Version Final

Mid North Coast LHD Review November 2023

Matthew Daly
Deputy Secretary
System Sustainability and Performance

Justin English
A/Director
System Performance Support

Jacquie Edgley
Senior Manager
Northern Sydney LHD

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Executive Summary

Mid North Coast Local Health District (MNCLHD) extends from the Port Macquarie Hastings Local Government Area in the south to Coffs Harbour Local Government Area in the north and provides healthcare services across a geographic area of approximately 11,335 square kilometres. Services are provided through 7 hospitals and 12 community health centres and other facilities. The district employs over 4,000FTE staff.

The MNCLHD key strategic focus areas of the District are:

1. Informed, engaged, empowered, community.
2. Positive and personalised care experiences.
3. Strong prevention and early intervention.
4. Partnering, collaboration, communication.
5. Streamlined processes that support safety and best practice.
6. Research, health intelligence, strategic management.
7. People, culture and capability.
8. Resource stewardship.

Like all health services, MNCLHD faces cost pressures to deliver services within the funding provided. The LHD must make choices that result in high quality care being equitably accessible across the district. An emerging issue in achieving the District's strategic objectives is the delivery of an end-of-year unfavourable financial performance (UF) in 2022/23 of $37.8m against a budget of $837.3m. This result included one-off $8.9M HCA and $1.1M PH funds and a one-off $4.0M revenue budget reduction. Prior to this result it is acknowledged that the LHD has consistently delivered an on-budget position.

Table 1: MNCLHD FY23 Result & MoH Budget Support

MNCLHD	FY23		MoH Budget Support
	$M	% Var to Budget	$M
Expenditure	(30.5)	-3.6%	$8.9M HCA one off $1.1M Public Health funding one-off
Own Source Revenue	(7.3)	-9.0%	$4.0M revenue budget reduction one-off
Net Cost of Service	(37.8)		

Of concern is that the unfavourable budget performance continues unabated in this new financial year, despite current efforts by District leadership to mitigate, including significantly increasing their targeted savings program from $2.2m delivered in FY23 to a current target of $21.584m in FY24. As at the end of October 2024, the District is forecasting an end-of-year position of $33.6m (UF).

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It is recognised that the LHD has historically delivered on-budget results and has faced challenges associated with a number of natural disasters with a resulting impact of locum and significant agency costs. However, contributing to this position has been a growth in FTE which has outpaced the increase in funded activity.

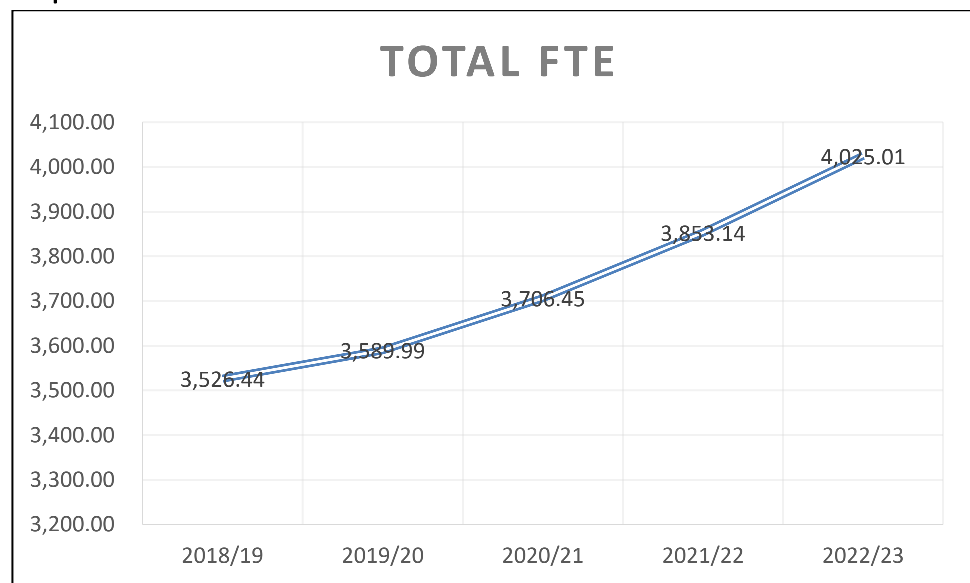
In order to assist the District return to financial suitability a review was undertaken by Ministry of Health System Sustainability and Performance Division in partnership. As a result, a number of recommendations are provided in the areas of:

1. Governance and Leadership
2. Workforce Efficiencies
3. Quality Improvements and Model of Care Initiatives
4. Non-workforce Efficiencies

FTE Growth

The review analysed FTE data provided by the LHD from over a 5-year period from FY19 to FY23. Covid, Commonwealth and own-source-revenue funded FTE was omitted from the data set. During the financial years analysed the LHD grew from 3,526 FTE in FY19 to 4,025 FTE in FY23, a total of 499.58 FTE (14.14% growth). FTE growth has occurred through NWAU funding, Coffs Redevelopment, dedicated funded initiatives such as NHPPD and Workforce Resilience funding as well as through internal CE approved enhancements.

Graph 1: Growth in FTE



	2018/19	2019/20	2020/21	2021/22	2022/23
Total FTE	3,526.44	3,589.99	3,706.45	3,853.14	4,025.01

Source: MNCLHD

Significant growth was experienced in major staffing categories as follows:

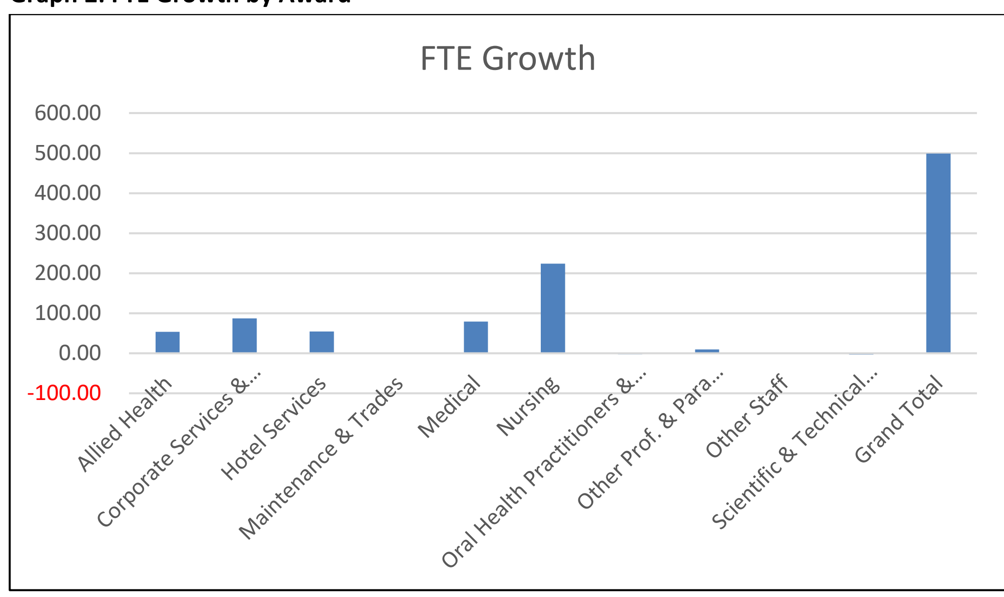
- Nursing & Midwifery – 222 FTE (12.1% growth)
- Corporate and Hospital Support – 96 FTE (15.4%)
- Medical – 78 FTE (22.9% growth)

Table 3: Growth in FTE by Staff Award

Staff Award	19/20	20/21	21/22	22/23	23/24	Since FY20 FTE	%
Medical	340	358	375	397	418	78	22.9%
Nursing	1836	1926	2024	2042	2058	222	12.1%
Corporate/Hospital Support	622	655	7087	715	718	96	15.4%
Hotel Services	259	279	295	304	302	43	16.6%
Allied Health	316	341	351	373	388	72	22.8%

Source: MNCLHD

Graph 2: FTE Growth by Award



Source: MNCLHD

Of the FTE growth, 65% is accounted for within Coffs and Port Macquarie Base Hospitals. Outside of these two major services larger FTE growth was experienced in Mental Health, Kempsey Hospital and Allied Health and Integrated Care services. Of the LHDs district-wide directorates most FTE growth was experienced in People and Culture Directorate (13.98 FTE or 33%), Public Health ((9.79 TFE or 34.9%) and the Nursing and Midwifery Directorate (6.31 FTE or 38.5%).

Table 4: Growth in FTE by Major Facility/Service

Service/Facility	FY19	FY23	FTE Growth	% Growth
Coffs Harbour Base Hospital	903.82	1,072.07	168.25	18.6%
Port Base Hospital	792.69	948.73	156.04	19.7%
Mental Health	275.30	309.42	34.12	34.12%
Kempsey Hospital	215.43	249.01	33.58	15.6%
Allied Health & Integrated Care	67.95	100.93	32.97	48.5%

Source: MNCLHD

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Activity Growth

A key source of LHD funding is through NWAU activity funding. It should be recognised that the LHD activity peaked at a high of 130.8K NWAU in FY21 during Covid years followed by a decline in FY22. However, a significant uplift in NWAU in FY23 (5.4% year-on-year growth and 6,638 NWAU) has resulted in MNCLHD experiencing an overall 2.7% growth in activity since the baseline FY18.

Acute Admitted activity mirrors the NWAU trend with an overall small growth experienced since FY18 of 1.5%.

Non-admitted activity experienced a growth of 19.8% between FY19 and FY22 before a 21% decline in FY23. ED presentations within the LHD demonstrated an overall 7.8% increase since FY19.

Graph 3: Total NWAU Activity FY19 to FY23

Total

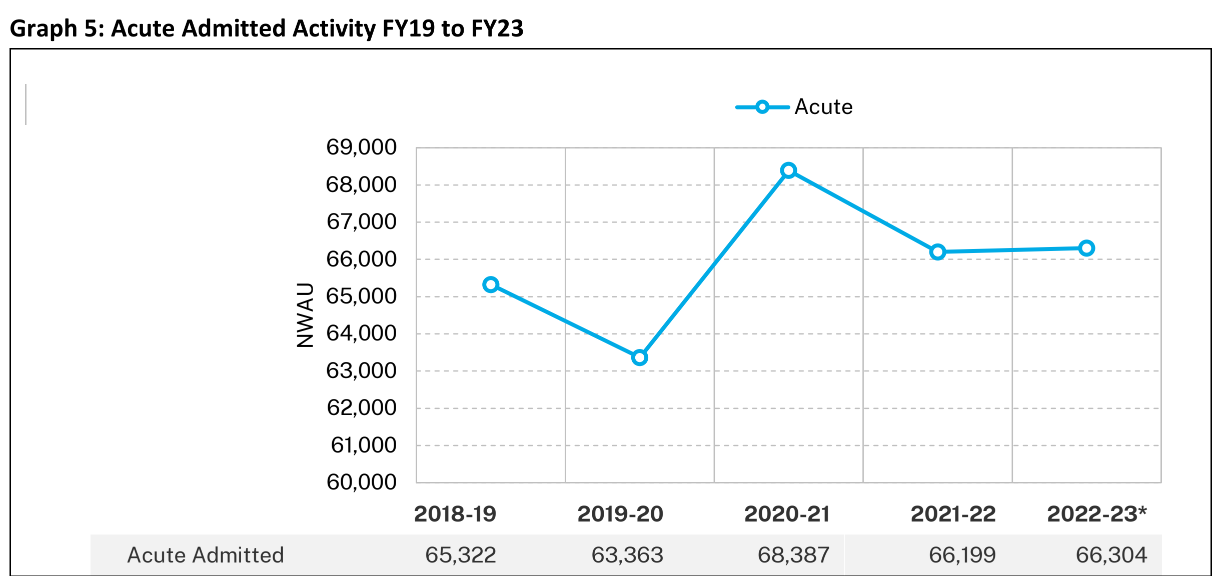
NWAU

132,000
130,000
128,000
126,000
124,000
122,000
120,000

	2018-19	2019-20	2020-21	2021-22	2022-23*
Total NWAU	126,973	125,773	130,892	123,714	130,352

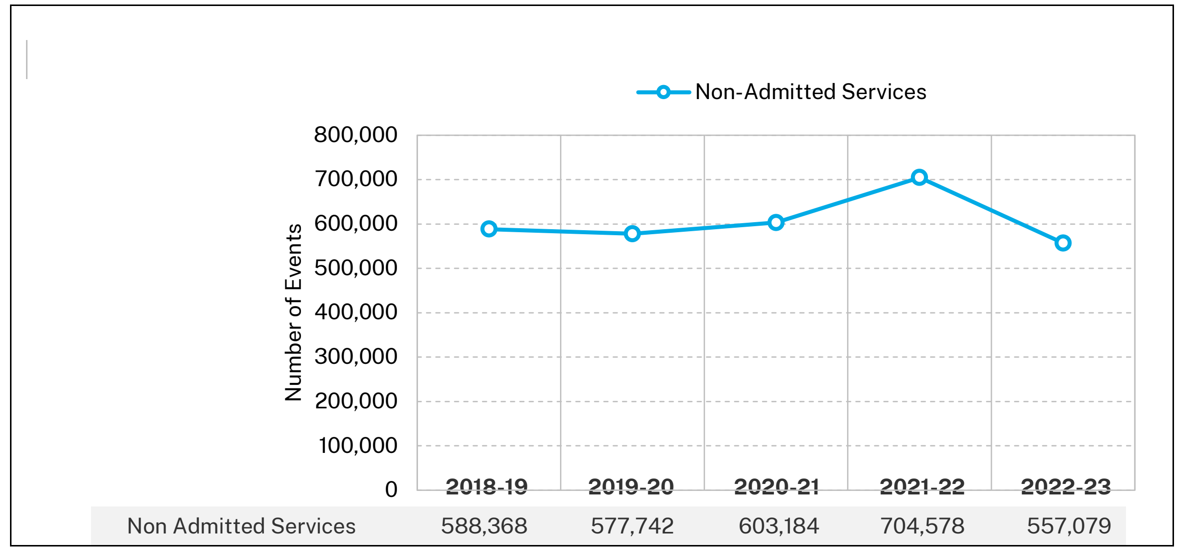
Source: MoH SIA

Graph 5: Acute Admitted Activity FY19 to FY23



Source: MoH SIA

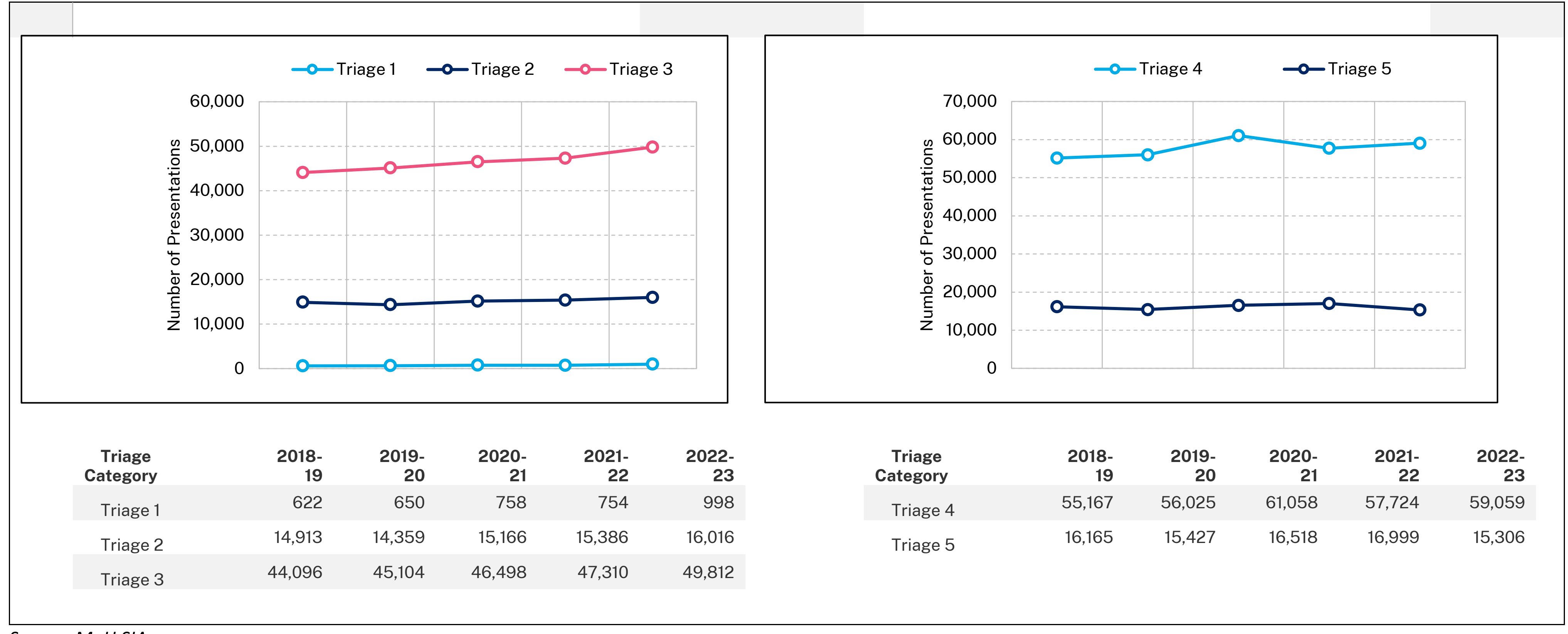
Graph 6: Non-Admitted Activity FY19 to FY23



	2018-19	2019-20	2020-21	2021-22	2022-23
Non Admitted Services	588,368	577,742	603,184	704,578	557,079

Source: MoH SIA

Graph 7: MNCLHD ED Presentations FY19 to FY23



Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 1	622	650	758	754	998
Triage 2	14,913	14,359	15,166	15,386	16,016
Triage 3	44,096	45,104	46,498	47,310	49,812

Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 4	55,167	56,025	61,058	57,724	59,059
Triage 5	16,165	15,427	16,518	16,999	15,306

Source: MoH SIA

FTE Realignment to Outputs

Over the last five financial years FTE growth has out-paced activity. It is therefore recommended that MNCLHD achieve a conservative reduction of 160 FTE over a time-period negotiated directly with the NSW Health Chief Finance Officer. This reduction will enable the LHD to return to an on-budget position and an 'affordable' FTE profile. Returning to this level will provide approximately $19.854m in expense relief, the equivalent of a 2.4% reduction of the LHDs total expense budget, based on an average salary of $120,000. These FTE reductions will be achieved through implementing the recommendations in this review report particularly those focused on NHPPD, nursing specials, supernumerary nursing. Failure to realise benefits from the LHDs FY24 Efficiency Improvement Plan and planned strategy to reduce reliance on nursing and medical agency staff and locums will require additional FTE to this recovery target in order to bridge the gap. If the LHD chooses not to implement the recommended strategies, then alternate ones must be implemented that achieve the same result.

Table 2: Affordable FTE

Existing FTE Profile	Required FTE Reduction Target	End of recovery Plan Affordable FTE
4,025 FTE	160 FTE	3,865 FTE

Table 3: Strategy by FTE Reduction and Targeted Savings

Strategy	Estimated FTE Reduction	Target Savings
Managing NHPPD to Award	34.4	$3,598,824
Improving Specials Policy Compliance	12.65	$1,337,573
Return to Peer Senior Management (HSMs)	50	$6,250,536
Health Roster Improvement	9.46	$845,896
Return to Peer Supernumerary Nursing - CNCs	12	$1,585,917
Return to Peer Supernumerary Nursing - CNEs	8	$849,008
Low Activity Plans	3.78	$400,000
Affordable FTE Reprofile of non-NHPPD wards and all District Services	30	$3,586,472
Additional RMR reduction	0	$500,000
Pharmaceutical Rebate Revenue	0	$900,000
Total	**160.29**	**$19,854,226**

Increasing NWAU Reporting

The LHD should undertake audit and education activities to improve NWAU coding. Increasing complexity reporting would enable MNCLHD and the State to attract further ABF funding from the Commonwealth and lead to lower cost.

Efficiency Improvement Plans

There is a robust efficiency improvement plan (EIPs) process embedded across NSW Health which provides transparency of savings and benefits achieved to both the LHD executive and to MoH. A clear challenge for MNCLHD will be to deliver on the FY24 EIP program but increase the focus of the savings program on reducing employee related expenses (ERE), especially when ERE accounts for between 60-70% of an LHDs total expenditure. This challenge is further highlighted when examining the LHDs FY23 EIP program which, despite the significant budget unfavourability emerging, only delivered on $2.282m in savings. Furthermore, of this total there was no savings made against ERE.

For FY24, the District has implemented a significantly increased EIP program of work under the branding of 'Renew and Re-set'. As at November 2023, a total of $25.155m has been submitted. However, only 26.6% of this program is targeting ERE savings with 34.2% targeting goods and service expense reduction and $6.674m targeting productivity benefits which will not impact materially on the unfavourable budget position. There is currently only one revenue EIPs, focused on Private Patient Identification and Conversion, although during the review visit it was noted that it was anticipated that approximately $900k in pharmaceutical rebates would be received by the LHD in the financial year. It is strongly recommended that these be included in the EIP program.

Table 4: MDNCLHD FY24 Efficiency Improvement Program

FY24 EIPs (12 November 2023)	# of EIPs	Sum of Planned value	%
Employee Related Expenses	18	$6,683	26.6%
VMO Payments	1	$237	0.9%
Goods & Services	11	$8,615	34.2%
Repairs, Maintenance & Renewals	1	$2,400	9.5%
Own Source Revenue	1	$546	2.2%
Productivity Category	5	$6,674	26.5%
Grand Total	**37**	**$25,155**	**100.0%**

Source: MoH Efficiency Improvement Team

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 Observations

The following key observations were made:

1. The Executive Leadership Team were aware of the financial challenge and the need to accelerate strategies to address this. However, feedback provided to the review team was that key activities focused on reducing ERE such as revisiting staffing profiles, were relatively recent commissioned activities.
2. Whilst it is evident senior management understood the LHDs financial position, most staff spoken with were unaware of the issue or its magnitude. It will be important that staff understand the situation and their role in creating a prudent culture of minimising wastage, disinvesting in areas not providing benefit, lower cost service delivery and assessing return-on-investment when considering new enhancements.
3. There is no dedicated resource to support the delivery of the efficiency and savings program. In some LHDs where significant financial recovery has been required, benefit has been derived from appointing a senior role reporting to the Chief Executive or an ELT member with authority to identify, coordinate, monitoring and report on savings. Such roles also identify other opportunities and strategies being successfully implemented in other LHDs and ensure continued focus on achieving financial sustainability. This mitigates the issue of placing this responsibility on a staff member who has already daily BAU tasks. Consideration of establishing such a role should be given which could be time-limited to the agreed recovery time-frame.

Recommendations

The following recommendations are made:

1. Executive Leadership Team

Maintain the ELT focus on the delivery of expense efficiencies and minimise wastage. In particular:

- Consider implementing a regular and specific ELT member-based meeting focused entirely on financial recovery/Re-set and Renewal. This will ensure dedicated time is focused on this objective and enable the usual ELT to maintain its BAU focus. As the LHD returns toward an on-budget position this meeting can be scaled-back and eventually dissolved. This focused 'Reset & Renewal' meeting should:
  - 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 MNCLHD 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.
- Identify and agree on conservative FTE reduction targets and/or limiting growth in cost and allocate financial efficiency outcomes across the services and facilities to be delivered and factored in to FY24 and out year projections.
- Ensure return-on-investment (ROI) is well understood on any service enhancement or FTE request and furthermore that benefits realisation is appropriately evaluated in a well understood framework.
- Monitor closely the implementation steps of EIPs to ensure they are implemented on time and that any risks are mitigated. ELT sponsors should report on progress and mitigations they have implemented to address any short-fall in targets.
- Review and identify opportunities for service disinvestment where savings can be used to meet the recovery target or off-set required enhancements.

2. Board and Finance and Performance Committee

- That the Board understand the approach and communicates support for the CE and ELT in achieving the required savings.
- The CE provide a regular update on recovery activity and achievements as part of the CE Board report.
- That the DOF provide F&P Committee with a regular report on all recovery activity.
- That services or directorates consistently not performing to budget (UF ≥4% to budget) be required to present to the Finance and Performance Board Sub-committee on their approach to mitigate their budget position.

3. Dedicated Recovery Project Officer

Consider developing a senior project officer role which is responsible for leading and supporting Executive with the recovery plan.

4. 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 (or equivalent formal meeting between the manager and their direct line supervisor). 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/re-profiled FTE profile.

5. Recovery Communication Plan

Throughout stakeholder engagement it was clear that staff outside of the leadership team were 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

6. 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 number of LHDs have implemented a similar tool. Contact the Efficiency Improvement Team MoH for options.

7. Concept Development/Capture

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, agree to not proceed or place it on hold for a later date. The CCLHD Concept template is included in the appendix.

WORKFORCE EFFICIENCIES

The fundamental issue to be addressed in order to recover to an on-budget and sustainable position is the 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 last five years and this should be utilised to inform the decisions made in the return to sustainability.

Recommendations

The following recommendations are made:

1. Affordable FTE Profile

It is imperative that MNCLHD work towards an affordable FTE profile. The DOF should identify with the ELT at a service and cost-centre level how the agreed FTE reductions will be assigned. These should be communicated to managers who are responsible for managing their services to the affordable FTE profile. The FTE target is the number of FTE based on an average LHD salary that matches the gap to the available budget. An average salary has been determined by MoH at $120,000 and the initial target for the LHD is a reduction of 160 FTE ($19,854m). Transition to Affordable FTE targets may need to occur over 12-18 months, however, this recovery timeframe must be negotiated with the NSW Health Chief Finance Officer. As strategies are implemented and employee related expense 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 some FTE lower than this average (i.e. support and admin staff). This profile needs to be understood by all managers, monitored, and met by services within the timeframe of the recovery plan. Whilst additional budget supplementation or other own source income come with obligations for additional service delivery and advancing patient outcomes that must be met, each should be looked at as an opportunity to close the gap on Affordable FTE.

2. Enhancement Approvals

A number of district officers advised of approval of new funding commitments without a clearly designated funding source. In some instances, there was a belief that funding would come from a source i.e. MoH, and the LHD moved to implement only to find that no funds were made available. As such it is recommended that a register of these expenditure commitments be developed and regularly reviewed to assess their delivery of the proposed return on investment used for justifying the expenditure approval, be that funding source identification or contributing to the Districts improved performance, e.g., ED access, patient flow, etc. Enhancements of material values must have DoF review and ideally be considered by the broader Executive. Approval of new positions must reside only with the Chief Executive.

3. 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.

4. Review of all vacant positions

The LHD should review all vacant positions and consider deleting any position which has been vacant for 6 months or more. A risk to the LHD is that if these vacant positions are subsequently recruited to, the expense associated with the salary and wages will add further to the current budget unfavourability.

5. 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 with rostering best practice 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. Once the revision of the staffing templates are completed approval of new FTE must be restricted to the Chief Executive.

Shift Force Finalisation

Currently an average of 11.6% of HealthRoster Shifts are forced finalised by the local rostering administrator, meaning that these shifts have not been approved by the relevant manager prior to them being submitted to the payroll. This allows overpays or inaccurate wages to be paid without governance.

Unfilled Demand and Additional duties

Unfilled demand is 42% and additional duties added 7.1% indicating demand templates may be inaccurate or that additional duties are being assigned and should be reviewed. Unused contracted hours – currently there are 16% of unused contracted hours, indicating that either we are not optimising the staff we have, or we have not updated stafflink to reflect staff members current hours. Updating stafflink with current hours would allow understanding of accurate vacancies and planning for same.

Publish Rosters On-time

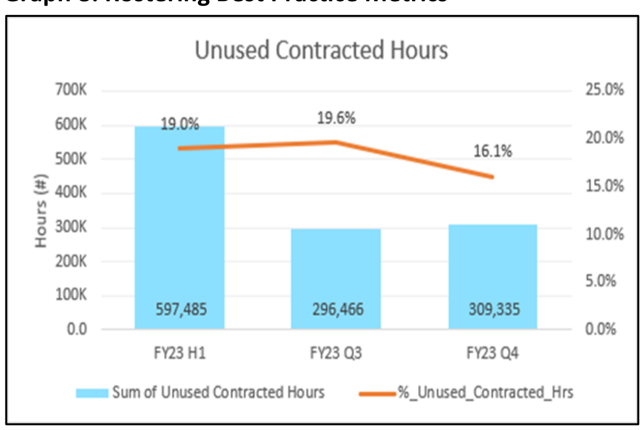
55% of rosters are not published on time. This prevents proactive planning to fill any roster vacancies ahead of time to reduce premium labour. Nurse employees are on-boarded within StaffLink and are generally assigned a pay averaging 1.0 FTE pay in HealthRoster. If a shift in HealthRoster is left blank 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. As this enterprise system is key to the rostering of nursing workforce it is important for the District to consider allocating resources to immediately upskill staff. If the District do not have these resources then urgent support should be sought from the MoH Best Rostering Team. Addressing this issue can 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. An annual plan for addressing rostering best practice should be established with support from the MoH Rostering Best Practice Unit. An annual internal audit plan should be developed for the District with input from senior executives and management to measure the success of implementation and identify gaps to address.

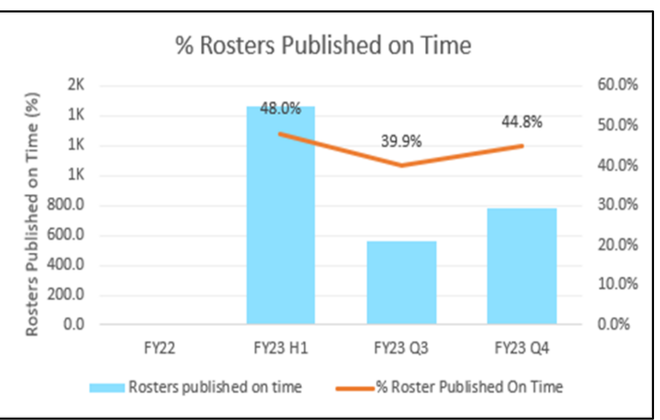
Report Generation

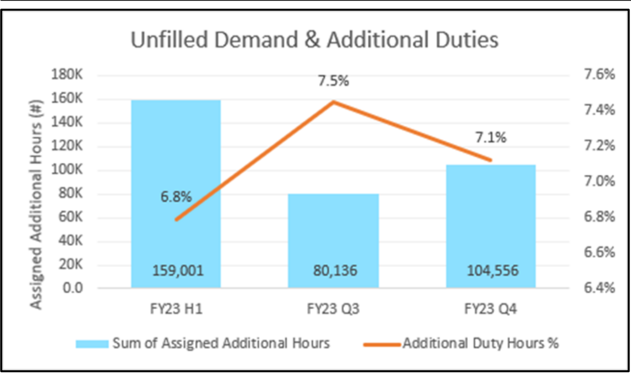
It was evident during the review that there was a lack of awareness of the report suites available in HealthRoster and how to generate/access these. As part of the strategy to increase knowledge management and Executive staff should be trained in running and accessing required reports.

Addressing the HealthRoster knowledge gaps and improving workforce demand templates would deliver an estimated 8 FTE savings ($845,896).

Graph 8: Rostering Best Practice Metrics







Source: MoH Rostering Best Practice

6. Nursing Workforce Efficiencies

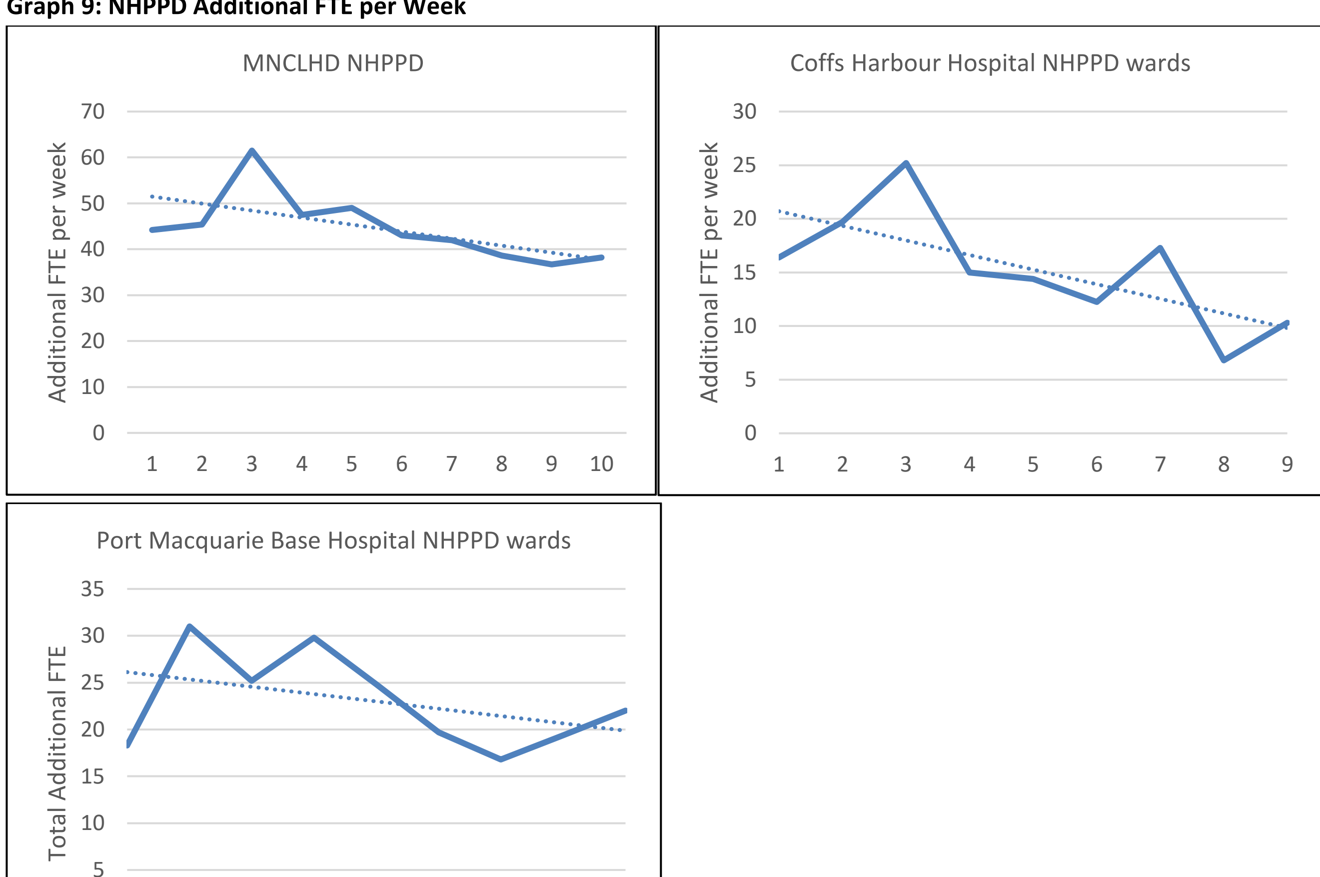
The following key observations were made:

1. The Mid North Coast Nursing FTE has increased by 17.7% since 2017/18, but activity has not increased, rather length of stay has.
2. Premium labour has increased by 40% since 2017/18 and increasing each year despite the pandemic response ceasing.
3. Sick leave in Nursing has increased by 28% since 2018/19.
4. Nursing overtime has increased by 27% since 2018/19.
5. Currently the weekly medium overstaffing for 2023-24 FY on the NHPPD wards for Coffs Harbour Hospital is 15 FTE (possible saving of $1,586055 per annum based on average cost FTE) above NHPPD and 19.4 FTE (possible savings $2,012769 per annum based on average cost FTE) for Port Macquarie Hospital.

7. Nursing Hour per Patient Day

The LHD should continue to monitor NHPPD usage and ensure that the award requirements are met but not exceeded. This monitoring needs to be daily and along with other recommendations outlined on improving HealthRoster literacy and Nursing Special policy compliance, will be integral to available savings. The NHPPD should be discussed/monitored and adjusted at the daily staffing meeting with accountability at the Executive huddles. The review team also identified that there are staff being rostered in nursing as contingent worker. This results in this FTE not be counted in the NHPPD hours or as agency. This needs to be reviewed so the LHD can ensure it is accurately meeting the award level for the ward. In addition, any workers compensation staff who are on return to duty assignment in the wards should be assessed to identify if their activities should be included in the NHPPD count, for example undertaking observations or providing patient medications.

Graph 9: NHPPD Additional FTE per Week



Source: MNCLHD

Table 5A: MNCLHD Additional hours above NHPPD FY24

Date	Additional	Under	Total additional Hours	Total Additional FTE
03.07.23- 09.07.23	1678.1	24.9	1678.1	44.2
10.07.23-16.07.23	1724.9	5.7	1724.9	45.4

17.07.23-23.07.23	2340	14.5	2340	61.5
24.07.23-30.07.23	1806.5	35.5	1806.5	47.5
31.07.23-06.08.23	1868.3	55	1868.3	49
07.08.23-13.08,23	1636.9	155.5	1636.9	43
14.08.23-20.08.23	1597.8	65.5	1597.8	42
21.08.23-27.08.23	1466.3	198	1466.3	38.6
28.08.23-03.09.23	1393.8	0	1393.8	36.7
04.09.23-10.09.23	1450.3	113	1450.3	38.2

Source: MNCLHD

Table 5B: Coffs Harbour Base Hospital Additional hours above NHPPD FY24

Date	Additional	Under	Total additional Hours	Total Additional FTE
03.07.23- 09.07.23	622.5	0	622.5	16.4
10.07.23-16.07.23	747.8	0	747.8	19.7
17.07.23-23.07.23	970.6	14.5	956.1	25.2
24.07.23- 30.07.23	606	35.5	570.5	15
31.07.23-06.08.23	601	55	546	14.4
07.08.23-13.08.23	621	155.5	465.5	12.25
14.08.23-20.08.23	724.6	65.5	659.1	17.3
21.08.23-27.08.23	457.6	198	259.6	6.8
28.08.23-03.09.23	391.2	0	391.2	10.3
04.09.23-10.09.23	381	113	268	7.1

Source: MNCLHD

Table 5C: Port Macquarie Base Hospital Additional hours above NHPPD FY24

Date	Additional	Under	Total additional Hours	Total Additional FTE
03.07.23- 09.07.23	736.8	24.9	711.9	19.4
10.07.23-16.07.23	702.7	5.7	697	18.3
17.07.23-23.07.23	1179		1179	31
24.07.23- 30.07.23	956.5		956.5	25.2
31.07.23-06.08.23	1133.1		1133.1	29.8
07.08.23-13.08.23	941.4		941.4	24.8
14.08.23-20.08.23	750		750	19.7
21.08.23-27.08.23	638.8		638.8	16.8
28.08.23-03.09.23	736		736	19.4
04.09.23-10.09.23	836.4		836.4	22

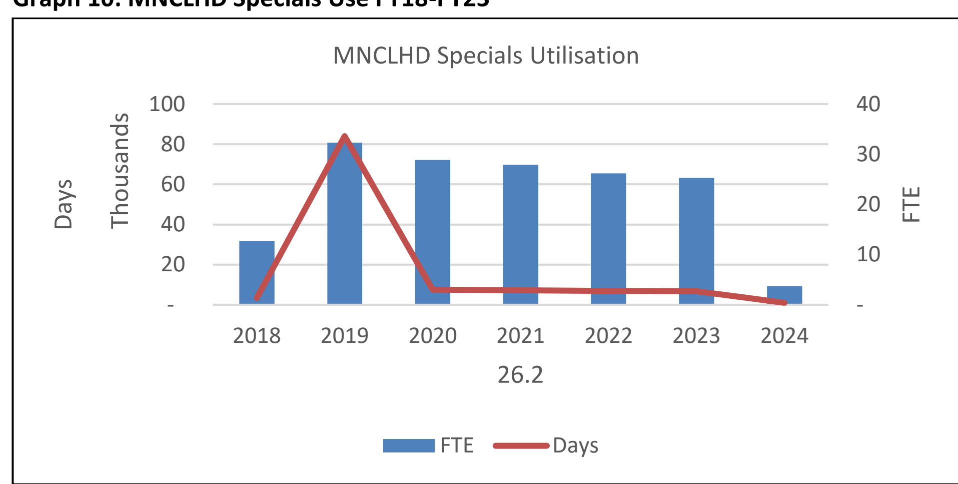
Source: MNCLHD

8. Nursing Specials

Nursing Specials have increased 99.9% since FY18, and although slightly decreased from the pandemic era, the decrease has not been substantial despite the implementation of a comprehensive procedure and the employment of a Transitional Nurse Practitioner (TNP) to assess patients. The LHD should as a priority review and update the LHDs policy on use of nursing specials and in particular the approval steps and should be well

communicated to NUMs and routinely audited for compliance. This update should include returning authorisation to the site DON level and eliminate the use of an NP FTE for this work.
Through tighter monitoring, education, and compliance with the revised policy the LHD should aim for a 50% reduction from FY23. Achieving this reduction target should provide $1.337m in savings (12.65 FTE). Note that Western NSW LHD and Far West LHD have returned to below the pre-Covid FY18 baseline and South West Sydney LHD has been able to return close to this same baseline. As the TNP is being utilised in this role a review should be undertaken of any aged care CNC (including delirium and dementia) should be undertaken now that the TNP is employed to look to reduce or eliminate roles that overlap. To assist with controlling specials (including security specials) the LHD should ensure that after-hours approval must be made by the Executive On-Call. The reduction in specials expenditure should form a routine component of the LHDs reporting on recovery at the recommended recovery governance meeting.

Graph 10: MNCLHD Specials Use FY18-FY23



Source: MNCLHD HealthRoster

9. Overseas Recruitment

It is recognised that a critical strategy to reducing nurse agency/premium labour costs is the recruitment of a large cohort of overseas Nurses and Midwives. It should be noted that it was reported to the MoH review team that the vacancy rate is currently 180 FTE and the nursing staff recruit target is 176 FTE. This would reduce nursing to virtually no vacancies and needs to be monitored to ensure that when these permanent staff are onboarded that the LHD is not further compounding over-NHPPD award FTE impacts already identified.

10. CNC Roles

The LHD should review CNC positions which have increased by 41% since 2017/18, which is higher than the State average of 33%. Although some may be attributable to TNP roles that have been funded, a review should be undertaken to ensure historical positions are still meeting the needs of the organisation and staff meeting their job descriptions, with opportunity to identify positions to change or be deleted. NP are an expensive staff resource ($135,127-$144,684.8 with no shifts/ or oncosts) and therefore in the LHD's current financial position employing NPs where their scope of practice is not fully utilised should be reconsidered.

Consideration when reviewing senior nursing roles is to utilise the CNS2 grading which allows a skilled experienced nurse to provide care, advise and policy reviews for example without having to achieve the domains of a CNC such as research, this also reduces the cost by over $15k (CNC1 to CNS2). The CCLHD framework for review of CNCs is attached and should be localised by the LHD. This includes identifying roles that needed to change from a CNC to a CNS2 so the LHD moves to regrade these roles as staff resign and not automatically recruit. The LHD should target returning toward FY19 CNC staffing levels bringing it in line with peers. A target reduction has been initially set of 12 CNC FTE which would provide $1.585m in savings.

Table 6: CNC FTE Growth since FY18 v Peers

LHD -CNCs	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FTE FY18-24	%
MNCLHD	64	66	73	76	81	85	91	27	41%
MLHD	48	49	46	48	52	60	61	13	27%
NNSWLHD	45	46	43	51	55	62	67	22	49%
SNSWLHD	43	45	46	49	50	57	53	10	24%
WNSW LHD	77	80	82	81	84	83	87	9	12%

Source: MoH SMRS

11. CNE Roles

Review CNE positions - these positions have grown 37% since 2017/18, whilst the number of New Graduate positions requested have not met the organisations expectations. The LHD should determine if the New Graduates/ overseas nurses can be supported for the first 3 months and once acclimatised the affordable CNE FTE can be reverted to which is recommended to be FY19, providing $849K in savings (8 FTE).

Table 7: CNE FTE Growth since FY18 v Peers

LHD - CNEs	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FTE FY18-24	%
MNCLHD	30	33	34	36	35	40	41	11	37%
MLHD	29	32	36	34	35	40	45	16	55%
NSWLHD	31	40	46	44	47	52	53	22	70%
SNSW LHD	21	24	23	26	27	39	43	22	105%
WNSWLHD	43	45	43	46	51	55	68	25	59%

Source: MoH SMRS

12. Additional nursing workforce opportunities

1. Ensure that nurse/ midwife staffing is in line with the allocated budget i.e. RN's are not against EN/AIN lines etc. (average base cost is an additional $37K per position without shift penalties and on-costs).
2. Models of care change opportunities which could also result in lower FTE expense. Currently there is an 84:16 % RN to non-RN workforce, there is opportunity to provide an 80:20 RN to non-RN workforce, reducing costs.

3. Ensure excess sick leave is monitored in line with policy and have a procedure to stop staff picking up overtime if they have excess sick leave. This approach will assist in reducing daily staff shortages.
4. Ensure excess leave is managed in line with policy and ADOs are taken where possible in the month accrued.
5. Consideration could be given to the large number of Nurses and Midwives recruited overseas to ensure that accommodation is available to prevent these anticipated staff finding roles elsewhere.

13. Review Health Service Management Positions/FTE

The LHD, as part of the One District Reform program, should look to reduce HSM FTE back to pre-Covid years (FY19). HSMs have grown by 55 FTE (27%) from FY18 202 FTE to a FY24 FTE of 257. Returning to FY19 level, a reduction of 50 FTE, would provide the LHD with $6.25m in savings. There has emerged across LHDs in recent years a trend of using the HSM classification instead of the professional award (i.e. pharmacy or relevant allied health). This is often because the HSM role provides greater financial renumeration even though the role requires the professional registration of the employee. The LHD should ensure any new positions requiring professional registration to not use the HSM grade and identify any similar roles where once they become vacant can be regraded to the professional award.

Table 8: HSM FTE Growth since FY18 v Peers

Grade	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FTE FY18-24	%
HSM01	44	48	45	41	43	51	58	14	32%
HSM02	62	61	60	59	60	60	64	2	3%
HSM03	51	53	58	64	68	72	78	26	51%
HSM04	31	29	33	35	37	36	37	6	19%
HSM05	12	14	15	16	17	17	19	8	66%
HSM06	2	2	2	3	3	3	2	0	0%
	202	**207**	**212**	**217**	**230**	**240**	**257**	**55**	**27%**

Source MoH SMRS

14. Other Affordable FTE Target

Outside of the Nursing and HSM targets the LHD should review all non-NHPPD staffing profiles, allied health, PSA and administration roles to identify and meet a target reduction of 30 FTE. Based on an average NSW Health FTE cost of $120k this will provide $3.5m in savings. Underachievement on other FTE targets will require higher achievement in this strategy. In addition developing a comprehensive surge bed plan will provide further affordable FTE relief.

15. Covid FTE

Discussion held during the review with senior managers indicated it was possible that some Covid related FTE was still in place i.e. Public Health and other areas. The LHD should identify these roles and as a high priority disinvest in them. Reductions in FTE and savings achieved will contribute towards the Affordable FTE target reduction.

16. JMO ADO and Overtime Management

The LHD saw the second largest increase in JMO overtime (OT) spend across the state since FY19 – an increase of 44%. Whilst this would coincide with increase locum and medical agency use as strategies implemented to reduce the reliance on this medical workforce, JMO un-rostered OT and ADO should be strictly controlled. Where possible the LHD should ensure no overlap of JMO shifts and ensure Heads of Department / Senior Medical Officers ensure that JMOs hand-over their patient work to reduce un-rostered overtime. This control also applies to ADO management. ADOs form an important part of ensuring the wellbeing of our JMOs and they should not be able to cancel scheduled ADOs. If cancelled these ADOs are paid-out with penalty rates. MoH Medical Workforce have identified that the goal state is for JMOs to have no more than 2 accruing ADOs. While the LHD is improved in this KPI compared to a number of peers, it still needs improvement and should be in line with CCLHD where the forementioned strategies have been implemented.

Table 9: JMO ADO

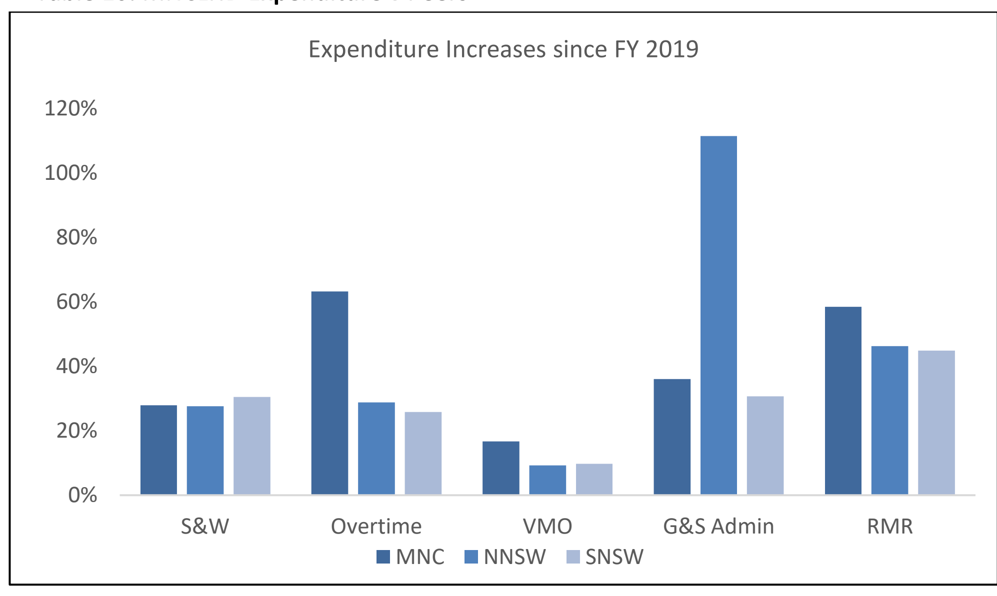
Row Labels	Sum of Sum ADO DAYS	Count	W/AVG
CCLHD	1150	560	2.053571
MLHD	715	183	3.907104
MNCLHD	877	305	2.87541
NNSWLHD	1030	363	2.839207
WNSWLHD	964	260	3.707692
SNSWLHD	94	23	4.086957

Source: MoH Medical Workforce

17. Overtime

Overtime spend has increased 63% since FY19, significantly higher than peers (29% and 26%) and is the second highest spend across all the LHDs since FY19. Nursing and medical overtime FTE are significantly higher than peers. Strategies must be implemented to ensure appropriate approval of overtime and to reduce this expense.

Table 10: MNCLHD Expenditure v Peers



Source MoH Finance

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18. 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. Whilst no VR program has yet to be approved it is recommended that MNCLHD prepare an initial submission to support recovery should a FY24 program be announced.

19. Agency Utilisation

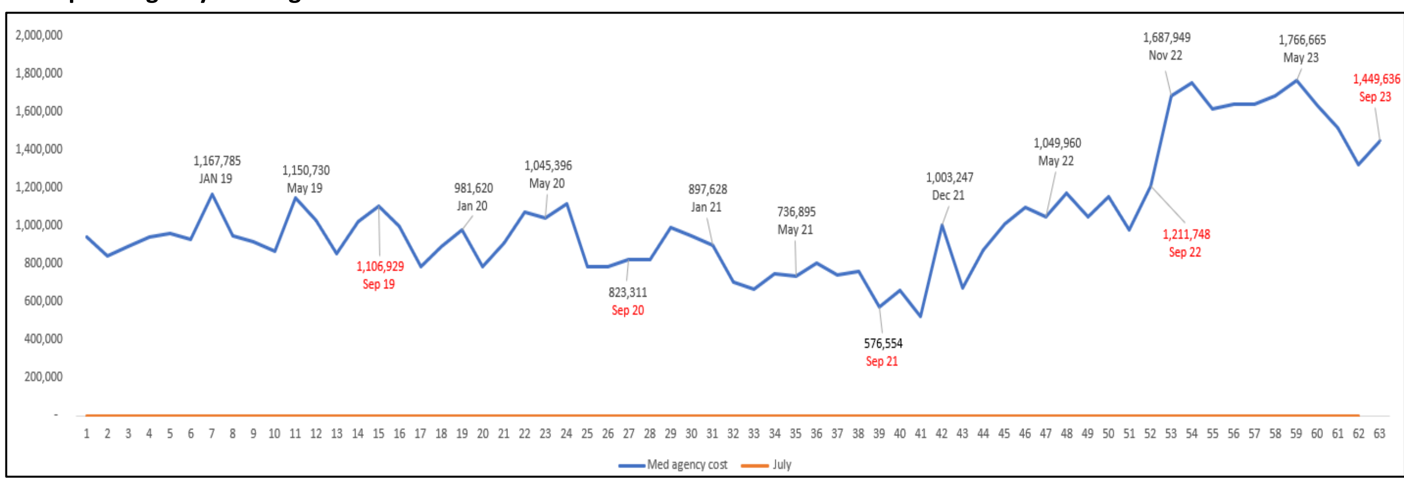
It is recognised that a significant contributor to the LHDs financial unfavourability has been the cost in the agency supply of medical and nursing workforce. The LHD has implemented a number of strategies to address this, including overseas recruitment and renegotiation of agency contract fees. Whilst these market determined costs are challenging to address, the LHD must focus on returning to sustainability in the areas of service where it has greater influence and control. However, vigilance must be maintained on monitoring, reporting and ultimately reducing the reliance on agency. Of concern is that although there is a downward trend in agency expenditure year-on-year, for the month of September reveals that expenditure was considerably higher than September FY23.

Table 10: Agency Staffing Cost

$ Millions Actual Trend Analysis	FY19 YTD	FY20 YTD	FY21 YTD	FY22 YTD	FY23 YTD
Nursing Agency costs	0.2	0.1	0.5	1.2	5.5
Med Agency Costs	2.1	2.5	1.4	1.9	3.8
Overtime	12.4	12.3	15.4	18.8	20.3
Sick leave	8.4	9	9.8	12.1	12.8
Staff Accommodation costs	1.9	1.5	1.6	2.6	3.4
Workforce Structural Costs #	**25**	**25.3**	**28.8**	**36.6**	**45.7**
Agency S&W Medical & Nursing	10.1	9.4	9.6	10.5	17.3
Total Agency Costs (Structural & S&W)	**35.1**	**34.7**	**38.4**	**47.1**	**63**
Est costs of permanent staff to replace Agency	6.2	5.84	6.89	7.49	12.45
(NET) Total Agency Costs (Structural & S&W)	**28.9**	**28.86**	**31.51**	**39.61**	**50.55**

Source: MNCLHD Finance

Graph 9: Agency Staffing Costs



Source MoH

QUALITY IMPROVEMENTS and MODEL OF CARE INITIATIVES

It is recommended that the District consider a number of model of care changes. These changes could 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.

1. Financial Literacy and Leadership Education

A regular challenge in health settings is the requirement of non-finance trained managers to oversee budget performance of operational services. A finance literacy program should be developed which is compulsory for all cost-centre managers that outlines how the District allocates its budget, expenses vs revenue (highlighting the difficulty for revenue to off-set expense), NWAU, FTE, how to access reports, and undertaking variance analysis. An outline of a similar program developed by external expertise and used to assist other LHDs during their recovery provided in the appendices as a guide.

2. Map DRGs to Beds

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. Consideration should be given to reduce the bed base to reduce length of stay and nursing premium labour.

3. Ward Consolidation of Nursing Home type patients

Feedback provided to the review team was that major facilities within the LHD had a high number of nursing home type patients utilising hospital beds. The LHD should review the number of these patient types and consider consolidating nursing home type patients onto one ward (i.e. becomes a non -acute ward and reduces the nursing hours per day from 6.0 to 5.0 NHPPD). This will not only provide staffing and savings relief as the NHPPD award requirement changes, it will provide productivity efficiencies for services (i.e. social work) who can maximise their time on the one ward and not have to track down these patients who are outliers on a number of different wards. Consolidating a 28-bed ward at one hospital would provide savings of 6.3 FTE and $637K. For a 20-bed ward this would provide a saving of 4.47 FTE and $472K.

4. Workers Compensation

The LHD has worked hard to ensure workers compensation strategies are implemented and which in turn are having a positive year-on-year impact on premiums and hindsight payments. The LHD should consider strengthening this program with successful initiatives undertaken at other LHDs including pre-employment screening assessment (identifying preferred candidates for vacancies who are at risk of injury), terminations of staff unable to return to meaningful work after 6-month in-line with legislation, separating claims and rehab management, where new injuries occur the Chief Executive calls the relevant staff's manager to understand what happened and what is being put in place to get the staff member back to work. These strategies have a long-term financial impact but also reduce the need for premium staffing coverage if an injured worker is able to return to work as quickly as possible.

5. Low Activity Plans

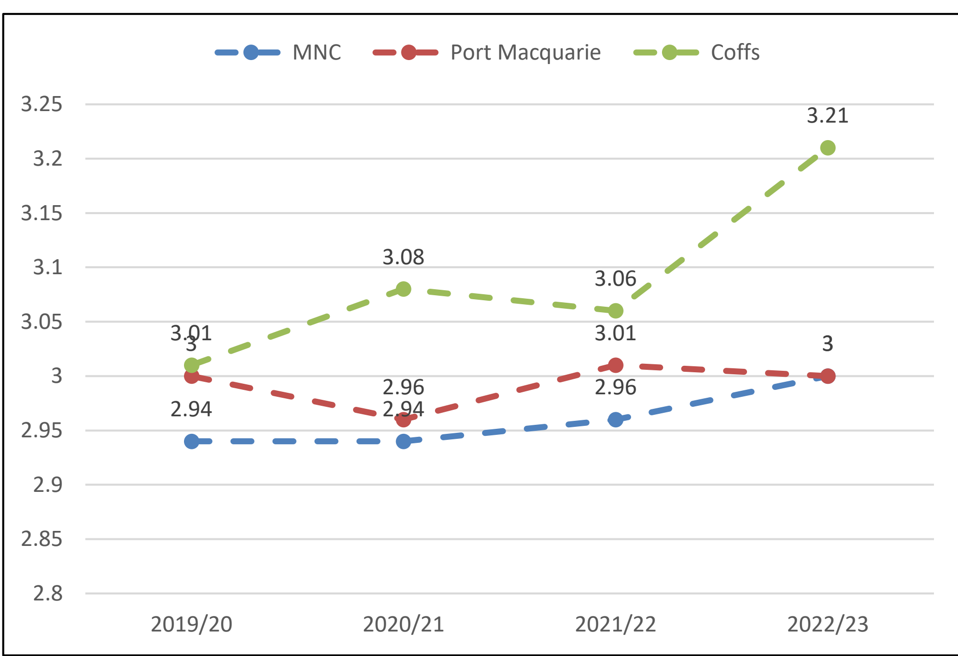
Management should use historical activity data patterns to identify periods of lower activity i.e. October school holidays and some parts of Xmas and New Year holidays. Plans should be developed in advance to ensure

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 if closing wards is not an option. 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. Opportunities include consider either closure of a single ward or pods of 4-beds across multiple wards. Wyong hospital in CCLHD has used the 4-bed reduction approach and consistently delivered approx. $300-400K per annum, whereas Gosford hospital due to its size has frequently closed entire wards. The LHD should develop a 12-month plan based on known activity and target $400K in total for the LHD (3.78 FTE).

6. Reduce Length of Stay

A review of LOS data reveals that there is some variance occurring particularly at Coffs Harbour Hospital. A program to reduce this variance to the NSW State average should be implemented. If the LHD then chose to close beds there would be an expense savings or if the beds remained open there would be a productivity benefit as well as associated goods and service (consumables) expense reductions. The projected average G&S cost per Acute Overnight Stay in MNCLHD is $342.69.

Graph 10: Overnight Acute Length Of Stay FY19 to FY23



Source MoH ABM Portal

NON-WORKFORCE EFFICIENCIES

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.

1. Revenue

There is an opportunity to work with the MoH Revenue Team and increase revenue in FY24. Increasing revenue will assist in reducing net cost of service unfavourability. This should be a focus of the LHDs Recovery Committee. There is currently only one revenue EIPs submitted by the District. Areas to address include:

- Private Health Insurance Identification rate reduced by the largest amount in the state in FY23, across the year. MNCLHD was one of only three LHDs which experienced a decline in the private health insurance (PHI) identification rate.
- The LHD has the second lowest PHI conversion rate (68.9%) in the state, state average was 74.6%. Clearly this is an opportunity for improvement.

Strategies to employ include:

- Develop a district-wide VMO out-of-pocket list and review annually
- Improve staff onboarding and training in revenue opportunities and requirements
- Increase the usage of the relevant Doctors tables in the NSW Health Revenue Portal
- Facilitate patient liaison officer interview, training and upskilling
- Review PLO structure, onboarding, and location. Ensure they are not being utilised for other administrative tasks outside of their revenue scope
- Maximise pharmacy rebate revenue received

Table 11: MNCLHD PHI Conversion and Patient Fees Revenue

PHI Conversion

Patient Fees Revenue Budget vs Actual ('m)

No Clinician Billing

KPI	FY 21_22	FY 22_23	FY 23_24 YTD
No Clinician Billing <10%	13%	7%	7%

Source: MoH Finance Revenue Team

2. Goods and Services Expenditure Benchmarking

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. MoH Finance provided a benchmark analysis of expenditure against peer LHDs. The LHD should explore opportunities to reduce expenditure to

peer levels in G&S medical and surgical supplies, drugs, prosthetics and RMR which are at higher levels than peers. While the state average increase for RMR is 32.8%, the LHD has experienced a 58.5% increase on spend since FY19, also shown below considerably higher than peers.

Table 12: Peer LHD Expenditure Analysis FY23

Key Account Categories	MLHD	MNCLHD	WNSWLHD
G&S Drugs (excl HCD)	13,149,553	19,870,974	16,649,940
G&S Med and Surg Supplies	20,502,590	34,574,358	24,975,384
G&S Prosthetics	10,014,711	16,075,585	11,735,938
G&S Admin	22,759,353	96,352,180 ^	30,923,057
G&S Other	91,750,106	80,925,384	74,705,575
Intra Health Pathology Expense	16,818,795	22,880,477	23,393,643
Intra Health Expense	296,073	375,294	1,097,805
Repairs & Maintenance	19,866,814	23,253,310	19,017,941
Private Hospital Activity Payment	7,012,753	4,884,926	1,908,262

^ Includes $74M in Nursing and Medical Agency expenses

3. VMoney Audit

The LHD should consider implementing a biennial internal audit of VMoney claims and payment system to ensure all claims are compliant with policy and Medicare.

4. Pharmacy Rebates

The LHD is about to receive for the first time pharmacy rebates from the contracted service provider for the provision of chemotherapy drugs. It is estimated that these rebates are approximately $900K per annum. It has been indicated that the District pharmacy service would like consideration of strengthening their service through the use of some of these rebates for establishing FTE. The LHD needs to carefully consider the ROI and other benefits gained from approving any such business case, in particular the ability to convert rebates to off-set operating cost given the deteriorated revenue position the LHD finds itself in. It is recommended that the LHD review the pharmacy business case options with assistance from the Director Efficiency Improvement and Support Team, who has strong pharmacy service experience.

SUMMARY of RECOMMENDATIONS

Governance	Recommendation
FTE Realignment to Outputs	MNCLHD achieve a conservative reduction of 160 FTE over an agreed recovery period negotiated with the NSW Health Chief Finance Officer.
ELT Governance	Maintain the ELT focus on the delivery of expense efficiencies and minimise wastage and monitoring and reporting on financial recovery activity and targets. Consider a dedicated meeting be held to focus on recovery activities so leadership are focused on these activities and not distracted by BAU.
Recovery Budget Performance Framework	Adopt a budget performance framework similar to the CCLHD recovery one, that is used at a service level to identify performing and under-performing services.
Board and Finance & Performance Committee	Ensure reporting on recovery plan and activity is in place.
Dedicated Recovery Project Officer	Consider establishing role.
Communication Plan	Develop and enact a plan that ensures all staff are aware of the budget performance challenges and the need to reduce expenditure and eliminate wastage.
Recovery Initiative Tracking Tool	Implement a tracking tool for monitoring and reporting purposes.
Concept/Idea capture	Develop a simple approach that captures all ideas from managers for minimising wastage and reducing expense (or maximising revenue).
Workforce Efficiencies	**Recommendation**
Affordable FTE	Establish and report on an affordable FTE profile.
Enhancement Approvals	Establish a register of enhancement approvals. Ensure all requests are regularly reviewed on ROI and have DoF approval and broader Executive review.
Temporary Contracts	Regularly review all expiring contracts and temporary positions to identify opportunities to achieve FTE savings.
Vacant Positions	Review all vacant positions and consider deleting any position which has been vacant for 6 months or more.
HealthRoster	• Priority should be given to ensure all HealthRoster demand templates for rostering are within affordable FTE and agreed upon staffing establishment/staff profile. Upon confirmation CE approval is required to alter. • Develop an annual plan for addressing rostering best practice with support from the MoH Rostering Best Practice Unit.

	• Develop an annual internal audit plan to measure the success of implementation and identify gaps to address. • Upskill and train staff in HealthRoster including awareness and use of reports.
Nursing - NHPPD	• Monitor NHPPD usage daily and ensure that the award requirements are met. • Ensure contingent worker and workers compensation staff (who are doing clinical duties) are included in the NHPPD count.
Nursing - Specials	• Expedite as a priority the review and update of the LHDs policy on use of nursing specials, including educating staff on the policy. • Returning authorisation of specials to the site DON level. • Authorisation after-hours must be made by the Executive On-Call. • Review other roles involved in specialling decision making to eliminate all duplication. • Deliver 50% reduction on nursing specials in FY24 on the baseline of expenditure in FY23. Consider a further reduction of 50% in FY25 on the base year of FY23. • Reporting specials reduction at the recommended recovery governance meeting.
Nursing - Overseas Recruitment	• Monitor vacancy FTE numbers to ensure that when these permanent staff are onboarded that the LHD is not further compounding over-NHPPD award FTE impacts already identified.
Nursing - Review of CNCs	Target returning to FY19 CNC staffing levels. Target reduction 12 FTE.
Nursing - Review of CNEs	Target returning to FY19 CNE staffing levels. Target reduction 8 FTE
Nursing - Ensure RNs not against AIN shifts	Ensure that nurse/ midwife staffing is in line with the allocated budget i.e. RN's are not against EEN/AIN lines.
Nursing - 80:20	Review and work towards achieving an 80:20 RN to EN/AIN workforce in acute facilities.
Nursing - Sick Leave	Review and ensure staff with excess sick leave are not offered overtime.
Nursing - Excess Leave	Ensure excess leave is managed in line with policy and ADOs are taken where possible in the month accrued.
Review Health Service Management Positions/FTE	As part of the One District Reform program: • Target returning to FY19 HSM staffing levels. Target reduction 50 FTE. • Ensure HSM classifications are not used where there is a professional award available. Identify any positions where there is occurring and revert back to professional award when position becomes vacant.
Other Affordable FTE Target	LHD should review all non-NHPPD staffing profiles, allied health, PSA and administration roles to identify and meet a target reduction of 30 FTE. Underachievement on other FTE targets will require higher achievement in this strategy. In addition, developing a comprehensive surge bed plan will provide further affordable FTE relief.

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Covid FTE	Identify any remaining FTE that was established as part of Covid response and/or funding and disinvest in them.
JMO ADO and Overtime	Implement recommended strategies to reduce un-rostered overtime and pay-outs of ADOs scheduled but are then cancelled.
Overtime	Review controls and ensure that all overtime is approved by a delegated authorised manager.
Voluntary Redundancy program	It is recommended that MNCLHD prepare a VR program to support recovery.
Medical and Nursing Agency Utilisation	Ensure vigilance is maintained on monitoring, reporting, and ultimately reducing agency staff use.
Quality Improvements & Model of Care Initiatives	**Recommendation**
Financial Literacy and Leadership Education	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.
Map DRGs to Beds	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.
Ward Consolidation of Nursing Home type patients	The LHD should review the number of these patient types and consider consolidating nursing home type patients onto one ward creating productivity and staffing efficiencies.
Workers Compensation	The LHD strengthen the current program of work with additional strategies that have proven successful in other LHDs.
Reduce Length of Stay	The LHD should review opportunities to reduce length of stay and closure of beds.
Pharmacy	The LHD review with the MoH EIST the ROI and other benefits gained from altering the current Oncology Pharmacy model.
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.
Reduce Length of Stay	Implement a program to reduce ALOS variance to the NSW State average.
Non-Workforce Efficiencies	**Recommendation**
Revenue	Implement, in partnership with the MoH Finance Revenue Team, a range of strategies to increase LHD revenue. These strategies and progress are to be reported at the LHDs recovery governance committee.
Goods and Services Expenditure Benchmarking	The LHD should explore opportunities to reduce expenditure to peer levels in medical G&S, prosthetics and RMR which are at higher levels than peers.
VMoney Audit	Due to the high use of locum services a biennial internal audit of VMoney claims and payment system to ensure all claims are compliant with policy and Medicare. This audit should commence in FY24.
Pharmacy Rebates	All rebates obtained should be used for revenue and not used to off-set new FTE.

STAKEHOLDERS CONSULTED

- Stewart Dowrick, Chief Executive
- Peter Treseder, Governing Board Chair MNCLHD
- Kate Vandoros, A/Director of Finance & Performance
- Jo Campbell, A/Coordinator HMCN and General Manager PMBH
- Dr Malcolm Leek, Director Medical Services PMBH
- Kirsty Mullin, State General Manager Pharmacy Services NSW
- Jill Buxton, HMCN Finance & Performance Manager
- Claire Latham, Director of Pharmacy CHHC
- Dorothy Ayers, Network Finance Manager CCN
- Tom Dickson, Deputy Chief Medical Imaging
- Stephen Cunningham, Chief Radiographer CHHC
- Jenny Chapman, Manager Allied and Community Health CCN
- Penelope Pink, Director of Nursing PMBH
- Jill Wong, Director Integrated Care Allied Health & Community Services
- Taresa Rosten, Director People and Culture
- Andrew Little, District Manager Health Safety & Wellbeing
- Emma Ttooulou, Injury Management & Recovery Service Manager
- Lydia Dennett, Coordinator Coffs Clinical Network & General Manager CHHC
- Dr Simi Sachdev, A/Director Medical Services
- Janelle Goodall, Director of Nursing CHHC
- Carolyn Heise, District Director Nursing & Midwifery Services
- Penny Jones, Director Integrated Mental Health, Alcohol and other Drug Services
- Teresa Howarth, Director Clinical Governance

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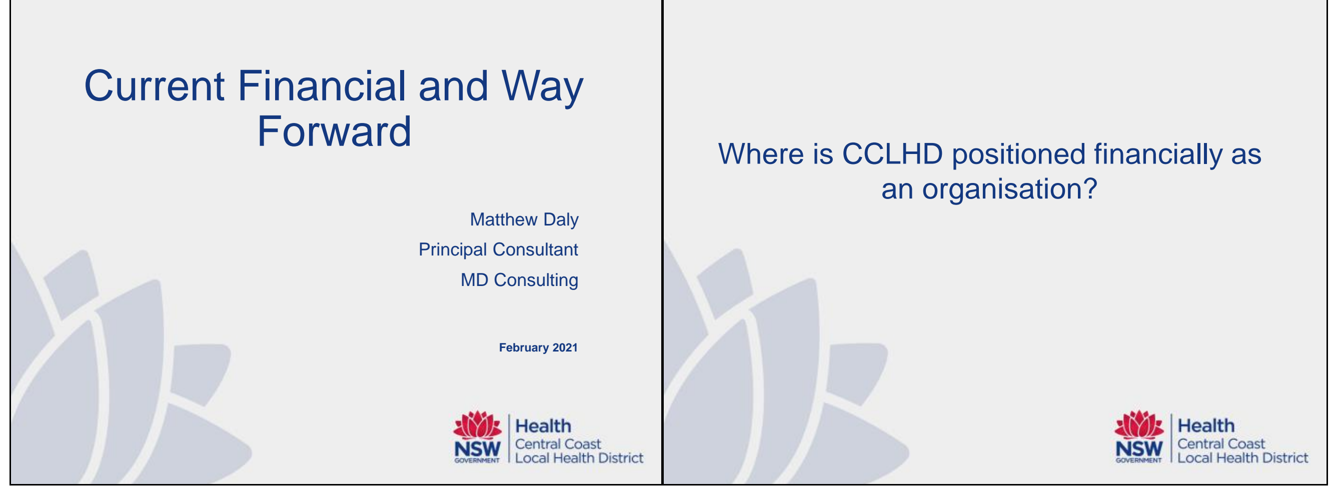
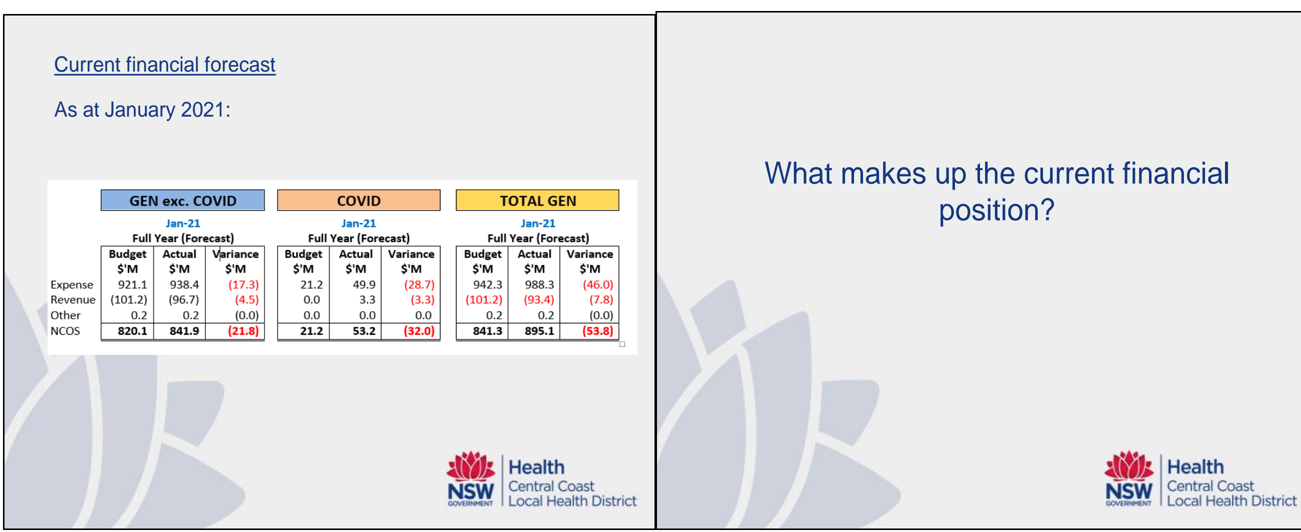
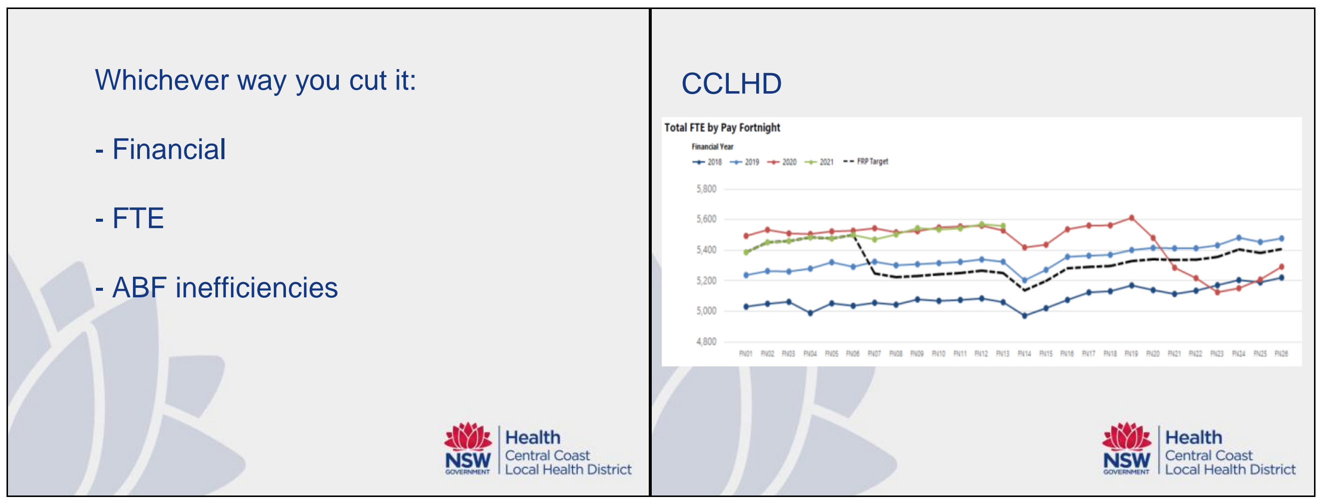
Appendix 1 – Financial Literacy Program





	GEN exc. COVID Jan-21 Full Year (Forecast)			COVID Jan-21 Full Year (Forecast)			TOTAL GEN Jan-21 Full Year (Forecast)		
	Budget $'M	Actual $'M	Variance $'M	Budget $'M	Actual $'M	Variance $'M	Budget $'M	Actual $'M	Variance $'M
Expense	921.1	938.4	(17.3)	21.2	49.9	(28.7)	942.3	988.3	(46.0)
Revenue	(101.2)	(96.7)	(4.5)	0.0	3.3	(3.3)	(101.2)	(93.4)	(7.8)
Other	0.2	0.2	(0.0)	0.0	0.0	0.0	0.2	0.2	(0.0)
NCOS	**820.1**	**841.9**	**(21.8)**	**21.2**	**53.2**	**(32.0)**	**841.3**	**895.1**	**(53.8)**



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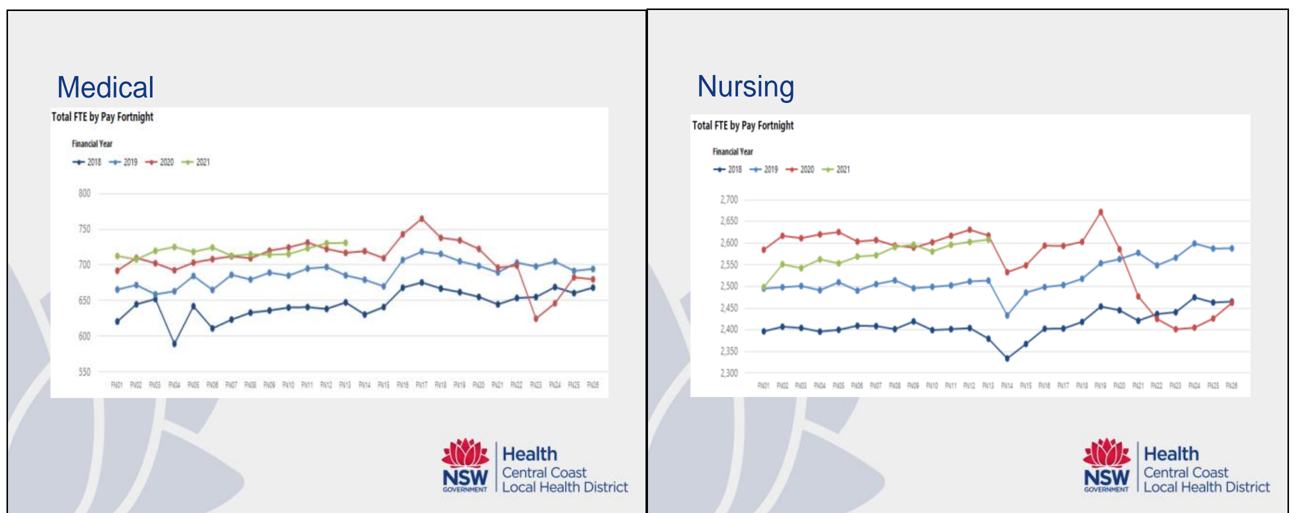
Medical



Nursing

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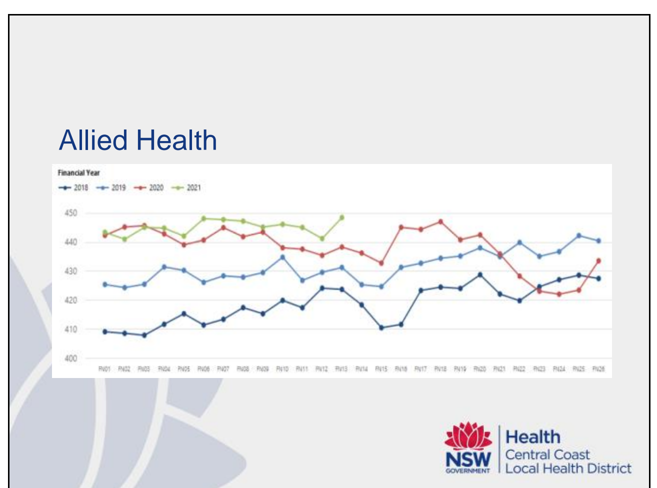
Allied Health



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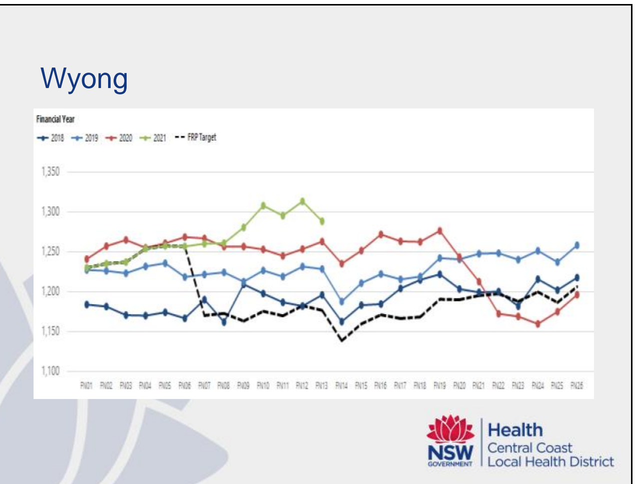
Wyong



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Framework to return to sustainability

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Road to Recovery

- Organisational Sustainability Program (OSP)
  - The Financial Recovery Plan is a key plank in the OSP
  - Reduce actuals
  - Ensure budget management controls are in place
  - Review and identify opportunities for efficiencies within your areas (salary & wages, overtime, goods and services, contracts)

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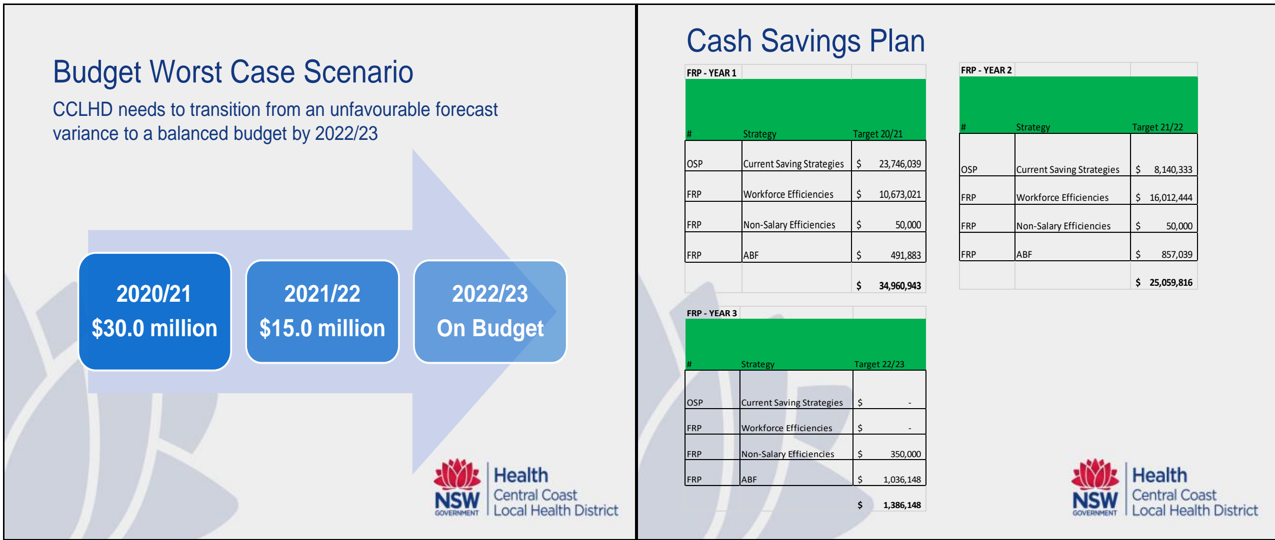


FRP - YEAR 1

#	Strategy	Target 20/21
OSP	Current Saving Strategies	$ 23,746,039
FRP	Workforce Efficiencies	$ 10,673,021
FRP	Non-Salary Efficiencies	$ 50,000
FRP	ABF	$ 491,883
		$ 34,960,943

FRP - YEAR 2

#	Strategy	Target 21/22
OSP	Current Saving Strategies	$ 8,140,333
FRP	Workforce Efficiencies	$ 16,012,444
FRP	Non-Salary Efficiencies	$ 50,000
FRP	ABF	$ 857,039
		$ 25,059,816

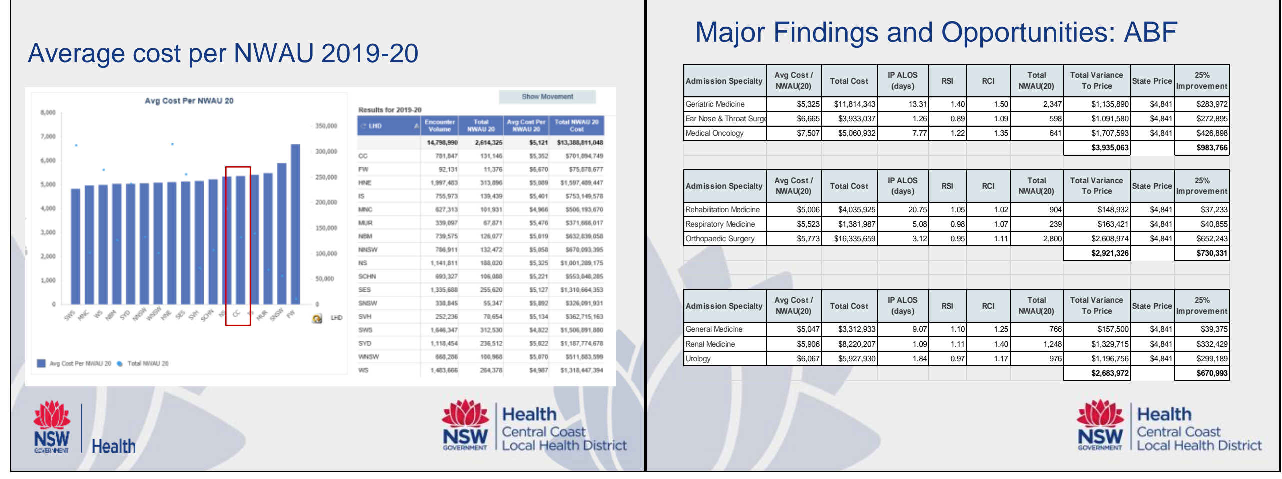
FRP - YEAR 3

#	Strategy	Target 22/23
OSP	Current Saving Strategies	$ -
FRP	Workforce Efficiencies	$ -
FRP	Non-Salary Efficiencies	$ 350,000
FRP	ABF	$ 1,036,148
		$ 1,386,148

Major Findings and Opportunities

1. Unfunded FTE growth is the challenge
2. Complete the Structural Transition to Site/Directorate accountability
3. ABF
4. Accelerated adoption of nursing monitoring (NHPPD, Specials etc)
5. Amend Governance systems to oversee progress

- Redistribute resources to focus on the nine (9) ABF outlier priorities
  - Focus the priorities of the Healthcare Improvement Team to support the Health Information & Business Support Team
  - Achievable targets set for movement toward the NSW average NWAU cost - aiming for a 25% improvement
  - Focus the team on understanding and reducing staffing costs only. Avoid distraction of LOS and G&S
  - Focus on a 3-year program targeting 3 specialities per year – target $2.4M over period of the program



Results for 2019-20

LHD	Encounter Volume	Total NWAU 20	Avg Cost Per NWAU 20	Total NWAU 20 Cost
	14,798,990	**2,614,325**	**$5,121**	**$13,388,811,048**
CC	781,847	131,146	$5,352	$701,894,749
FW	92,131	11,376	$6,670	$75,878,677
HNE	1,997,483	313,896	$5,089	$1,597,489,447
IS	755,973	139,439	$5,401	$753,149,578
MNC	627,313	101,931	$4,966	$506,193,670
MUR	339,097	67,871	$5,476	$371,666,017
NBM	739,575	126,077	$5,019	$632,839,058
NNSW	786,911	132,472	$5,058	$670,093,395
NS	1,141,811	188,020	$5,325	$1,001,289,175
SCHN	693,327	106,088	$5,221	$553,848,285
SES	1,335,688	255,620	$5,127	$1,310,664,353
SNSW	338,845	55,347	$5,892	$326,091,931
SVH	252,236	70,654	$5,134	$362,715,163
SWS	1,646,347	312,530	$4,822	$1,506,891,880
SYD	1,118,454	236,512	$5,022	$1,187,774,678
WNSW	668,286	100,968	$5,070	$511,883,599
WS	1,483,666	264,378	$4,987	$1,318,447,394

Admission Specialty	Avg Cost / NWAU(20)	Total Cost	IP ALOS (days)	RSI	RCI	Total NWAU(20)	Total Variance To Price	State Price	25% Improvement
Geriatric Medicine	$5,325	$11,814,343	13.31	1.40	1.50	2,347	$1,135,890	$4,841	$283,972
Ear Nose & Throat Surge	$6,665	$3,933,037	1.26	0.89	1.09	598	$1,091,580	$4,841	$272,895
Medical Oncology	$7,507	$5,060,932	7.77	1.22	1.35	641	$1,707,593	$4,841	$426,898
							$3,935,063		**$983,766**

Admission Specialty	Avg Cost / NWAU(20)	Total Cost	IP ALOS (days)	RSI	RCI	Total NWAU(20)	Total Variance To Price	State Price	25% Improvement
Rehabilitation Medicine	$5,006	$4,035,925	20.75	1.05	1.02	904	$148,932	$4,841	$37,233
Respiratory Medicine	$5,523	$1,381,987	5.08	0.98	1.07	239	$163,421	$4,841	$40,855
Orthopaedic Surgery	$5,773	$16,335,659	3.12	0.95	1.11	2,800	$2,608,974	$4,841	$652,243
							$2,921,326		**$730,331**

Admission Specialty	Avg Cost / NWAU(20)	Total Cost	IP ALOS (days)	RSI	RCI	Total NWAU(20)	Total Variance To Price	State Price	25% Improvement
General Medicine	$5,047	$3,312,933	9.07	1.10	1.25	766	$157,500	$4,841	$39,375
Renal Medicine	$5,906	$8,220,207	1.09	1.11	1.40	1,248	$1,329,715	$4,841	$332,429
Urology	$6,067	$5,927,930	1.84	0.97	1.17	976	$1,196,756	$4,841	$299,189
							$2,683,972		**$670,993**

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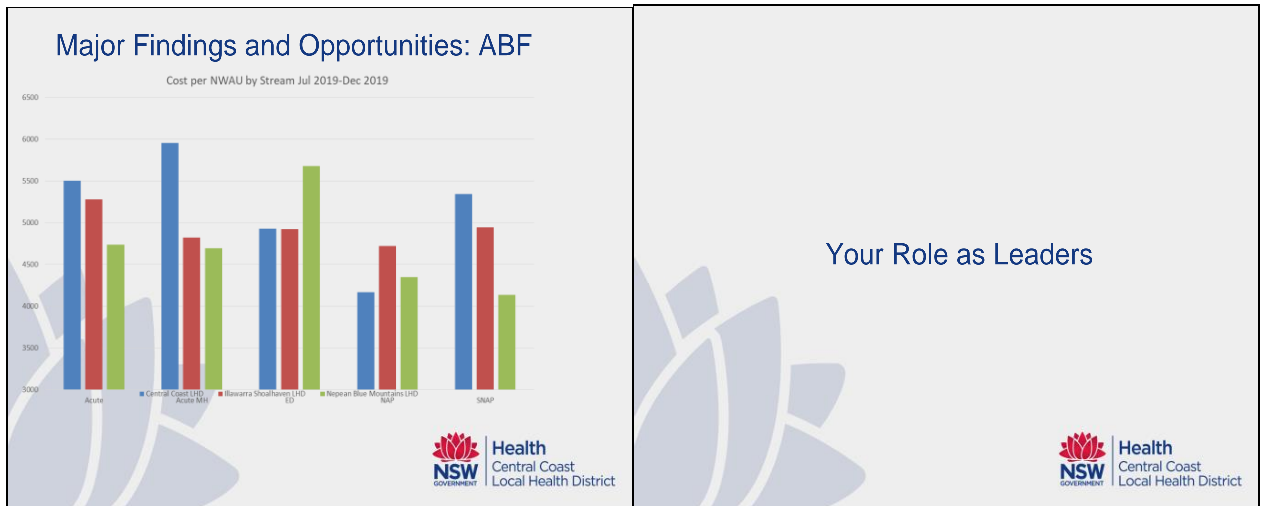

- Look at activity levels and costs and compare to like type services across the State
- Work with Managers so that we get the best outcome possible
- Manage access for patients (e.g. ETP, TOC, Triage, Wait Lists)
- Managing safety and quality which includes patients and our workforce
  - Pressure Injuries (per 10,000 episodes of care – December 2020 data)
    CCLHD 9.1 against a target of 6.6 (not achieving performance target)
  - Fall Related Injuries in Hospital (per 10,000 episodes of care)
    CCLHD 7.3 against a target of 6.7 (not achieving performance target)
  - Healthcare Assoc. Infections (per 10,000 episodes of care)
    CCLHD 137 against a target of 117.6 (not achieving performance target)
  - What is the quality and safety of care provided in your unit?
  - Do you know what the financial impact of this is?

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- Take ownership
- Be accountable and responsible
- Develop your colleagues/teams to take the same approach

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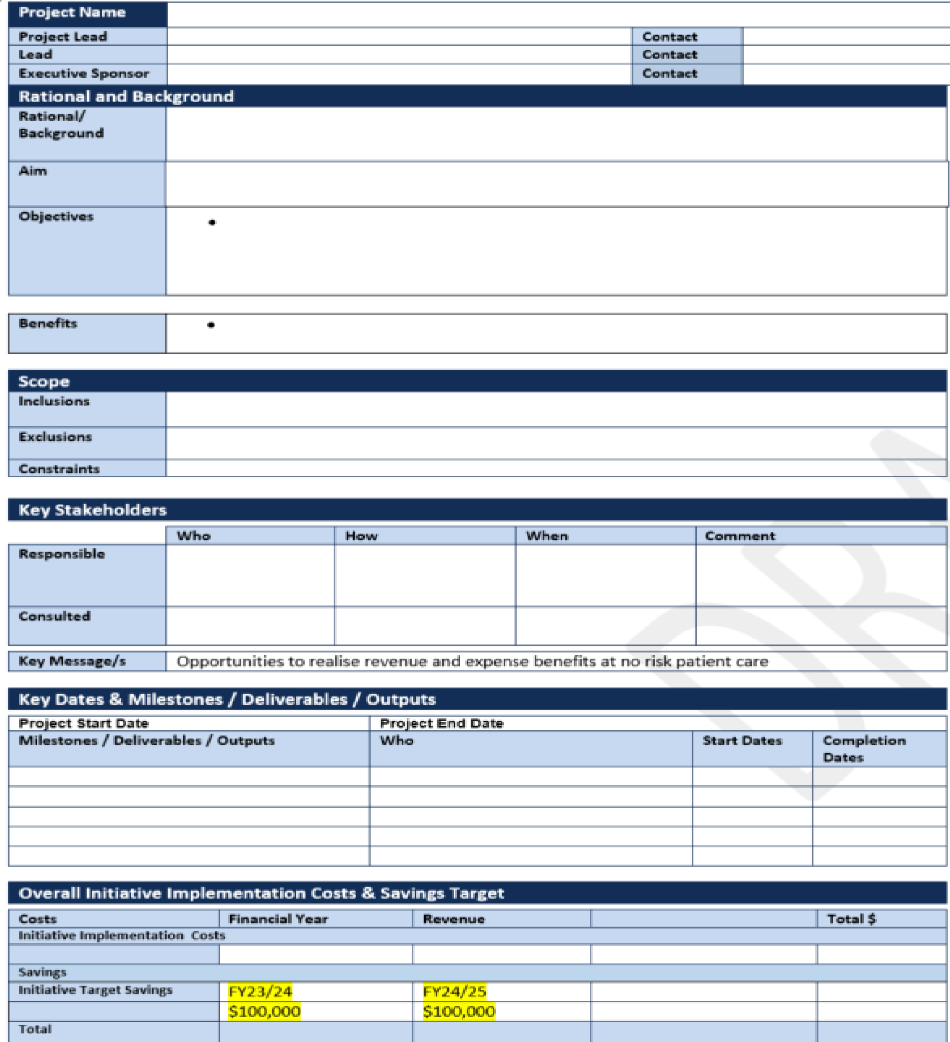
Appendix 2 – Project on a Page template for Concept/Idea capture



OSP - A3 Project Plan on a Page

Project Name			
Project Lead		Contact	
Lead		Contact	
Executive Sponsor		Contact	

Rational and Background

Rational/ Background	
Aim	
Objectives	•

Benefits	•

Scope

Inclusions	
Exclusions	
Constraints	

Key Stakeholders

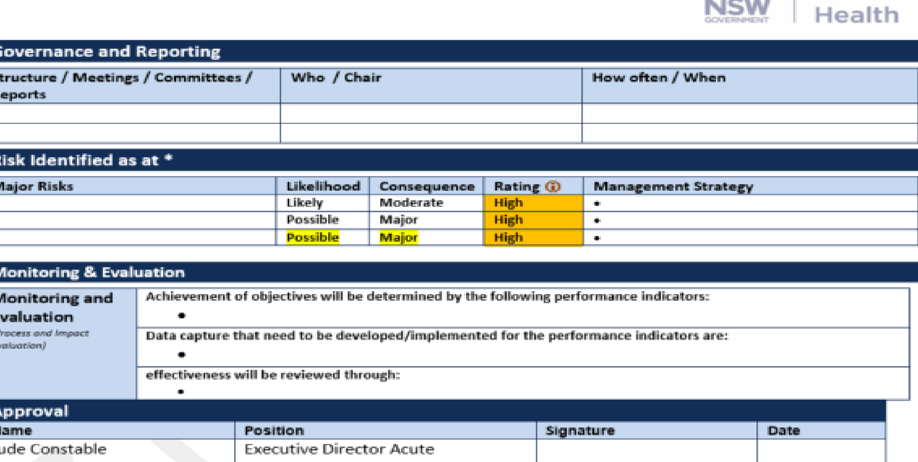
	Who	How	When	Comment
Responsible				
Consulted				
Key Message/s	Opportunities to realise revenue and expense benefits at no risk patient care			

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				



NSW GOVERNMENT Health

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		

Appendix 3 - 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.