other services have implemented and which can be replicated.
- Provide reporting to District and MoH (i.e. PMO) on savings performance.

It is important to note that there is a risk that this position is seen as sole responsible for delivering savings. This role is a lead role in coordinating, identifying and reporting on savings. It is the responsible of all managers and Executives for delivering on savings in their areas.

5. Monthly Accountability Meetings (MAMs)

With many competing service issues which staff and managers need to discuss it is not uncommon for efficiencies and budget management to either have little time to discuss or not be addressed at all in MAMs. This can also occur if the staff member is not confident in financial literacy. It is recommended that in order to promote the sense of urgency around recovery that recovery Initiatives and/or savings and budget performance become a priority in MAM agenda's. This should commence with senior leadership down and include discussion on cost centre performance review, savings identification and achievement against the Affordable FTE target.

6. Recovery Communication Plan

Throughout stakeholder engagement it was clear that staff outside of the leadership team where not aware of the financial situation. A key to creating a strong culture and discipline around budget performance and identification of savings will be to engage all service staff. A communication plan should be developed which:

1. Informs staff of the current financial position and need to recover
2. Steps being undertaken to mitigate the financial unfavourability
3. Encourages staff to identify efficiencies and which recognises/celebrates savings identified

7. New Service Enhancements

Historically a number of service enhancements are being approved without budget being allocated. It is recommended that no further enhancements be approved unless:

- There is an identified new dedicated funding source (i.e. project grant, MoH enhancement, Commonwealth grant)
- Proposed new expense is off-set by an approved disinvestment plan
- Proposed new expense is off-set by a source of revenue/rebate that has been approved to offset operating expense
- The enhancement is in-line with the highest priorities for the organisation as deemed by the Chief Executive
- The enhancement is deemed by the Chief Executive to mitigate 'extreme' or 'high risk' as per the NSW enterprise risk management framework

8. Financial Literacy

A regular challenge in health settings is the requirement of non-finance trained managers to oversee budget performance of operational services. A health literacy program should be developed which is compulsory for all cost-centre managers and outlines how the District allocates its budget, expense v

revenue (highlighting the difficultly for revenue to off-set expense), NWAU, what FTE is, how to access reports, and undertaking variance analysis.

9. Recovery Initiative Tracking Tool

It is recommended that a tracking tool be used that details all strategies being implemented and identifies who the key sponsors are, target savings (if known) and whether these savings are recurrent or once off, key milestones and timing of savings. This tool can be used for governance committee reporting and rolling up savings into MoH efficiency roadmaps. A CCLHD tracking tool has been modified and all recommended initiatives has been included in the appendix. It is recommended that the Recovery Plan Project Manager is responsible for maintaining the tool.

10. Concept Development

A number of times many staff will have an idea for a savings efficiency but not have all details available to verify the level of savings or to implement. It is important to capture all ideas with further work done to verify if they are in fact a cash expense savings as opposed to cost avoided or productivity efficiency. It is recommended that a Project on a Page template is used to capture this information from staff by the Recovery Project Manager. The governance committee can then review and agree for further initiative work-up or place it on hold. The CCLHD Concept template is included in the appendix.

WORKFORCE EFFICIENCIES

The fundamental issue to be addressed is the unfunded growth of FTEs over multiple financial years. Whilst patient safety will always remain the priority in the decision making on position retention or otherwise, the LHD has quality data at its disposal which identifies clearly where this growth has occurred over the least three (3) years and this will be utilised to inform the decisions made in the Recovery Plan.

Key Observation

The following key observations were made:

1. An FTE profile is being used which is not aligned to the actual budget provided. Services can be managing to their FTE profile and believing they are on-budget, however, in most cases they are not. The situation is worsened when a service is above the FTE profile as this is additional expense (above budget). The budget gap to the FTE sits in central SDMH cost centre and thus not visible to the cost-centre manager(s).
2. Opportunities exist to review temporary and expiring contracts to provide FTE relief. This can be a routine approach by Leadership.
3. Opportunities exist to maximise the achievement of Nursing Hours Per Patient Day (NHPPD) daily which will result in a lower number of over-NHPPD reports and reduction in FTE expense. The NHPPD should be discussed/monitored and adjusted at the daily staffing meeting with accountability at the Executive huddles.
4. Opportunities exist to map DRGs to beds and reconfigure beds into current requirements ensuring efficient use of nursing staff on both a day to day basis and when surge is required.
5. Models of care change opportunities which could also result in lower FTE expense. See *Models of Care* section.
6. Opportunities to benchmark and review supernumerary roles (team leaders, CNCs, CNS2's, CNE's).
7. Opportunities to standardise the amount of supernumerary time new nursing/ midwives currently are allocated to reduce expense.
8. Opportunities exist to reduce the time staff are off work with a workplace injury and return to work reducing replacement costs with a standardised approach and involvement of senior management to ensure early return to work opportunities are created.
9. Service enhancement requests approved and staff recruited however no new budget is available.
10. A sense of activity surge at peak times (i.e. Easter) but no long-term low activity planning that will reduce staffing costs and maximise staff use of leave.

Recommendations

The following recommendations are made:

1. **Affordable FTE Profile**

It is imperative that SMDH work towards an affordable FTE profile. Affordable FTE is the number of FTE based on an average SDMH salary that matches the available budget. The average salary has been determined at $122,705. As FTE is reduced the affordable FTE profile will need to be revisited as some FTE will be at higher salary cost (i.e. medical, senior nursing and admin). This profile needs to be understood by all managers, monitored and met by services within the timeframe of the recovery plan.

1. Tracking against the Affordable FTE should routinely occur at the end-of-month budget performance reporting.
2. Affordable FTE KPI should form part of the MAM reporting and discussions with cost centre management.
3. A quarterly adjustment of the Affordable FTE target should be undertaken. This will take into account over achievement of savings targets and therefore reduce the Affordable FTE target or under achievement requiring an increase to the base.

2. Review of temporary and expiring contracts

A key to recovery will be returning to an affordable FTE position. A recommended approach is to regularly review all expiring contracts and temporary positions to identify opportunities to achieve FTE savings without displacing ongoing roles. Excluding medical, student and Commonwealth funded positions there is a total of 84.31 FTE of temporary contracts that are due to expire in 2023/24.

Table 3: Affordable FTE

Employee Type	Number	FTE
Administration	17	10.7
Allied Health / Pharmacy	31	20.62
Health Service Manager	4	2.05
Security / Hotel Services	6	4.89
Nursing & Midwifery	68	46.05
Total	**126**	**84.31**

3. Increase knowledge and accuracy of use of HealthRoster

Priority should be given to ensure all HealthRoster templates for rostering are within affordable FTE. Increasing rostering knowledge and compliance will deliver a reduction in overtime and other penalties (i.e. sleep days), will reduce unnecessary FTE, improve compliance with the Nursing Award and improve flow through freeing up shifts to flexibly meet high demand times or weekend requirements.

It is strongly recommended that as a priority HealthRoster upskilling commences immediately with nursing workforce NHPPD and roll-out across organisation in a planned approach including:

1. It is recommended that a dedicated resource be allocated by the District to change templates by 30 June 2023.

2. HealthRoster templates are reviewed, updated and approved to be within affordable FTE and signed off by NUM/ OM and DON, the GM and finance before mid-May.
3. That NUMs monitor additional shifts through HealthRoster reports and assign accountability.
4. That the current practice by some roster managers to be the first and second approvers in HealthRoster is required to cease immediately. This is allowing mangers to publish unbalanced rosters, e.g. Surgical ward/theatres/patient flow (examples of night's not filled and additional staff on the morning shift). Operational managers or equivalent should be the second approvers and accountable for staffing.
5. Consistent shift hours are agreed. There currently a mixture of 12- and 8-hour shifts on the wards (even 8, 10 and 12) leading to inefficiencies and increased FTE overrun. Rosters should be changed to either a 12:12 roster or an 8:8:10 roster in consultation with staff. Establishing consistent hours would prevent additional shift overlap. One example of this occurring is in ICU where staff are rostered 12-hour nights, but in some cases 8-hour days and afternoons. Eliminating this unnecessary overlap not only in the pm but from the night shift as well, would save approximately 1.84 – 3.00 FTE ($220K-360K) in ICU alone. There are other wards and departments where such rostering is occurring.
6. There is variability of capability of HealthRoster among both junior and senior managers. It would benefit the organisation financially if this was addressed. It would allow rosters to be published on time that were balanced. Accurate use of HealthRoster would allow reports to be pulled such as patient specials, study, overtime and sleep leave and supernumerary shifts and allow for the development of a consistent approach across the organisation. It would also reduce the cost of retrospective pays to the organisation ($15-$30 charge by HealthShare per shift change).
7. Increased capability and education of HealthRoster and Stafflink in the junior and senior group would assist in preventing errors and possible overpayment. For example, when a new fulltime nurse employee is on-boarded within StaffLink they are generally assigned a pay averaging 1.0 FTE pay in HealthRoster. If a shift in HealthRoster is left blank for this staff member as they have reduced hours and this reduction has not been reflected in StaffLink, they will be paid the fulltime pay. This situation is highlighted in the current Rehab Ward roster (17 April to 14 May) where four such incidents can be seen.

As this enterprise system is key to the rostering of nursing and hotel service workforce it is important for the District to allocate resources to immediately upskill Shoalhaven staff. If the District do not have these resources then urgent support should be sought from the MoH Best Rostering Team. Addressing this issue will lead to significant savings through more efficient use of resources that align to budget. A process should also be built into this initiative where compliance and support is provided at periods post the initial training in order to maximise knowledge retention. Equally important is that all approved FTE reductions are updated in both HealthRoster and StaffLink to ensure correct payments are made.

4. Additional nursing workforce opportunities

1. Ensure that nurse/ midwife staffing is in line with the allocated budget i.e. RN's are not against EEN/AIN lines etc. (average base cost in additional $37k per position without shift penalties and on-costs). Examples rehab, medical ward north.
2. Recent enhancements to Emergency Nursing, has seen 3 areas increased to over night cover, these include RAZ, Paeds and Fast Track, opportunity to reduce staffing overnight as the presentations reduce significantly from 12 MN to 0700am (reduction of 2 out of the 3 positions would save 4.42FTE and $540k). Adjustment of when the nurses in these areas commenced shift would be required to ensure roles are covered into the evening. A CNS2 0.6FTE was recently created, review function and what this position achieves. Shoalhaven ED has not increased its presentations significantly for 5 years, 2019 – 42,401 presentations 2023 on track to have 42, 766 presentations by June 30.
3. Review the role of ASET in the ED and effectiveness of preventing admissions. Consider using the rural Nurse Practitioner funding that has been identified as a Nurse Practitioner that visits Aged Care facilities and is able to treat patients within the facility to prevent transport to hospital as an alternative model.
4. Unfunded enhancements to patient flow has increased the FTE by 1.84 by providing a 10 hour overlap shift. In a hospital this size 1 person on for patient flow should be adequate, benchmarked with Ryde and Wyong Hospitals (a care coordinator is already in place to assist with discharge planning).
5. Recent enhancements to ICU Nursing have increased staffing 2 nurses per shift, 1 supernumerary and an additional RN on the floor (8.84FTE plus c1.02 FTE annual leave relief). If reduced back to previous FTE savings of $1.2M. Consideration to revisit this and not replace vacancies or sick leave.
6. The nursing staffing for the ICU is based on providing 1:1 care for 3 ventilated patients (3 nurses per shift). A review of the ventilated hours (rounding up to 24 hours) demonstrates there is opportunity to reduce staffing on a day by day basis/ or consider rostering 2 nurses on and using casuals or part time staff if a third ventilated patient is admitted to the unit.

Table 4: ICU Ventilated Hours

Month Financial Year 22/23	Percentage Occupied
June	14%
July	42%
August	31%
September	15.5%
October	28%
November	22%
December	8.6%
January	30%
February	30%
March	9.6%

7. CNC review, to ensure historical positions are still meeting the needs of the organisation and meeting their job descriptions, with opportunity to identify positions to change or be deleted. The CCLHD framework for review of CNCs is attached.
8. CNE review, look at additional CNE positions provided for New Graduates and ascertain if the New Graduates have acclimatised and affordable CNE FTE can be reverted too.
9. NM Perioperative Services has stated that the GM has requested more theatre sessions and thus an increase in FTE, decisions need to be made in regard to the surgical wait list vs returning to budget.

5. JMO ADO separations/pay-outs

This strategy aims to reduce trainee level ADO balances by rostering excessive balances of ADOs (greater than 3) and ensuring that all trainees are rostered ADOs each month. Trainees should be asked to utilise excessive ADOs first when applying for Annual Leave. Where possible JMO ADOs are scheduled and Heads of Department/Operation Managers refuse requests to cancel these, only swapped and where a trainee elects to work instead of taking a rostered ADO, without prior approval, they will not be paid. This will reduce the expense to the hospital in cashing out excess ADOs at the end of the JMOs assignment which are often paid at an overtime rate. The District paid approximately $500K in ADO pay-outs in March at JMO separation.

6. JMO unrostered overtime

Explore the implementation of rosters with staggered starts to reduce afternoon overtime. Implementation of processes to scrutinise URO for JMOs claiming in terms with staggered start times or alternative models to provide evening staffing. Implementation of a process to scrutinise URO claims for JMOs on terms with a Junior Evening Team Staffing (JETS) and a plan to support these JMOs to go home on time.

7. Voluntary redundancy program opportunities

Each year the MoH write to LHDs outlining the approval process for VR programs. Stage one of a three stage process requires LHDs to provide an indicative estimate only (often by the end of October). It is recommended that ISLHD submit one for Shoalhaven recovery. This can be for a range of positions, and average length of service etc. can be developed based on the SMDH employee StaffLink profiles. Discussions should be held with MoH Finance and Workforce to obtain special consideration and support for SMDH due to being ion recovery. Approved programs enable the site to receive MoH funds for the VRs. For example in FY22, CCLHD undertook a restructure of pharmacy services. In stage one a wide range pf pharmacy services were submitted even though no staff at that stage had been identified.

Diagram 1: Example VR Stage One submission – Estimated Only

No	FTE	Age	Years of Service	Award Classification	Annual Salary	In Lieu of Notice	> 45 yrs and/or > 5 Years Service	Severance Payment	VR Component
1	1	45	18.58	Pharmacist Group A.Gde 7.Pharmacists.Health Employees	$157,168.11	$ 12,043.53	$ 3,014.35	$ 117,559.58	**$ 132,617.46**
2	1	45	29.25	Pharmacist.Gde 5.Pharmacists.Health Employees	$132,908.73	$ 10,184.58	$ 2,549.07	$ 99,413.89	**$ 112,147.55**
3	2.53	45	17.17	Pharmacist.Gde 3.Pharmacists.Health Employees	$121,692.42	$ 9,325.09	$ 5,904.91	$ 230,291.35	**$ 245,521.35**
4	2.21	45	15.23	Pharmacist.Gde 2.Pharmacists.Health Employees	$106,709.34	$ 8,176.96	$ 4,522.97	$ 176,395.82	**$ 189,095.75**
5	1	45	6.25	Pharmacist.Gde 1.Pharmacists.Health Employees	$ 93,390.76	$ 7,156.38	$ 1,791.15	$ 33,584.13	**$ 42,531.67**
6	8.37	45	21.57	Pharmacy Tech.Gde 3.Health Employees.Health Employees	$ 76,361.42	$ 5,851.45	$ 12,258.25	$ 478,071.70	**$ 496,181.40**
7	0.83	45	20.71	Pharmacy Tech.Gde 2.Health Employees.Health Employees	$ 69,440.28	$ 5,321.09	$ 1,105.40	$ 43,110.51	**$ 49,537.00**
8	2.16	45	9.96	Pharmacy Tech.Gde 1.Health Employees.Health Employees	$ 58,950.56	$ 4,517.28	$ 2,442.14	$ 72,971.16	**$ 79,930.59**
9	3	33.8	11.25	Pharmacist.Gde 5.Pharmacists.Health Employees	$130,734.97	$ 10,018.01	$ 7,522.15	$ 253,872.57	**$ 271,412.72**
10	11.54	36.5	10.1	Pharmacist.Gde 3.Pharmacists.Health Employees	$121,472.82	$ 9,308.26	$ 26,885.24	$ 814,622.73	**$ 850,816.23**
11	12.03	33.6	7.69	Pharmacist.Gde 2.Pharmacists.Health Employees	$104,377.52	$ 7,998.28	$ 24,082.50	$ 555,583.28	**$ 587,664.06**
12	14.49	31.4	3.85	Pharmacist.Gde 1.Pharmacists.Health Employees	$ 86,096.96	$ 6,597.47	$ -	$ 276,354.89	**$ 282,952.36**
13	6.6	40.5	13.25	Pharmacy Tech.Gde 3.Health Employees.Health Employees	$ 76,556.78	$ 5,866.42	$ 9,690.73	$ 377,938.53	**$ 393,495.69**
14	2.75	25.4	3.03	Pharmacy Tech.Gde 1.Health Employees.Health Employees	$ 58,951.45	$ 4,517.35	$ -	$ 28,263.12	**$ 32,780.47**

8. Low Activity Plans

Management should use historical activity data patterns to identify periods of lower activity i.e. October school holidays and some parts of Xmas and New Year holidays. Plans should be developed in advance to ensure resourcing is reduced. This can include reducing ward bed stock in pods of four so as to still maintain services but ensure staffing is lower. Minor refurbishment of wards (i.e. painting) can also be undertaken to maximise non-use of these beds as well as providing an improved environment for patients and staff when activity returns to BAU.

NON-SALARY EXPENDITURE EFFICIENCIES AND COST SAVINGS

While the largest part of the budget savings requirement will be obtained through workforce efficiencies all opportunities for savings in non-salary areas should be undertaken. A significant challenge for the Hub is that many of the savings in this area are the responsibility of district-wide services – Procurement and ICT.

Observation

1. It was an observation that if savings are being made through these district-wide services on behalf of the Hub, they are not well understood by the Hub senior leadership and Finance teams nor identified in the General Ledger, particularly in the case of Procurement. As Procurement is the largest proportion of potential savings in goods and services, any savings and efficiencies must be reported as year-on-year expense reduction against the Hub GL. Currently cost-avoided and rebates are included in any benefit reporting which is not providing clarity of expense savings.
2. SDMH has a number of private property leases incurring significant expense.
3. Shoalhaven operates a mixed pharmacy production model where items are both compounded in-house and procured through external providers. Opportunity exist to review this approach and undertake a cost-benefit analysis similar to the approach undertaken in CCLHD to ensure the right production mix is occurring where items on urgent timeframes and/or are less expensive are made in-house and PBS revenue is maximised through external providers.

Recommendations

1. **Benefit reporting by the District Procurement Service**
   The district procurement service must prioritise reporting of year-on-year expense savings that impact the Hub general ledger (i.e. price reductions negotiated on goods and services used). This should be separate from 'cost avoided' reporting (where an items price rises but the original price is negotiated to remain the same), or rebate/revenue reporting where the latter cannot be used to offset expense.

2. **SDMH review and pursue a range of savings in:**
   - Pharmaceutical drug expenditure and the introduction of most cost-effective medicines to the hospital formulary. This includes reviewing opportunities to switch to generics and bio-similar, more rapid introduction of the NSW state-wide formulary, increasing the percentage of drugs purchased off the State contract.
   - Review of prosthetics and other clinical equipment where the numbers of items can be rationalised
   - Review and reduce discretionary food expenditure. Establish a working party and identify food expenditure reduction opportunities. The working party should include cost-centre managers and a dietician/nutritionist. The working party should review their cost centre food expenditure reports to reduce unnecessary purchases, restrict food and water purchases being made via the stationary provider, restrict any food provided to staff for meetings, review patient discretionary food options i.e. ED and recovery and limit to set items, expensive desert options. CCLHD were able to achieve savings of over $500K in this area.

- Through the introduction of the new HealthShare deliverEase project there should be realised improved stock and waste management savings. These need to be recorded and reported.
- SDMH should work with ICT to review and reduce unrequired eHealth licenses, and review and eliminate all unrequired mobile phone and SIM cards.
- Review ordering via the stationary supplier and eliminate unjustified expenses such as ICT equipment being purchased via this instead of ICT, refusal to approve expensive stationary item purchases when cheaper alternatives are available and reduce the amounts of stock ordered to ensure stock-hoarding is not occurring.
- Review of all P-Card use for appropriateness and to ensure that items are not being purchased via the P-Card which should be purchased via other agreed approaches i.e. ICT, stationary provider etc.
- Centralising fleet and looking at opportunities to reduce the number of fleet cars based on activity (each vehicle contributes approximately $20K expense per annum). The Manager Corporate Services has identified at least two vehicles which could be eliminated savings $40K per annum.

3. Reduction in pathology costs:

It is recommended that the Director Medical Services lead a review of pathology orders to reduce site ordering in line with peers. Significant work has been undertaken at Wollongong with clinicians and these learnings should be leveraged at Shoalhaven. Furthermore, the District should partner with NSW Health Pathology to review and amend rejected Medicare order claims and set up quality improvement processes to reduce the number of future rejected claims.

- Pathology ordering by clinicians. Opportunities to transfer learnings and clinical practice from Wollongong to reduce initially Liver Function and EUC test orders to within peer levels (45%) generating significant savings. Once this is completed a review of the next top 2-3 order tests should be undertaken.
- Retrospective review of reject pathology claims. Opportunity for the District to replicate CCLHD approach and work with Pathology to re-review all rejected claims in the last 22-months. As practice NSW Pathology will review all site pathology claims and reject ones they consider not eligible for Medicare rebates. As a result rejected claims mean the pathology order costs is against the ordering sites general expense. In working with NSW Pathology a review can be conducted for up to 22-months of rejected claims and for those addressed Medicare rebate will be received and will off-set expense. Prospective quality checks can be put in place to mitigate future claiming rejection. This should provide significant savings opportunity for all District sites. CCLHD recovered over $2M in expense savings through this partnership initiative. As this is a District benefit it should be led by District Finance and benefits provided on to the Hub.

4. Private Leases

SDMH currently have three property leases incurring approximately $100K per annum in lease arrangements plus fit-out and utility expenses. Opportunity to bring one or all services back into SDMH should be expedited.

5. Review of In-House Pharmacy Production

A review should be undertaken to establish a baseline of in-house production costs in comparison to maximising outsourcing where PBS revenue off-sets the cost of the drug. Like Shoalhaven, Gosford Hospital manufactures (compounding) some drugs in-house and also contracts compounded drugs from external providers. A cost-benefit revue was undertaken in 2021 identified that the mean cost per unit produced in-house is $176, whereas the mean cost per unit outsourced is $69. Taking into account revenue, the net cost per unit produced in-house is -$165 compared to every outsourced unit at a net cost of $59. As a result CCLHD set a target of increasing cytotoxic outsourcing by 15% which resulted in reduced expense (savings) of $150K and additional revenue of $180K.

STRUCTURAL TRANSITION

Whilst the reviewers were not provided a scope to review the structure of the organisation in identifying barriers to achieving efficiencies some considerations have been put forward. Such considerations are made in line with the following principles:

1. To speed up decision making and improving communication and direction,
2. Giving greater controls and accountability points,
3. Remove ambiguity, emphasising single point accountability,
4. Reduce management expenditure.

1. Consider Operation Managers reporting directly to the DoN for nursing/midwifery matters.

- This would ensure the GM has accountability for nursing workforce and activity in one senior expert role. In turn the DoN can ensure that portfolio work is evenly distributed and less barriers to balancing rosters and flexibility in reallocating staffing across services.

2. Consider a "centralised" nursing model.

It was observed there is no central point to review NHPPD and agile resource allocation. A centralised model where staffing is monitored and distributed across the organisation, would enable:

- Monitor and "own" NHPPD, daily, ensuring staffing compliance
- Ensure rosters were balanced across the facility, rosters checked and approved on time. Ensure that rosters are rostered as per rostering best practice guidelines , i.e. nights first, evening next etc., not approved until agreed shifts are covered
- Manage vacant shifts ahead of time (ideally at least a week ahead except unplanned leave), fairly and in line with NHPPD and affordable FTE
- Approve specials and companions from an agreed procedure, monitor by ward and monthly via HealthRoster reports
- Have agreed rules/time on supernumerary time for new graduates and new starters
- OT to be approved by agreed delegation. Consider Exec on call afterhours.
- Overtime with sleep leave is the last resort
- Consider transit/surge beds to be rostered by casuals and cancelled if not needed at weekends
- Consider reconfigure bed base to ensure nursing resources maximised
- Consider replacing EENs due to non-availability with AINs and New Graduates (not RN's as costs increase)
- Ensure excess sick leave is monitored in line with policy, and have a procedure to stop staff picking up overtime if have excess sick leave
- Ensure excess leave is managed

- Develop a process to ensure all cost centre managers are trained in Healthroster and in running reports to inform their business. Currently training is not provided /accessed and so capability is inconsistent across the organisation
- Review workers compensation to ensure that nurses are facilitated back to work in line with their capacity to assist in returning to work as soon as possible with support from operational managers
- Ensure CSOs working across two departments can adjust pays on any day they are at work

REVENUE EFFICIENCIES

The MoH allocates expenditure budgets (to provide healthcare services) based on the expectation that ISLHD will meet its revenue targets. One of those targets relates to own source revenue, comprising: patient fees, user charges and other revenues. The hospital will continue to aim to identify those patients with private health insurance, DVA, etc. as well as focusing on efficiency and process improvements to improve the collection of these revenue streams. While the hospital is focused on reducing budget expenditure this will not be at a risk to ensuring the District meets its revenue targets. In fact a number of strategies complement a reduction in expenditure through maximising costs that are eligible for Medicare funding (i.e. pathology, medical imaging, pharmacy, private patient activity etc.).

Strategies

In addition to the review of pharmacy manufacturing and pathology costs and claims, which would likely result in increased revenue other initiatives should be explored.

- Maximising the identification of all patients with private health insurance
- Ensure compliance in billing practices for outpatient and specialist services are occurring where eligible.
- Improve salary packaging performance.
- Consider implementing patient co-payments for medicines where eligible within NSW Health policy.

MODEL OF CARE INITIATIVES

It is recommended that SDMH consider implementing a number of model of care changes. These changes will assist in improving patient flow and provide savings efficiencies. Ultimately improving flow, benchmarking, analysing LOS and patient DRGs accompanied with workforce efficiencies already outlined will lead to lower costs of episodes of care and improved NWAU.

Observations

1. Nurse Practitioner model in ED underutilised.
2. A high number of ward-bed configurations which create risk of additional and inefficient resourcing being required
3. Opportunity for service reconfiguration based on patient mix and DRG analysis to provide optimal mix and use of resources
4. Use of ED short-stay inefficient, including not being used at all despite significant presentations.
5. Greater use of LOS and benchmarking data to review services.

Recommendations

Recommended changes include:

- Nurse Practitioners in ED, currently not assigned to Fast Track, consider assigning to Fast Track and the medical officer no longer needs to work there.
- ED short stay utilisation currently 2 nurses for 6 beds (EDSSU's "normal ratio" is 1:4). This space is underutilised due to rules of admitted beds not going there. Consider changing the rules so space fully occupied, and increased to 8 beds or reducing to 4 beds and reducing the nursing staff. Other models that could be considered are streaming low to mid risk chest pains to ESSA from ED or using some of the beds as a surgical short stay taking the pressure off the ward beds.
- Review services and models of care for opportunities for savings for consideration. For example the rehabilitation ward has a wards person who does not report to corporate and washes and dresses patients and restocks shelves essentially enhancing the nursing workforce.
- Milton- Ulladulla has recently commenced 1 day a week day- surgery, consideration could be given to moving the surgery back to Shoalhaven given the Milton – Ulladulla budget situation as efficiencies can be made by centralising.
- Milton – Ulladulla is utilizing unfunded FTE in both Nursing and Clerical positions. Review activity/ LOS to ensure increases are in line with activity. Consider having pods on the ward as currently all 25 beds are designated 6 NHPPD and there may be opportunity to have a pod of maintenance patients which is staffed to 5 NHPPD which may allow the additional staff it saves to fund the unfunded nursing FTE in the Emergency Department.
- Review outpatient clinics being conducted from rented space in the community. Consider opportunities to co-locate to save on rent and clerical costs. Examples of opportunities are the Perinatal clinic where costs increased last year despite 120 less birthing women. Or the Paediatric outpatient clinic to bring back on site to reduce costs and have clinicians on site.
- Review the bed base as a whole and the DRG's currently being admitted to adjust the bed base to meet the needs of the organisation and also to address odd-numbered ward configurations. Whilst reviewing

the bed base, it could be an opportunity to look at some of the co-location of models that has occurred, for example acute stroke, is not normally attached to rehabilitation, but managed in Acute Medical wards. Special Care Nursery is normally collocated with maternity. Look for an opportunity to create space of a cost effective surge for when activity increases. Consider staffing these models with casuals to allow for cancellation and reduce overtime.

- Review opportunities to explore reducing LOS which would reduce surge, overtime etc., benchmarking with Wyong who have similar demographics shows that there are opportunities to improve in cardiac (Wyong LOS 3.9 Shoalhaven LOS 5.1, or geriatric medicine, Wyong LOS 14 to Shoalhaven 14.7).
- Consolidate nursing home type patients on one ward (i.e. becomes a non -acute ward and reduces the nursing hours per day from 6.0 to 5.0 NHPPD).
- Reduce the NHPPD from 6 to 5 in SAGU as the patients are Geriatric Evaluation Management type and under the Award have 5 NHPPD. Consider reducing SAGU from 11 to 10 beds and increasing David Berry rehab from 17 to 18 beds to even the numbers for staffing.
- Increasing the education of clinicians in clinical documentation. Through education clinicians there should be an increased quality of clinical documentation which in turn will enable medical record coders to assess whether patients are at a higher DRG/NWAU complexity. Shoalhaven have recently commenced an initiative to improve clinical documentation.
- Explore opportunities to develop increased collaboration with Tafe to allow the training of AINs and EENs to increase to meet the needs of the organisation. Equally speaking at schools to encourage the next generation into the healthcare workforce
- Explore opportunities to promote Shoalhaven as a desirable and affordable place to live and work within nursing/ midwifery profession as nurses/ midwives can no longer afford to buy and in some cases rent in Sydney.
- Explore opportunities to fast-track virtual care models that can provide services from the District, which would otherwise be costly to provide by SDMH alone and/or can allow SDMH to disinvest in existing resources

STAKEHOLDERS CONSULTED

- Craig Hamer - General Manager
- Shanyn King – DONM
- Dr Belinda Doherty - DMS
- Angela Jones - Operations Manager Women & Children's
- Suzanne Lide - Operational Manager Medicine
- Karon Stalgis - Operational Manager/ DDON Critical care, surgical and patient flow
- Jane Carr – Corporate Service Manager
- Damien Van Rosmalen – District Director of Finance
- Kristen Ireland – Finance Manager
- Leon Healy – Management Accountant
- Mark Nichols - Injury Advisor
- Alex Elgenstetter and Craig Scrowen – NSW HealthPathology
- Stuart Emslie DONM/Operational Manager MUH
- Sarah Smith A/DDON MUH
- Amelia Burton NUM Rehabilitation Shoalhaven
- Anna Munnoch NUM Emergency Department Shoalhaven
- Beverley Thomas NUM Maternity Unit Shoalhaven
- Jennifer Rudd NUM Medical Respiratory Shoalhaven
- Luke Royston NM Perioperative Shoalhaven
- Paola Sheridan NUM ICU Shoalhaven
- Amanda NUM Paediatrics Shoalhaven
- Emma Griffiths A/NM Workforce Shoalhaven
- Mark Farrah, Chief Pharmacist
- Deborah Lorkin, JMO Unit
- Peter Shiells Chief Information Officer
- Shoalhaven Executive Meeting
- GM / PSC / Finance Operational Monthly Meeting

APPENDIX

1. Project on a Page (Concept capture)

OSP - A3 Project Plan on a Page

NSW GOVERNMENT Health

Project Name			
Project Lead		Contact	
Lead		Contact	
Executive Sponsor		Contact	

Rational and Background	
Rational/ Background	
Aim	
Objectives	•
Benefits	•

Scope	
Inclusions	
Exclusions	
Constraints	

Key Stakeholders	Who	How	When	Comment
Responsible				
Consulted				

Key Message/s	Opportunities to realise revenue and expense benefits at no risk patient care

Key Dates & Milestones / Deliverables / Outputs			
Project Start Date	Project End Date		
Milestones / Deliverables / Outputs	Who	Start Dates	Completion Dates

Overall Initiative Implementation Costs & Savings Target				
Costs	Financial Year	Revenue		Total $
Initiative Implementation Costs				
Savings				
Initiative Target Savings	FY23/24	FY24/25		
	$100,000	$100,000		
Total				

Governance and Reporting		
Structure / Meetings / Committees / Reports	Who / Chair	How often / When

Risk Identified as at *				
Major Risks	Likelihood	Consequence	Rating ⓘ	Management Strategy
	Likely	Moderate	High	•
	Possible	Major	High	•
	Possible	Major	High	•

Monitoring & Evaluation	
Monitoring and Evaluation *(Process and Impact Evaluation)*	Achievement of objectives will be determined by the following performance indicators: •
	Data capture that need to be developed/implemented for the performance indicators are: •
	effectiveness will be reviewed through: •

Approval			
Name	Position	Signature	Date
Jude Constable	Executive Director Acute		

2. Savings Tracking (Full Excel Workbook Provided)

Review REC Stream	Directorate / Division	Initiative	Executive Sponsor	Verified FY21Initiatives (excludes concepts)	Recurrent or one-off or half-half	Verified FY2 Initiative savings growth	Verified Initiative Cumm. Total	FTE reduction	Initiative Planning Status Due diligence undeway, Completed	Prrogress Status	Initiative Description	GL IMPACT One-off or pro-rata	Original Target completed or commenced GL IMPACT
Governance	Chief Executive	Determine executive sponsorship of Recovery	Margot Mains	N/A					Due Diligence Underway		Determine Recovery executive sponsorship - Chief Executive or ED Clinical Operations		
Governance	ED Clinical Operations	Develop communication plan	Marg Martin	N/A					Due Diligence Underway		Develop a communications plan - staff sessions, electronic news to ensure staff understand the financial situation. Communication plan to include updates on progress and recognition of staff initiatives. Establish communication approach to MoH and to relevant industrial bodies (i.e. HSU, ANMF)		
Governance	Chief Executive	Appoint Recovery Plan Lead	Margot Mains	N/A					Completed		The General Manager has been appointed as the Recovery Plan lead.		
Governance	General Manager	Re-Establish the Financial Recovery Committee	Craig Hamer	N/A					Completed		Re-establish a governance committee for recovery oversight. Meet fortnightly.		
Governance	General Manager	Appoint a Recovery Plan Project Manager	Craig Hamer	N/A					Completed		Project Manager commences 17 April		
Governance	General Manager	Ensure budget and savings is a key MAM item	Craig Hamer	N/A					Due Diligence Underway		Budget and savings performance must become a key discussion point in all staff MAMs		
Governance	General Manager	Increase Health Financial Literacy	Damien Van Rosmalen	N/A					Due Diligence Underway		Increase all cost centre managers financial literacy. Facilitate compulsory education plans outlining - how the District allocates its budget, expense v revenue (particularly difficult for revenue to off-set expense), NWAU, what FTE is, how to access reports, variance analysis		
Governance	General Manager	Increase HealthRoster literacy	Workforce Director	N/A					Due Diligence Underway		Implement on-site training and support of NUMs and Managers. Prioritise Nursing. Consider MoH Roster Team support. Develop refresh training schedule. Review and focus on NUMs where errors are still occurring post training.		
Governance	General Manager	Implement a recommendation/savings tracking tool	Craig Hamer								Develop and use a tool for capturing savings initiatives, monitoring performance and reporting		
Governance	General Manager	Implement a tool for capturing savings ideas/concepts	Craig Hamer								Develop and use a simple tool for capturing savings ideas which is easy for staff to use and which can then be worked-up and then assessed by the governance committee as whether to implement.		
Governance	General Manager	Implementing a budget performance matrix/KPI to focus on services with highest underperformance (include in Budget Letters)	Craig Hamer	N/A					Due Diligence Underway		Similar to CCLHD a modified performance matrix. Level 0 - no action except recognition (Performing) Level 1 <2% UF - (Under performing) Manager to present at governance committee Level 2 <4% UF (Not Performing) Manager to present to ED Clinical Ops/GM Level 3 >4% UF (Critical) Manager to present to Chief Executive		
Workforce Efficiencies	General Manager	Establish and review Affordable FTE	Craig Hamer	4,417,373	R	4,417,373	8,834,746	108.00	Completed		Reduction plan to affordable FTE level (FTE profile matches budget) FY1 36 FTE FY2 36 FTE FY3 36 FTE Achieved through restricted recruitment to vacancies, non-renewal of temporary contracts, voluntary redundancies.	Pro-rata	July

Workforce Efficiencies	General Manager	Review temporary vacancies and contract expiry reports to reduce FTE	Craig Hamer						Due Diligence Underway		Analyse the temporary contract expiry for the next 6-months and identify non-renewal positions (reducing FTE). Repeat every 3-months. Initial review identfied 84 FTE expiring during FY24.		
Workforce Efficiencies	General Manager	Establish dedicated HealthRoster support project resources	Craig Hamer						Due Diligence Underway		Obtain dedicated support and prioritise review and correction of nursing workforce roster templates and education of rostering tool users.		
Workforce Efficiencies	Director of Nursing	Standardise roster nursing shifts	Shanyn King						Due Diligence Underway		Change ward rosters (in consultation with staff) to a consistent shift pattern to either 12:12 or 8:8:10		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance	Shanyn King		R				Due Diligence Underway		Roster compliance with NHPPD award. Reduced sleep shift payment, reduced payroll adjustment fees. Consider central monitoring daily of NHPPD, enabling flexible compliance through reallocation of over resources to under-resourced wards.		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance Med North -25	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 25) Nursing Employment target Includes Prod FTE and AL relief = 31.24 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance Med South- 17	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 17) Nursing Employment target Includes Prod FTE and AL relief = 21.99 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster complianceSurgical-26	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 26) Nursing Employment target Includes Prod FTE and AL relief = 32.49 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster complianceRehab-12	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 12) Nursing Employment target Includes Prod FTE and AL relief = 12.49 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance Acute stroke- 4	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 4) Nursing Employment target Includes Prod FTE and AL relief = 5 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance ICU & CCU- 13 (7:6)	Shanyn King	220,000					Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 13) Nursing Employment target Includes Prod FTE and AL relief = 34.88 FTE Mix of shifts duration 8 and 12 (ICU 1.84 FTE $220K)		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance Maternity & Labour 12:4	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 12:4) Nursing Employment target Includes Prod FTE and AL relief = X FTE Birth-rate+		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance Paeds and SCN 12:6	Shanyn King						Due Diligence Underway				
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance SAGU 11	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 11) Nursing Employment target Includes Prod FTE and AL relief = 11.42 FTE (leave an additional 1 FTE in for specials) Reduce from 6.0 NHPPD to 5.0 NHPPD		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance ED - 13	Shanyn King	540,000	R				Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 13) Nursing Employment target Includes Prod FTE and AL relief = 50.39 FTE Includes 4.42 FTE reduction overnight staffing ($540K)		

Workforce Efficiencies	Director of Nursing	NHPPD roster compliance ESSA - Suggest go to 8 and incorporate Pod of MAU or SSU	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds suggest go to 8) Nursing Employment target Includes Prod FTE and AL relief = 10 FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance SSSUSD 10	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 10) Nursing Employment target Includes Prod FTE and AL relief = X FTE		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance HiTH 13	Shanyn King						Due Diligence Underway				
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance (Transit) OTSD 4	Shanyn King						Due Diligence Underway				
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance DB Pall Care 8	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 8) Nursing Employment target Includes Prod FTE and AL relief = 10 FTE Based on 6 NHPPD		
Workforce Efficiencies	Director of Nursing	NHPPD roster compliance DB Rehab 17	Shanyn King						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 17) Nursing Employment target Includes Prod FTE and AL relief = 17.73 FTE Based on 5 NHPPD		
Workforce Efficiencies	Director of Nursing	Non-NHPPD service/ward roster compliance	Shanyn King		R		0		Due Diligence Underway		non-NHPPD wards recruitable FTE profile (ICU and ED)		
Workforce Efficiencies	Operations Manager MUH	NHPPD roster compliance	Stewart Emslie						Due Diligence Underway		Department Based on bed number shown and 100% occupancy (beds 267) Nursing Employment target Includes Prod FTE and AL relief = 32.49 FTE Based on 6 NHPPD		
Workforce Efficiencies	Operations Manager MUH	Administration affordable FTE	Stewart Emslie		R				Due Diligence Underway		Reduce administration FTE back to budgeted profile		
Workforce Efficiencies	Operations Manager MUH	Overtime reduction	Stewart Emslie	160,000	R				Due Diligence Underway		With staff vacancies filled there should be a reduction in overtime. Establish a 50% reduction target. FY24 forecast is $320K overtime expense	One-off	August
Workforce Efficiencies	Manager Corporate Services	Ancillary and Hotel/Corporate service expense reduction through improved roster compliance	Jayne Carr		R				Due Diligence Underway		Health roster corporate services - PSAs, cleaners		
Workforce Efficiencies	DMS	Ensure JMO wellbeing through non-cancellation of ADOs	Belinda Doherty						Due Diligence Underway		The District paid out approximately $500K in ADOs (overtime rates) that where not taken. This is a wellbeing initiative and can be communicated to JMOs in this way.		
Workforce Efficiencies	DMS	Ensure JMO wellbeing through staggered shifts and handovers	Belinda Doherty						Due Diligence Underway		Review opportunities for staggered shifts to ensure patient handover occurs and unrostered overtime is reduced Work with HODs to ensure handover occurs and JMOs start at and finish at scheduled times.		
Workforce Efficiencies	DMS	Reduce Pharmacy Call-Backs	Belinda Doherty		R				Due Diligence Underway		Review and reduce the amount of Pharmacy call-backs on weekends and after-hours by replicating CCLHD Pharmacy approach	One-off	November

Workforce Efficiencies	All Managers	Ensure stafflink updated with staff changes from full-time to part-time			R				Due Diligence Underway		Review and update so that average fulltime salary payment is not automatically applied. This will eliminate part-time staff who were previously full-time receiving full-time pay.		
Workforce Efficiencies	Director of Nursing	Reduce supernumerary roles	Shanyn King		R				Due Diligence Underway		Reduce number of supernumerary CNEs and team leader roles. Ensure consistency and short-term use of CNEs to support graduates	One-off	September
Workforce Efficiencies	Director of Nursing	Reduction in overtime, sleep shifts and minimum breaks as a result of improved HealthRoster use	Shanyn King		R	7	7		Due Diligence Underway		As a result of improved rostering and not allowing staff who have a pattern of sick leave after overtime to have overtime, a reduction will occur in these areas and corresponding savings.	One-off	February
Workforce Efficiencies	Workforce Director	Remove Rehab Ward Wards-Person supernumerary role.							Due Diligence Underway		Wards person not reporting to Corporate Services enhancing nursing workforce duties (washing & dressing patients, re-stocking imprest). Remove role.		
Workforce Efficiencies	General Manager	Low Activity Plans (October school holidays, Xmas & New Years, Easter)	Craig Hamer		O		0		Due Diligence Underway		Planned and targeted closure of Pods (4-beds) on wards for Xmas and New Years as per last year (reduction in staffing and G&S expenses).	Pro-rata	December
Workforce Efficiencies	General Manager	Develop a VR program for supporting recovery plan	Craig Hamer						Due Diligence Underway		As part of the annual MoH VR planning process establish a Shoalhaven plan with a range of roles (excludes Medical) to provide flexibility as estimates only (Stage 1). If approved by MoH, funding is received to support from Treasury.		
NON-Workforce Efficiencies	Manager Corporate Services	Fleet rationalisation	Jayne Carr	40,000	R	0	40,000		Due Diligence Underway		Centralisation of fleet resulting in removal of two cars ($10K p.a lease & $10K pa operating costs)		
NON-Workforce Efficiencies	DMS	Reduction in order tests in line with peers adopting Wollongong approach - 20% reduction in top 4 pathology order tests	Belinda Doherty	42,209	R		42,209		Due Diligence Underway		Obtain and transfer learnings from Wollongong Hospital on approach to reduce orders to peer levels: EUC, test count 3806, 20% = $8095 Full blood count, test count 3791, 20%= $13,814 Calcium magnesium phosphate, test count 1689, 20%= $4,956 Liver function test, test count 1554, 20%= $7248	Pro-rata	July
NON-Workforce Efficiencies	DMS	V-Money Compliance Check	Belinda Doherty								Finance or Internal Audit review of V-Money compliance. Correct any irregularities through education to increase compliance and reduce unnecessary expense (i.e. through overcharging/incorrect MBS items etc.)		
NON-Workforce Efficiencies	DMS	Review Pharmacy Production costs	Belinda Doherty		R				Due Diligence Underway		Review and develop a return on investment position on pharmacy production (in-house v outsourced) in line with CCLHD approach. Opportunities to maximise PBS revenue and off-set expense. In-house production costs to include: raw materials, labour costs, infrastructure maintenance to provide true cost comparison.	One-off	November
NON-Workforce Efficiencies	General Manager	Mobile phone/sim card review	Craig Hamer		R				Due Diligence Underway		review all HUB mobile phones/SIM card plans. Confirm usage with site leads/NUMs. Cancel non-used plans/plans not used in last 6-months	Pro-rata	July
NON-Workforce Efficiencies	General Manager	Discretionary Food Expenditure Reductions	Craig Hamer		R	0	0		Due Diligence Underway		Establish a working party and identify food expenditure reduction opportunities i.e. restrict purchases via stationary provider, restrict food to staff and workshops, review patient discretionary food options i.e. ED and recovery and limit to set items.	One-off	July
NON-Workforce Efficiencies	District Director of Finance	Retrospective review of rejected Medicare pathology claims	Damien Van Rosmalen		R				Due Diligence Underway		Establish agreement and terms of reference with NSW Health Pathology to undertake retrospective claims review of all District rejected claims in last 22-months. Provide Shoalhaven with reimbursed expense funds identified within initiative.		

NON-Workforce Efficiencies	District Procurement	Spend Analysis Review	Craig Hamer		R		0		Due Diligence Underway		Identify Shoalhaven spend against on-contract; off-contract; for clinical products, prosthetics etc. that impact GL year on year spending and where to focus approach	Pro-rata	July
NON-Workforce Efficiencies	District Procurement	Cost-effective medicines FY23 Target	Craig Hamer	0	R		0		Due Diligence Underway		identified drug savings (non HealthShare accelerated savings). In-scope drug price reduction (year on year), generic and bio-similar introductions. Maximise NSW health Formulary implementation (accelerate) and compliance. Monitor outcome of CCLHD Preferred Wholesaler tender and consider implementing similar approach.	Pro-rata	July
NON-Workforce Efficiencies	District Procurement	Reduce goods and services expense and stock on hand	Jodi Chiumento						Due Diligence Underway		Opportunities to reduce stock on hand/imprest holdings (DeliverEase savings), price reductions in clinical product purchases etc.		
NON-Workforce Efficiencies	General Manager	P-Card review and Stationary Supply review	Leon Healy								Review P-Card expenses to ensure that items limited or can be procured through other processes are not being purchased (i..e ICT equipment, food etc.) Review stationary supplier requests to limit excess stock purchases or items that should be procured through a different process (i.e. ICT equipment)		
NON-Workforce Efficiencies	General Manager	Reduction in private lease arrangements	Craig Hamer		R		0		Due Diligence Underway		Review and assess opportunity to reduce private property leases. SMDH currently has $7723 in private property leases per month (92,681 per annum). Does not include additional operational expenses (IT, telecoms, cleaning, utilities etc.	Pro-rata	July
NON-Workforce Efficiencies	ED Clinical Operations	Reduction in PTS costs	Marg Martin						Due Diligence Underway		Establish a working party to review and implement strategies to reduce PTS charges: reducing cancellation fees and increase prior day bookings ($100 cheaper). Identify savings and request reimbursement from HealthShare.		
NON-Workforce Efficiencies	CIO	Reduction in ICT related expenses	Peter Shiells						Due Diligence Underway		reduction in costs for licensing and hardware		
Models of Care	Operations Manager Critical Care	Nurse Practitioner in ED	Karon Stalgis						Due Diligence Underway		Review and determine opportunity to move to Fast Track I have deleted words here. Determine transfer of medical officer resource or deletion of NP role. Review ASET model of care and consider alternate use of rural NP role funding is to adopt CCLHD approach with NP working with Residential Aged Care facilities on their premise to reduce RCF hospital transfers.		
Models of Care	Operations Manager Critical Care	ED Short stay utilisation	Karon Stalgis						Due Diligence Underway		Review and adjust procedures for use in order to maximise beds. Increase to 8 beds or reduce to 4 beds.		
Models of Care	Director of Nursing	Configure nursing type patients ward		600,000	R				Due Diligence Underway		Identify and configure one ward for nursing home type patients. Adjust NHPPD compliance from 6.0 to 5.0 NHPPDs		
Models of Care	Director of Nursing	Replace RNs which are in EN/AIN budgeted shifts		225,000	R				Due Diligence Underway		Replacing EN and AIN budgeted positions with RNs ($36-40K per role), for example Rehab ward 1.63 and Medical 4.0 FTE which is $225K additional cost Work with local TAFE to increase intake. Impact FY2 of recovery plan		
Models of Care	Director of Nursing	Review Theatre Efficiencies	Shanyn King						Due Diligence Underway		Consider consolidation of all HUB surgery into Shoalhaven to maximise efficiency. Transition out of 1-day per week surgery at Milton Ulladulla and increase efficiency of Shoalhaven theatres and infrastructure.		

Models of Care	District DON	Review CNC	District DON						Due Diligence Underway		Utilise CCLHD framework to ensure CNCs are meeting the Award Domains. Provide opportunity for those not meeting to achieve this in a 12-month period or convert to CNS. Identify CNCs costed to Shoalhaven and if not receiving benefit ensure this occurs or cease role.		
Models of Care	District DON	Review CNE	District DON		R				Due Diligence Underway		Reduce number of supernumerary CNEs and team leader roles	One-off	September
Models of Care	Director of Nursing	Reduce SAGU bed configuration	Shanyn King						Due Diligence Underway		Change from 11 to 10 beds and change to 5.0 NHPPDs (from current 6.0 NHPPDs		
Models of Care	District DON	Review and benchmark CNC Cancer Care roles	District DON						Due Diligence Underway		A comparison of CCLHD to Shoalhaven Cancer Centre services identified that CCLHD had 0 CNCs within the District service (using CNS's) to 6.0 FTE for Shoalhaven		
Models of Care	Director of Nursing	Review Outpatient Clinics	Sharyn King						Due Diligence Underway		Review opportunity to co-locate back on site, reducing property lease related expenses. Review Perinatal clinic where costs increased despite 120 less birthing women than previous year.		
Models of Care	ED Clinical Operations	Use of virtual care models	Marg Martin						Due Diligence Underway		Limited utilisation/access to District Virtual Care models. Explore accelerating adoption of these given challenge of HUB population - socioeconomic status, geography/distances from services.		
Models of Care	Director of Nursing	Review all ward bed configurations to reduce addition labour costs and inefficiencies relating to odd-bed number configurations	Shanyn King		R				Due Diligence Underway		Maximise PODs of 4 beds and reduce odd bed number configurations. Assess return on investment of additional beds above PODs of 4. Review and conduct return on investment of having odd bed numbers where this requires additional staffing to meet Award. Opportunities to reconfigure wards and staff at lower Award NHPPD i.e. MUH from 6.0 NHPPD to 5.0 NHPPD.	One-off	October
Models of Care	General Manager	Increase staff education on clinical documentation	District Coding Manager						Due Diligence Underway		Through education clinicians there should be an increased quality of clinical documentation which in turn will enable medical record coders to assess whether patients are at a higher DRG/NWAU complexity.		
Models of Care	General Manager	Increase patient type change							Due Diligence Underway		Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding.		
Models of Care	General Manager	Use DRG analysis for ward reconfigurations/models of care	Craig Hamer						Due Diligence Underway		Utilise DRG and ABF information for reconfiguring wards. For example if reconfigure a nursing-home patient ward the focus of care and resources will assist in improving the episode of care, ALOS and cost of episode.		
Models of Care	District Director of Finance	Reflect improvements in Hub expenses in NWAU costings	Damien Van Rosmalen						Due Diligence Underway		The existing high salary and wage expenses will be contributing to the cost of episode/NWAU. As the Hub returns to an affordable FTE base this reduction in salary and wages expense should reduce the average NWAU cost.		
Revenue	General Manager	Maximise use of patient private health insurance	Leon Healy						Due Diligence Underway		Work with patient liaison officers to maximise private health usage. Review and set an achievable target increase i.e. 3-5%		
Revenue	General Manager	Maximise uptake of staff salary sacrifice	Leon Healy						Due Diligence Underway		Increase revenue through salary sacrifice arrangements		
Revenue	District Director of Finance	Retrospective review of rejected Medicare pathology claims	Damien Van Rosmalen		R				Due Diligence Underway		As per NON-Workforce Efficiency initiative - this will increase Medicare revenue through addressing rejected claims.		
Revenue	DMS	Maximise PBS revenue and rebates from chemotherapy and pharmaceuticals	Mark Farrah						Due Diligence Underway		Review and undertake cost-benefit analysis of in-house production in order to maximise external provider PBS revenue		

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3. Summary of Shoalhaven Nursing/ Midwifery FTE Opportunities

Department Based on bed number shown and 100% occupancy	Total FTE Including all productive FTE, AL relief & sick/Facs/ Mand ED relief At 100% occupancy	Nursing Employment target Includes Prod FTE and AL relief	80% RN Target Vs Non RN target	Comments	Official Actual Budget	Savings (FTE)
Med North -25	32.34	31.24	25:6.24	Based on 6 NHPPD NUM/CNE not included	20.71:13.27 Total 33.98	1.64
Med South- 17	21.99	21.24	17:4.42	Based on 6 NHPPD NUM/CNE not included	13.87:8.79 Total 22.59	0.6
Surgical-26	33.63	32.49	26:6.49	Based on 6 NHPPD NUM/CNE not included	18.85:16.65 Total 35.5	1.87
Rehab-12	12.94	12.49	8.74 :3.75 Based on 70:30		8.23:7.64 Total:15.87	3.38
Acute stroke- 4	5.17	5.00	100% RN	Based on 6 NHPPD NUM/CNE not included	4.45:0.46 Total :4.91	-0.09
ICU & CCU- 13 (7:6)	36.22	34.88	Based on 7:7 12 hour shifts	Based on 3 Ventilated patients , 2 HDU and 3 CCU (see occupancy data provided in report) No NUM	35.22:0.08 Total 35.3	-0.92
Maternity & Labour 12:4	38.58			2022 Birthrate plus for all maternity direct care plus leave is 38.58 .OM stated funded for 2019 levels which is 8.15 less	39.16:0.19 Total:39.35	0.77
Paeds and SCN 12:6	22.42	21.66	Based on 4/4/4	NUM/CNE excluded There are opportunities to save staffing to occupancy	19:4.06 Total 23.06	0.6
SAGU 11	11.83 / 12.83 Kristen suggest leaving 1 FTE extra costing in for specials, and track for the first year and then review	11.42		Based on reducing from 6 NHPPD to 5 NHPPD to meet award	7.96:7.45 Total 15.41	2.58 Plus 1FTE for specials
ED - 13	48.73	47.06	Suggest majority RN workforce due to supervision issues	Based on 12-hour shifts 10 nurses in day 1 Triage 1 CIN 1 RAZ 1 Fast Track I resus I paeds 4 Acute care plus 10 hour SAS (float Nurse) and 8 nurses at night Excludes NP/ NUM3/NUM1 (16 hours a day)/ CNE	61.17:2.92 Total :64.09 58.73 with ED and ESSA combined	5.36

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ESSA- 6 Suggest go to 8 and incorporate Pod of MAU or SSU	10.35	10.00		Based on 2 x 12 hour shift day and night	Combine with above	AA
SSSUSD 10 Day Surgery	11.21 3.7	10.83 3.57		Based on 2:2:2 Clinical NUM included 3 shifts per day with staggered starts Mon- Fri	14.36:7.71 Total:22.07	?Inflated due to surge beds Possible 10FTE savings ? need Surge cost centre to track costs? Not included in savings
OTSD 4				This is unfunded. Staffed by 2 nurses 2.1FTE for 1 shift additional FTE when staffing for surge.		Need to decide whether to fund or not Not included in savings
DB Pall Care 8	10.35	10.00		Based on 6 NHPPD NUM/CNE not included	10.67:1.64 Total:12.31	1.96
DB Rehab 17	18.36	17.73	12.41:5.32 Based on 70:30	Based on 5 NHPPD NUM/CNE not included	11.05:7.4 Total 18.45	0.09
MUH ward 26	33.63	32.49	26:6.49	Based on 6 NHPPD NUM/CNE not included	20.62:14.35 Total: 34.97	1.34
Total FTE Savings						19.18 FTE Reduction $2.34 m Savings

4. CCLHD CNC Review Framework

CCLHD Clinical Nurse Consultant review

Topic	CCLHD Clinical Nurse Consultant (CNC) positions were not included in the CCLHD restructure of 2018-19. The only key change as a consequence of senior Nurse Manager changes resulted in some reporting line changes. The Nursing and Midwifery Directorate (NMD) mapped the CNC positions across the organisation and collated their activities against the CNC domains according to their grade.
Analysis	The mapping demonstrated that realignment with current service priorities would provide increased patient outcomes. The snapshot of the CNC activities demonstrated that the CNCs were not performing all the domains and a system to monitor the CNCs needs to be developed, implemented and evaluated.

Key issues

Clinical Nurse Consultants within CCLHD have been historically created. In the District wide restructure of 2018/19, the CNCs positions were not included in any nursing and midwifery workforce realignment or changes. The only key change as a consequence of a senior Nurse Manager restructure resulted in some reporting line changes. After 12 months, indirect feedback has identified some role confusion and barriers changing reporting and support roles via the previous divisional structure versus the current site service structure. The CCLHD Managers restructure is now embedded and there is an opportunity to review the current structure to ascertain if it is meeting the needs of the patient population and clinical service requirements.

Benchmarking with like organisations in 2020-21 demonstrated:-

	CCLHD	NBMLHD	ISLHD
CNCs	83.91	75.84	115.22
CMCs	3.78	4.93	2.83
CNEs	58.17	48.16	47.36

The Nursing and Midwifery Directorate undertook a mapping exercise to ascertain an overview of the 80 FTE CNCs in the District, what departments and services they worked within and who reported to whom.

The CNCs were requested to provide a snapshot of their activities against the CNC domains for their CNC level over the month of November 2020. This was then collated onto spread sheets and can be filtered by department to provide feedback to the CNC managers. This was the CNCs self-reporting against the domains, there was no evidence provided, nor was it checked by their manager.

The following was highlighted:-

- The mapping of the CNCs across the district demonstrated there were efficiencies to be made by realigning some CNC roles to the north or south end. For example there are four CNCs in aged care and all four travel to all four facilities in the CCLHD. Reporting lines could also be realigned with the example that in Gosford Medicine, three CNCs report to the Operational Nurse Manager (ONM) compared with Wyong's Medicine

ONM that has 6 CNCs reporting to that position. These discussions and decisions should be referred to local site management. Professional nursing advice from the NMD can be provided.

- The CNC1's (19) employed across the CCLHD are not meeting the Research domain or the Clinical Services Planning and Management domain.
- The CNC2's (53) over 90% are not meeting the Research Domain and 79% did not meet the Clinical Services Planning and Management domain.
- The CNCs (6) only 1 person (16%) met the research domain.

Recommendations

1. A monthly template is developed based on the CNC domains and a process implemented so all CNCs meet with their line manager with the completed template to ensure staff are working to their job description.
2. Twice a year a list of achievements against the domains is set to the District Director of Nursing & Midwifery endorsed by the CNCs line manager.
3. Online education is developed and placed on the online learning platform that assists nursing in developing research and strategic planning skills.
4. The District Director of Nursing & Midwifery use the collated information to meet with the directorate leads and realign the CNCs across the District in an equitable manner to meet service delivery needs.

Contact and approval

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