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Murrumbidgee Local Health District Review December 2023

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Executive Summary

Murrumbidgee Local Health District (MLHD) extends from the Snowy Mountains in the east of NSW to the plains of Hillston in the northwest and all the way along the Victorian border in the south. The LHD provides healthcare services across a geographic area of approximately 125,243 square kilometres and employs over 3,500 staff. Services are provided across 17 hospitals, 16 multi-purpose services, 12 community health posts, a brain injury rehabilitations service, and mental health inpatient and recovery services.

The MLHD aims to provide safe, consistent, person led healthcare through the key strategic focus areas of:

1. Holistic health and wellbeing.
2. Lifting health outcomes.
3. Locally led reform.
4. Workforce at its best.
5. Foundations for success.

Like all health services, MLHD 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 issue in achieving the District's strategic objectives is the delivery of an unfavourable (UF) end of year variance to budget in 2022/23 in both expenditure ($20.5m UF against a budget of $814.5m), and own source revenue ($0.1M UF against a budget of $119.5M). This result included one-off funding provided through $15.8m HCA, $20.7m rural Health Workforce and $0.8m to establish a district program management office and a one-off $0.8m for vaccines in revenue budget.

Table 1: MLHD FY23 Result & MoH Budget Support

MLHD	FY23 $M	FY23 % Var to Budget	MoH Budget Support $M
Expenditure	(20.5)	-2.5%	$15.8M HCA one off $20.7 B&S Rural Health Workforce $0.8M District Efficiency Improvement Strategies - one off payment
Own Source Revenue	(0.1)	-0.1%	$0.8M Vaccine One Off
Other Items	0.8	65.2%	Provisions for D/Debts
Net Cost of Service	(19.8)	-2.84%	

Of immediate concern is that the unfavourable budget performance continues unabated in this new financial year, despite current efforts by District leadership to mitigate, including increasing their targeted savings program from $10.481m delivered in FY23 to $15.556m in FY24. As at the end of October 2023, the District is forecasting an end-of-year position of $44.3m (UF) a 124% increase on the FY23 UF result. Furthermore MLHD has not delivered a balanced budget in over ten years.

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

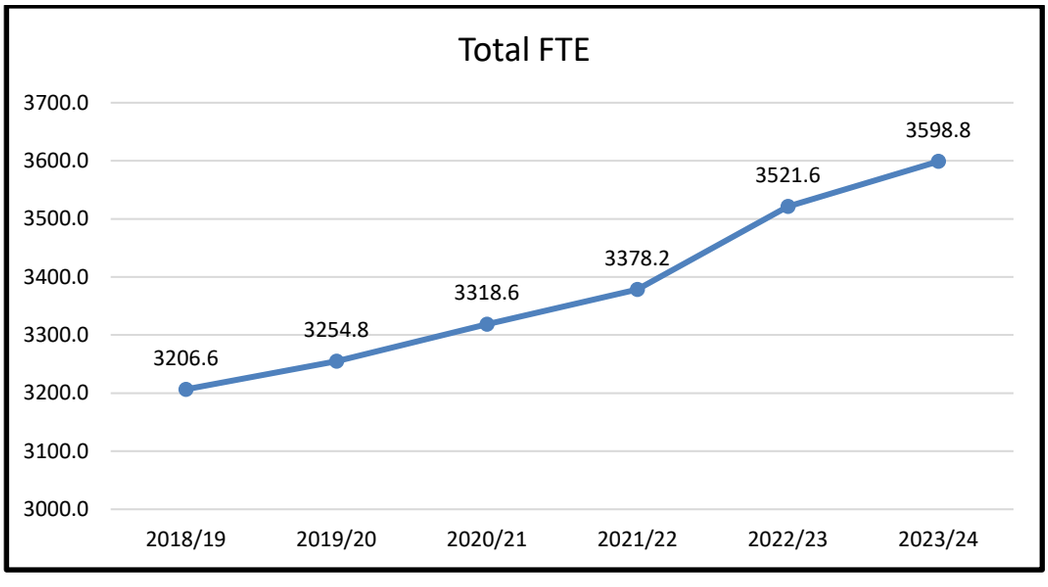
In order to assist the District return to financial suitability a review was undertaken by Ministry of Health System Sustainability and Performance Division in partnership. As a result, a number of recommendations are provided in the areas of:

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

FTE Growth - LHD

The review analysed FTE data provided by the LHD from over a 5-year period from FY19 to FY24. Covid, Commonwealth and own-source-revenue funded FTE was omitted from the data set. During the financial years analysed the LHD grew from 3,206 FTE in FY19 to 3,598 FTE in FY23, a total of 392 FTE (12.2% growth). FTE growth has occurred through NWAU funding, 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	2023/24*
Total FTE	3206.6	3254.8	3318.6	3378.2	3521.6	3598.8

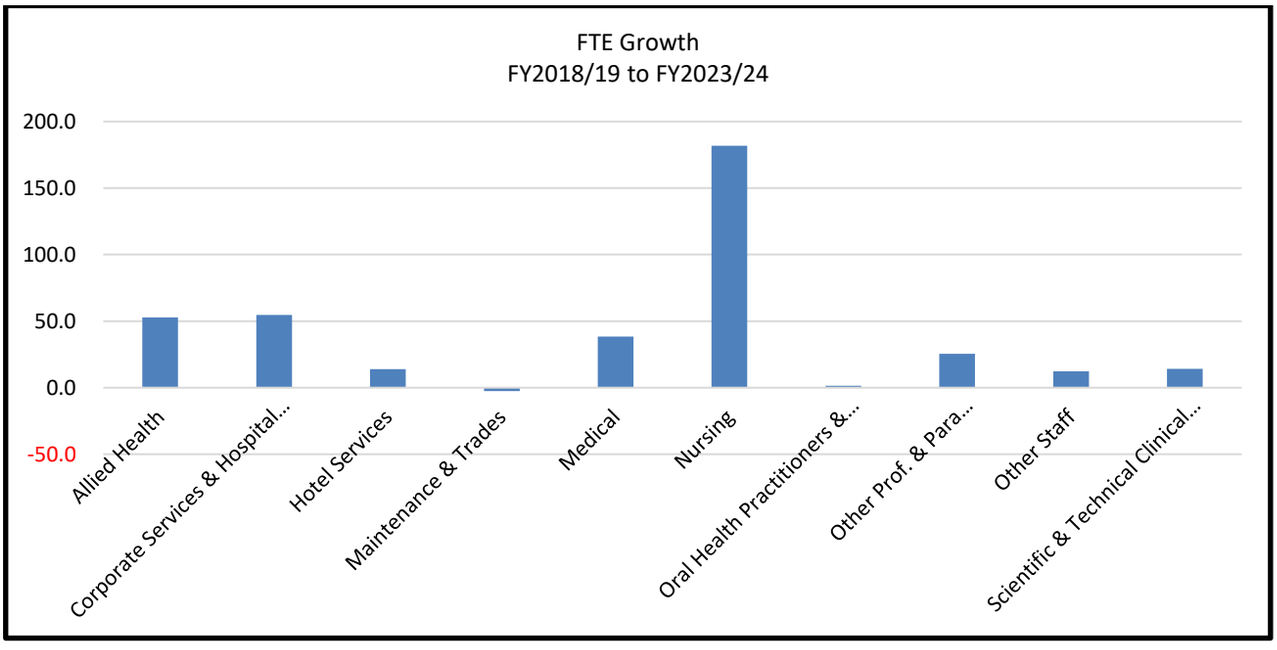
*Source: MLHD, *3-months of FY24*

The highest proportion of the 392 FTE growth by staff award is:

- Nursing and Midwifery - 181.8 FTE (46.4% of total FTE)
- Corporate Services & Hospital Support - 54.6 FTE 13.9% of total FTE
- Allied Health - 52.7 FTE (13.4% of total FTE)
- Medical - 38.3 FTE (9.8% of total FTE)

Since 2018/19 an additional $22.877m has been expended in Nursing ERE and $11.645m in Medical ERE.

Graph 2: FTE Growth by Award



Source: MLHD

FTE Growth – Facility/Service

Of the 392 FTE growth, 32% is accounted for within Wagga Wagga Base Hospital, 19% within Mental Health Services and 10% within the People and Culture Directorate (37.3 FTE). Wagga Wagga's FTE growth is slightly above the activity growth at this site, however, with the exclusion of Cancer Services, Renal and Mental Health, all other services have experienced FTE growth despite activity declining (see table 3 page 7).

Table 2: Highest number of FTE Growth by Site/Division

Site/Service	FY19	FY20	FY21	FY22	FY23	FY24	FTE growth	%
Integrated Care & AH	352.4	352.4	358.5	364.4	371.4	377.6	25	7.2%
Corowa Cluster	153.8	155.3	160.6	163.4	164.9	172.3	18	12.0%
Deniliquin Cluster	166.8	164.9	171.7	167.6	160.8	167.3	0	0.3%
Cancer Services	6.0	6.1	5.8	6.3	6.5	6.7	1	12.0%
MLHD Renal Stream	36.0	38.4	42.3	46.2	53.2	54.3	18	50.6%
Narrandera Leeton Cluster	155.6	156.5	161.0	163.8	158.8	171.3	16	10.1%
Temora Cluster	136.0	137.4	135.6	131.3	142.7	146.0	10	7.3%
Tumut Cluster	122.3	124.9	126.4	127.9	129.0	134.2	12	9.7%
Young Cluster	121.1	118.7	117.7	121.3	120.2	127.4	6	5.3%
Griffith	325.1	328.1	327.0	323.1	335.3	342.3	17	5.3%
Wagga Wagga	1034.7	1054.9	1068.5	1063.4	1145.5	1160.5	126	12.2%
D&A	15.0	14.2	13.8	13.6	14.9	13.2	-2	-12.1%
Mental Health	244.4	247.3	281.4	301.6	319.4	318.4	74	30.3%

Source: MLHD

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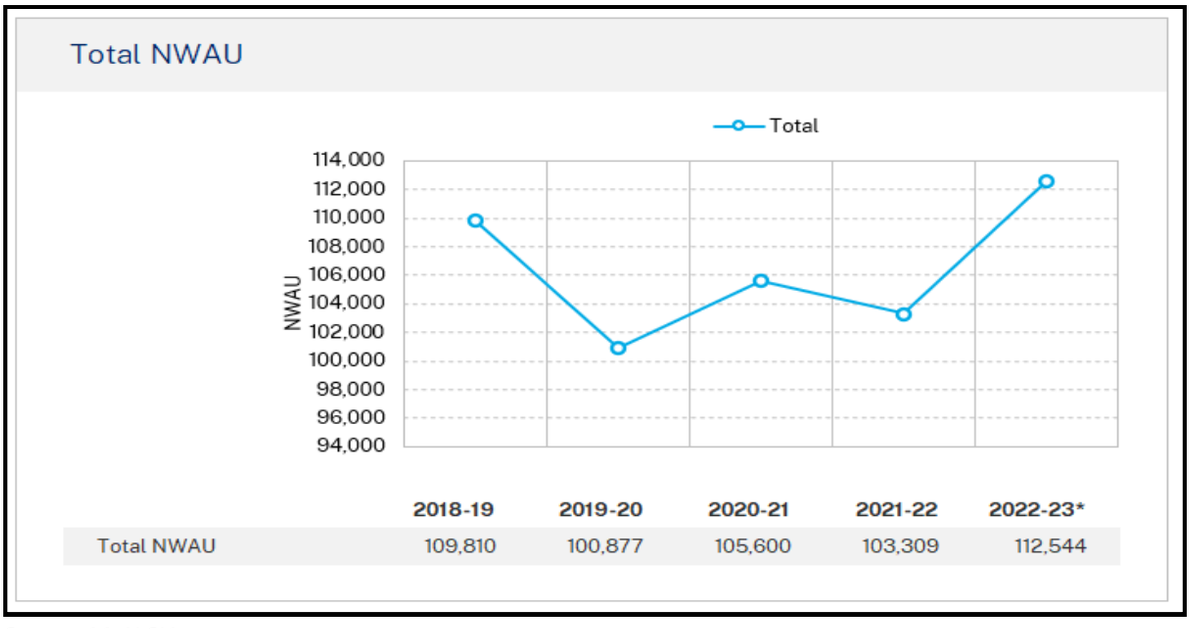
Activity Growth – District level

A key source of LHD funding is through NWAU activity funding. It should be recognised that the LHD activity declined during Covid years after FY19 until last FY where it posted a new high of 112.5K NWAU. This recent significant uplift resulted in MLHD experiencing an overall 2.49% growth in total NWAU activity since the baseline FY19. Acute Admitted activity mirrors the NWAU trend with an overall small growth experienced since FY19 of 4.98%, however, non-admitted activity experienced a growth during the Covid years with a peak in FY22 before a 26% decline in FY23. ED presentations within the LHD demonstrated an overall 1.4% decline since FY19.

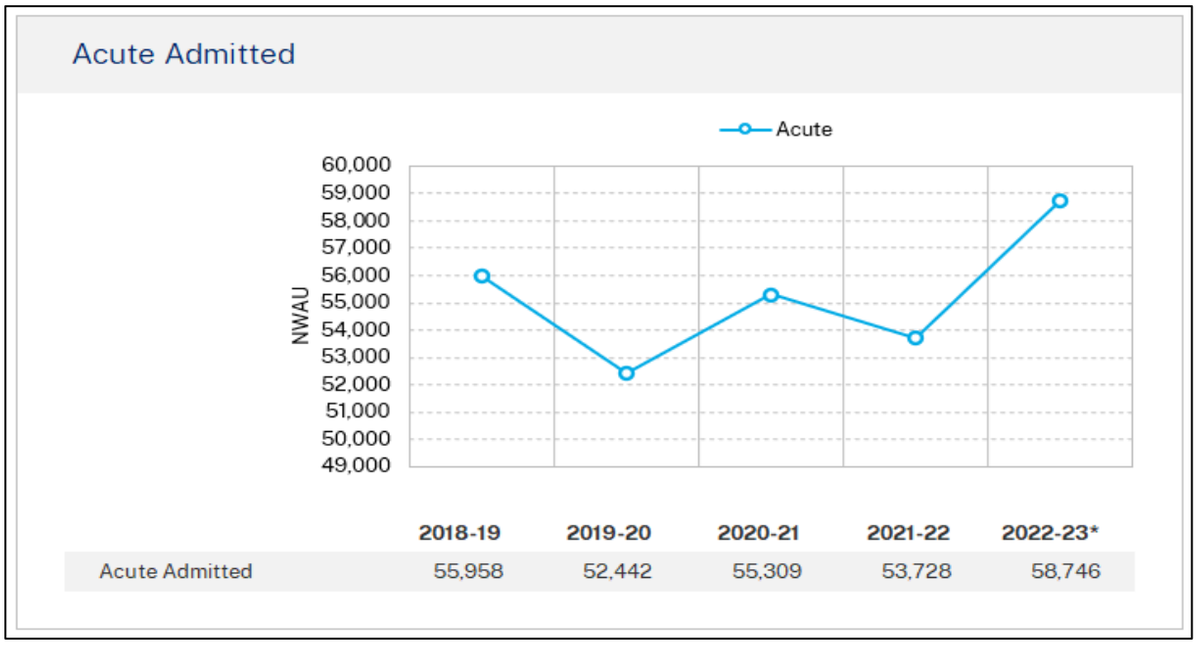
Graph 3: Total NWAU Activity FY19 to FY23



	2018-19	2019-20	2020-21	2021-22	2022-23*
Total NWAU	109,810	100,877	105,600	103,309	112,544

Source: MoH SIA

Graph 4: Acute Admitted Activity FY19 to FY23



	2018-19	2019-20	2020-21	2021-22	2022-23*
Acute Admitted	55,958	52,442	55,309	53,728	58,746

Source: MoH SIA

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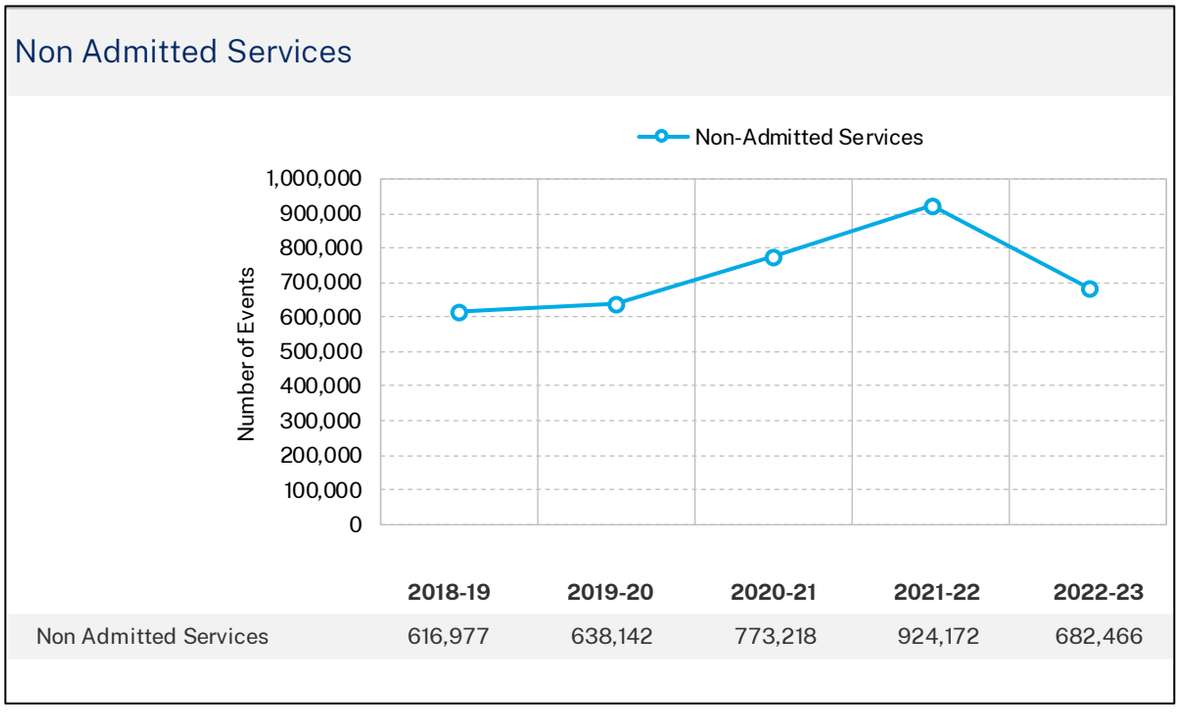
Graph 5: Non-Admitted Activity FY19 to FY23



Source: MoH SIA

Activity Growth – Site/Service level

Whilst MoH through the service agreement, provides the total activity target for the LHD, it is the decision of the LHD where to allocate within its services this activity. It is important to note that there is no difference in the NWAU funding provided whether the activity is delivered at Griffith, Wagga Wagga or Deniliquin etc. Apart from cancer and renal services, Wagga Wagga is the only contributor to activity growth. The LHD should review the activity currently being undertaken at Wagga Wagga that could be transferred to other sites, particularly Griffith Base Hospital. This would assist Wagga Wagga with its flow and surge bed control as well as maximising use of resources invested in at the other sites.

Table 3: NWAU by Site/Service FY19 to FY23

Site/Service	FY19	FY20	FY21	FY22	FY23	NWAU growth	%
Integrated Care & AH	5180	5754	5457	4780	5005	-175	-3.4%
Corowa Cluster	3165	2996	2774	2711	2643	-522	-16.5%
Deniliquin Cluster	6657	5324	5215	5226	5432	-1225	-18.4%
Cancer Services	5	76	108	81	106	101	1857.4%
MLHD Renal Stream	1311	1400	1883	1840	1954	642	49.0%
Narrandera Leeton Cluster	4234	4060	3930	3704	4120	-114	-2.7%
Temora Cluster	4892	4355	4122	3958	4427	-465	-9.5%
Tumut Cluster	3507	3202	3111	3099	3459	-48	-1.4%
Young Cluster	4358	4260	4060	3881	4313	-46	-1.0%
Acute Mental Health	3834.1	3602.5	3147.9	3315.0	4345.7	511	13.3%
Griffith	11553	10816	10942	10502	11341	-212	-1.8%
Wagga Wagga	42310	41051	43510	42832	47033	4722	11.2%

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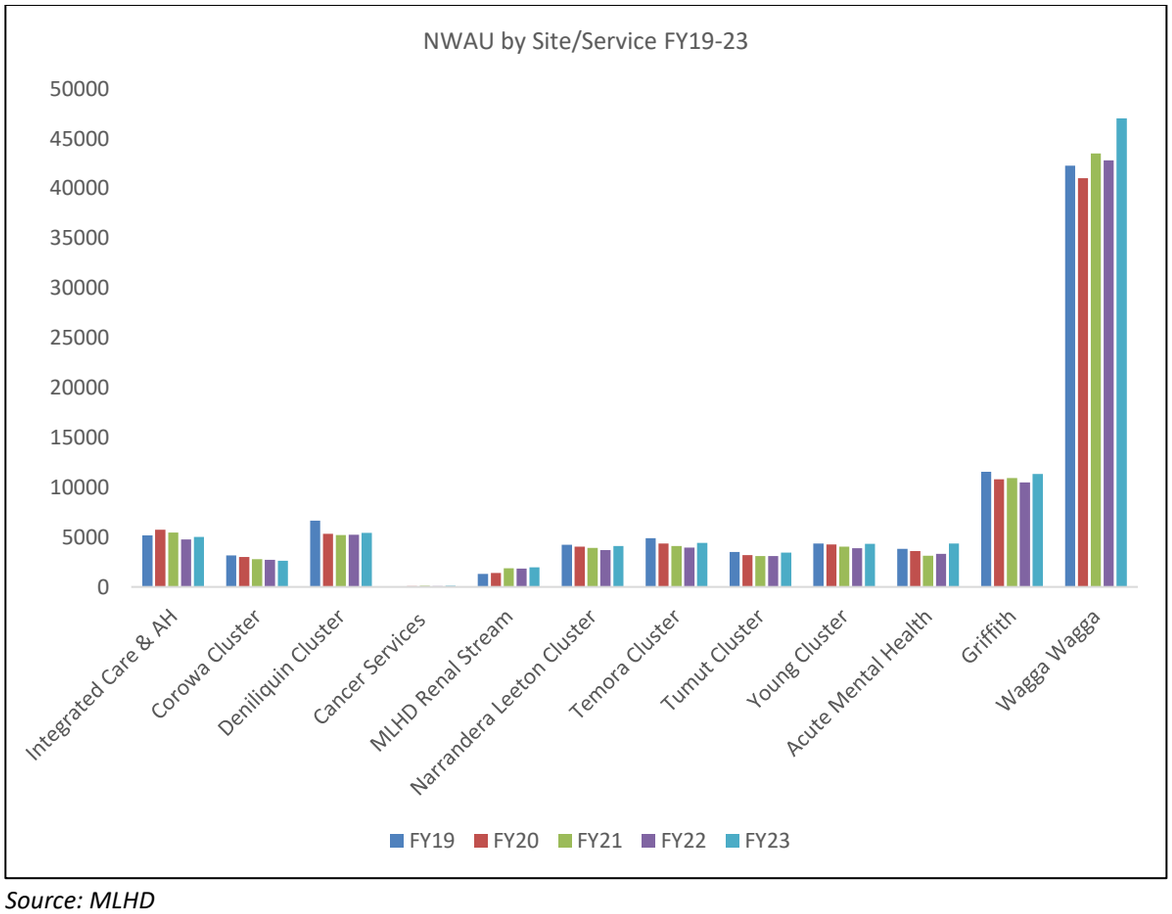
Source: MLHD

Graph 6: NWAU by Site/Service FY19 to FY23



Source: MLHD

NDIS and RACF Patients

It was noted through the review that there was a level of concern on the number of patients occupying a bed at Wagga Wagga Base hospital who were awaiting a residential aged care facility (RACF) bed, to return to a RACF bed or NDIS patient. Although in comparison to peer LHDs the District does not appear to have as many of these patients, however, it is acknowledged that it could be the majority are focused on the one facility. Given the District patient flow resources and the control over many MPS's, the District is in a good position to ensure that such patients are transferred back to their facility or to a new one in a timely manner.

Table 5: Total NDIS and RACF patients in acute facilities

LHD	Total NDIS Patients	Patients Exceeding EDD - NDIS	Total Bed days over EDD - NDIS	Total Patients - RACF	Patients Exceeding EDD - RACF	Bed Days Over EDD - RACF	Total Patients	Patients Exceeding EDD	Bed Days Over EDD
MNCLHD	17	7	385	18	12	143	35	19	528
MLHD	11	5	240	7	2	28	18	7	268
NNSWLHD	10	7	752	49	30	1,083	59	37	1,835
SNSWLHD	9	7	261	10	3	72	19	10	333
WNSWLHD	28	17	4,087	13	10	181	41	27	4,268

Source: MoH SIA

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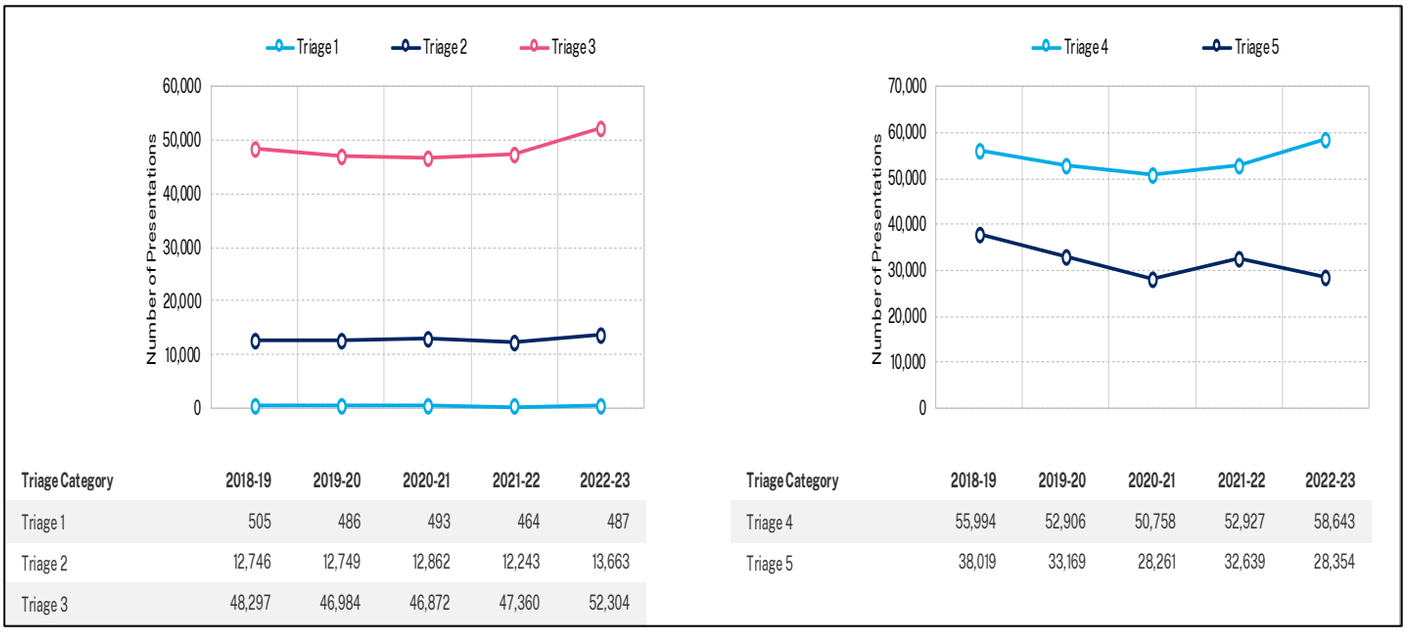
Activity - ED

Overall, ED activity for the LHD has declined by 1.4% since FY19. Declines have occurred in Triage Category '1's and '5's, whereas there has been growth between Triage Category '2's to '4's.

Graph 7: MLHD ED Presentations FY19 to FY23



Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 1	505	486	493	464	487
Triage 2	12,746	12,749	12,862	12,243	13,663
Triage 3	48,297	46,984	46,872	47,360	52,304

Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 4	55,994	52,906	50,758	52,927	58,643
Triage 5	38,019	33,169	28,261	32,639	28,354

Source: MoH SIA

FTE Realignment to Outputs

Over the last five financial years FTE growth has out-paced activity. In addition, the LHD has failed to achieve a balanced budget during the same time. It is therefore recommended that MLHD achieve a conservative reduction of 102 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 $15.089m in expense relief, the equivalent of a 1.8% reduction of the LHDs total expense budget and a conservative 26% reduction of the total FTE growth. These FTE reductions will be achieved through implementing the recommendations in this review report particularly those focused on NHPPD, nursing specials, supernumerary nursing. The LHD should also consider FTE reductions where FTE growth has occurred, but NWAU activity has declined. If the LHD fails to realise benefits from the LHDs FY24 Efficiency Improvement Plan and planned strategy to reduce reliance on nursing and medical agency staff and locums, then it 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. This savings target is in addition to the FY24 EIPs already submitted by the LHD targeting $15.56m.

Table 6: Affordable FTE

Existing FY24 FTE Profile	Required FTE Reduction Target	End of recovery Plan Affordable FTE
3,598 FTE	-102 FTE	3,496 FTE

Table 7: Strategy by FTE Reduction and Targeted Savings

Strategy	Estimated FTE Reduction	Target Savings
Managing NHPPD to Award	6.37	$750,673
Improving Specials Policy Compliance	14.46	$1,735,200
Return to benchmark Senior Management (HSMs)	16	$1,914,224
Health Roster Improvement	2	$235,690
Return to benchmark Supernumerary Nursing - CNCs	6	$792,958
Return to benchmark Supernumerary Nursing - CNEs	6	$636,756
Return to benchmark Allied Health	9	$1,123,569
Return to benchmark Hotel Services	4	$404,610
Low Activity Plans	3	$358,917
Affordable FTE Reprofile of non-NHPPD wards and all District Services	35	$4,187,365
Additional RMR reduction	0	$2,700,000
Pathology Cost reduction	0	$250,000
Total	**101.83**	**$15,089,962**

Increasing NWAU Reporting

The LHD should undertake audit and education activities to improve NWAU coding. Increasing complexity reporting would enable MLHD 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 MLHD 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 achieving $10.481m in savings only identified 5.5% of this against ERE.

For FY24, the District has implemented a significantly increased EIP program of work with $15.5m of EIPs. Importantly 74.5% of these savings are ERE focused. However, this total is well short of the preliminary assessment by the LHD of submitting a $20.1m savings plan, and almost two financial quarters completed.

Table 8: MLHD FY23 Efficiency Improvement Program

MLHD EIP Program FY23	Total Actual ('000)	# EIPs
Employee Related Expenses	$ 576	5
G&S Accelerated Procurement	$ 985	1
G&S Other	$ 2,216	8
G&S Local procurement initiatives	$ 1,899	1
Other Expense Categories	$ 315	1
VMO Payments	$ 118	1
Productivity	$ 693	3
Revenue	$ 3,679	5
Grand Total	**$ 10,481**	**25**

Table 9: MLHD FY24 Efficiency Improvement Program

MLHD EIP Program FY24	Sum of Total Actual	# EIPs
Employee Related Expenses	$ 11,592	4
Goods & Services	$ 2,614	4
Revenue	$ 1,350	3
Grand Total	**$ 15,556**	**11**

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. Many key recovery initiatives had been recently commenced, i.e. review of funded v unfunded staffing profile. It is important these are urgently completed.
2. Whilst it is evident senior management understood the LHDs financial position, most non-senior management 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. The LHD had established a Program Management Office to provide dedicated resource to support the delivery of the LHDs efficiency and savings program. The MLHD PMO should have oversight of all savings initiatives including those identified in this review report.
4. There was little understanding amongst many managers interviewed of the facilities/district misalignment of FTE growth verse relative stagnant activity.

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:

- Ensure ELT members take responsibility for initiatives that they are sponsoring and/or leading (including any working groups being chaired – i.e., pathology, discretionary food etc.), including those new strategies identified in this review report.
- Consider introducing a budget performance matrix for all services to improve Managers accountability for performance. The ELT would then receive an 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 MLHD 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

- 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 shortfall 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. 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.

4. 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 appropriate 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.

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. Complete Staffing Profile Review

The reviewers were informed that the LHD had recently commenced a review of the staffing profile, to determine funded and unfunded FTE and alignment of profiles with StaffLink. It was estimated that of the FTE growth the unfunded component of this growth could be as high as 60%. It is therefore critical that the LHD complete this required exercise as it will provide clarity on unfunded FTE growth areas and assist in determining the approach to returning services to an Affordable FTE profile.

2. Affordable FTE Profile

It is imperative that MLHD 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 MLHD at $119,639 and the initial target for the LHD is a reduction of 102 FTE ($15,089m). 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.

3. Enhancement Approvals

A number of district officers advised the reviewers of the approval of new funding commitments within their portfolios 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. Additionally, there were instances provided where there were enhancements approved by the Executive based on return-on-investment (ROI) and/or the disinvestment in services (i.e. closure of beds), however, it was agreed there was no systematic approach to evaluate the ROI and ensure that resources were disinvested in. As such it is recommended that a register of these expenditure commitments be developed and regularly reviewed by the District Program Management Office (PMO) to assess their delivery of the proposed ROI initially used for justifying the expenditure approval.

It is acknowledged that at times the Chief Executive must consider approving unfunded enhancements to improve patient flow, clinical service or mitigate risk. For new enhancements consideration should be given to using, where possible, the recently updated changes to NSW Health Recruitment and Selection policy that enables temporary appointed staff that then can be converted to permanent after 12-months, if the temporary offer refers to potential availability of ongoing employment. This would allow the LHD to assess the ROI and if the enhancement initiative is not returning benefits enable the LHD to disinvest.
The reviewers also noted the use of the innovative online SDA tool for enhancement submission and tracking. This should be strengthened to ensure that it requires ROI benefits before it can be completed. Whilst in financial recovery the approval of new positions must reside only with the Chief Executive.

4. 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.

5. 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.

6. 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 the 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. Once templates are approved, the site DONs should ensure that before published, the rosters are balanced, to prevent there being large deficits on certain days across the facility, meaning that overtime and agency will be the only choices.

Unfilled Demand and Additional duties

Unfilled demand is 49% and additional duties added 3.8% indicating demand templates may be inaccurate or that additional duties are being assigned and should be reviewed. Unused contracted hours – currently there are 26% 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

46% 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.

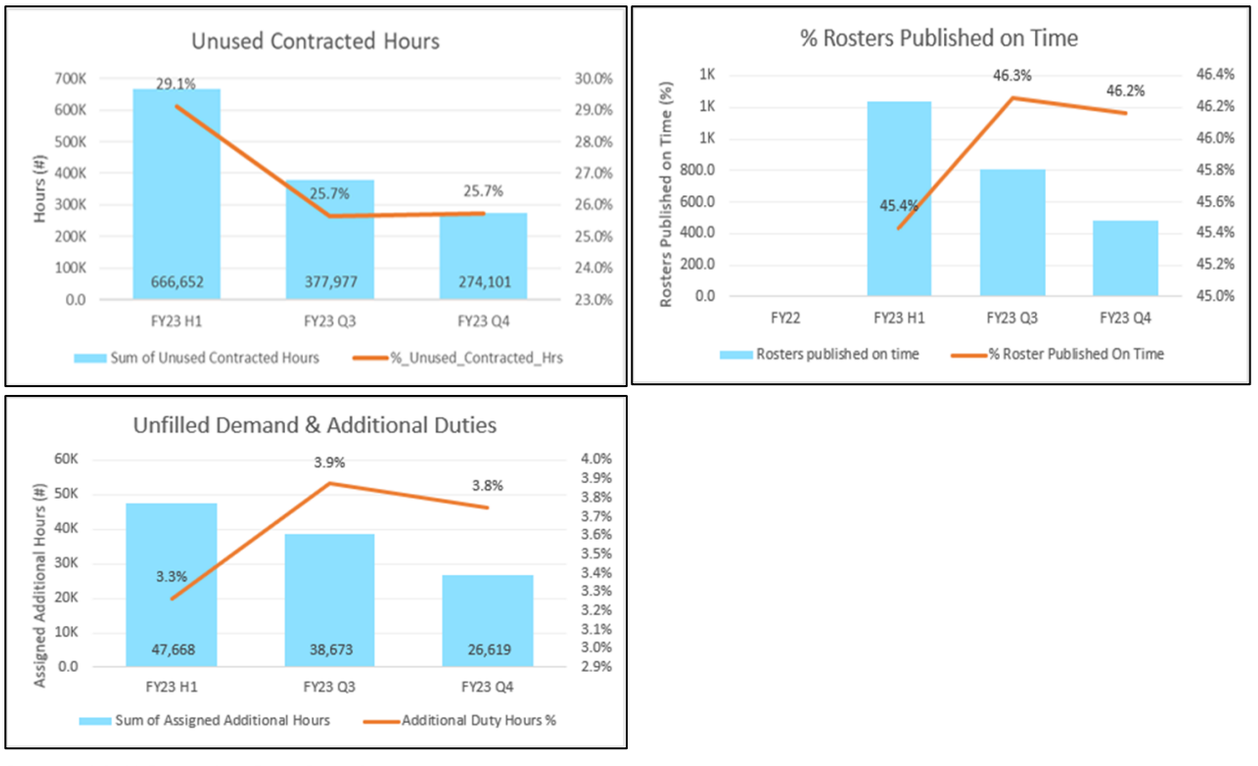
Coding

A review of how nursing is coded in HealthRoster is undertaken and clear guidance provided on when a special code should be applied to a shift that is consistent across all sites and endorsed by the District Nursing and Midwifery directorate.

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, appropriate 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 2 FTE savings ($235,690).

Graph 8: Rostering Best Practice Metrics



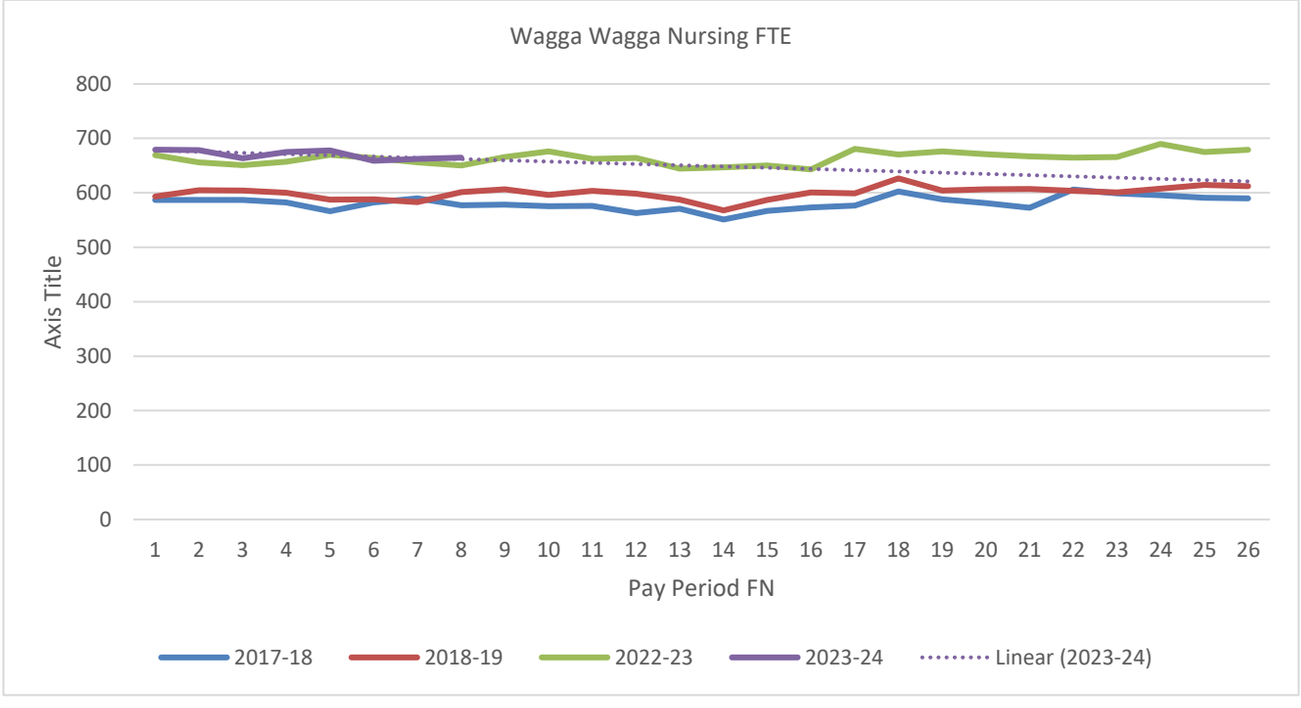
Source: MoH Rostering Best Practice

7. Nursing Workforce

The following key observations were made:

1. The MLHD nursing workforce FTE has increased by 46.4 % (182 FTE) since 2018/19, but activity has not increased at the same level with only a 2.49% growth in NWAU,
2. Since 2017/18 premium labour has increased by 1.1% to an average of 6.6% in Wagga Wagga and Griffith has suddenly increased, by 5-6% to over 15%. This could be because of the high premium labour use which has gone unreported as the staff were hired as contingent workers. This type of worker is not paid in HealthRoster or count towards NHPPD. These workers are being migrated to agency staff, so have commenced appearing in the premium labour percentages.
3. Nursing overtime has increased by average of 3% in comparison to the same month in 2018/19. Overtime is now over 9% and currently trending upwards. This is mainly driven by Griffith Hospital.
4. Currently the weekly average MLHD nursing overstaffing for 2023-24 FY on the NHPPD wards is 6.37 FTE (possible saving of $750,673 per annum based on average cost FTE).

Graph 9:Wagga Wagga Base Hospital Nursing FTE Growth



Average nursing FTE increase for Wagga Wagga Base Hospital from 2017-18 to 2023-24 is 87.6FTE

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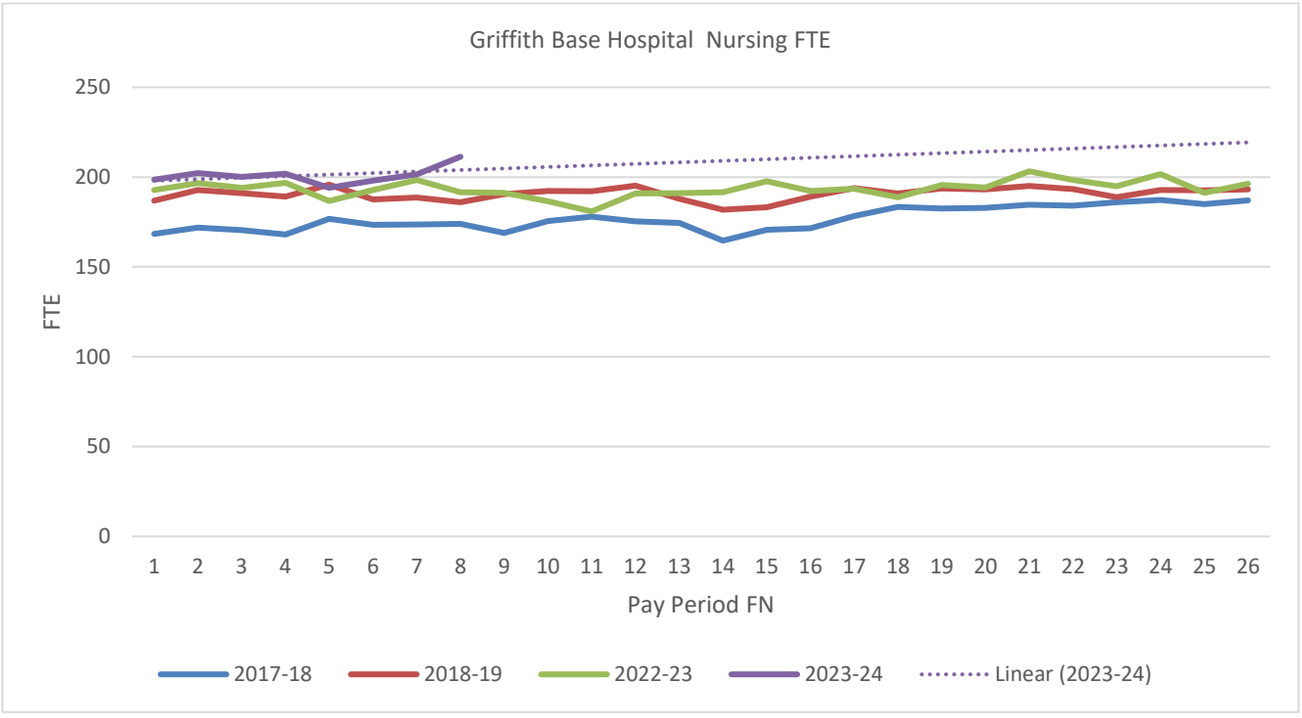
Graph 10:Griffith Base Hospital Nursing FTE Growth

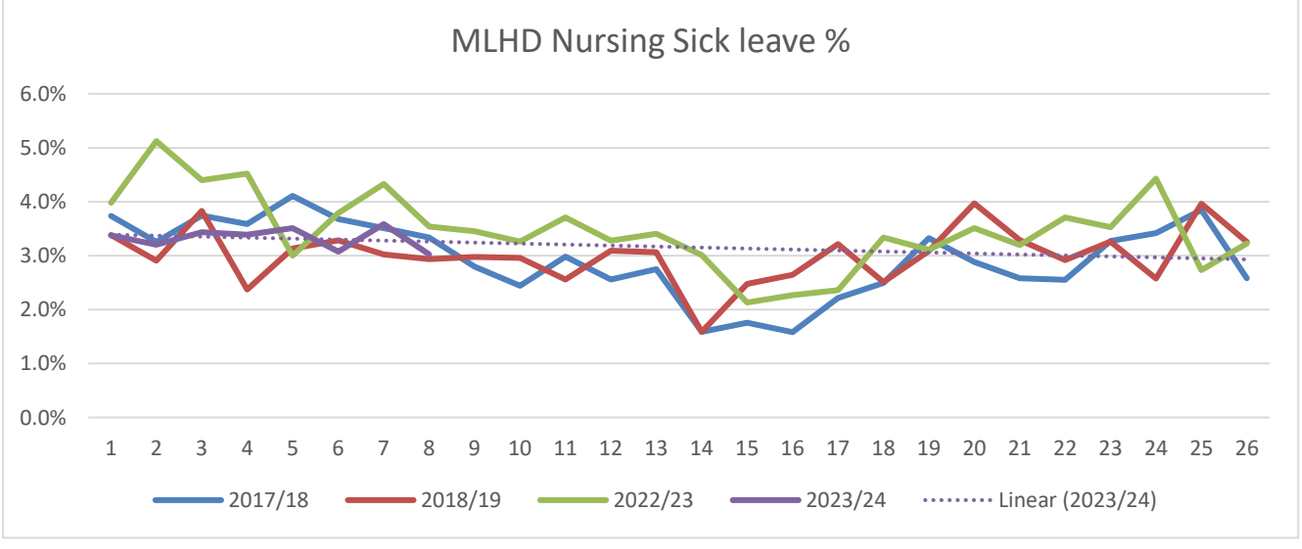


Griffith Base Hospital nursing average FTE Increase from 2017/18- 2023/24 is 28.75 FTE

8. Sick leave

Nursing's sick leave percentage increased during COVID but now appears to have returned to previous years levels . The District should continue to monitor, and ensure that excess sick leave is managed in line with policy.

Graph 11: MLHD – Nursing Sick Leave



9. Overtime

Whilst sick leave for nursing is being managed overtime continues to be of significant concern.

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Graph 12: MLHD – Nursing Overtime

10. NHPPD

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 being counted in the NHPPD hours or as agency, and therefore largely unknown. All staff who are from an agency need to be onboarded as agency nurses.
- A misconception that AINs do not counted in Griffith Base NHPPD (they are instead added as specials). This may have contributed to the large increase of specials reported. Although specials do count as NHPPD they are also noted separately and therefore usually in addition to NHPPD reported

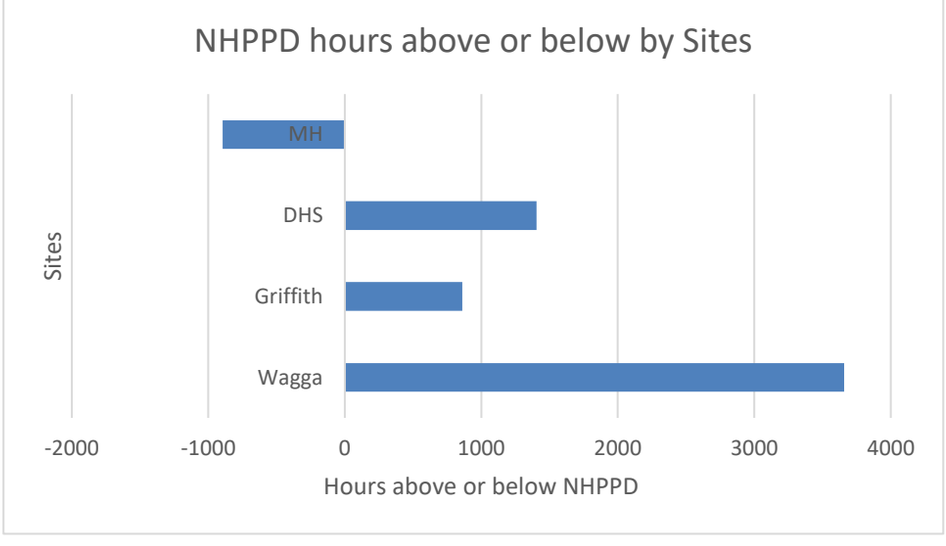
This needs to be reviewed so the LHD can ensure it is accurately meeting the award level for the ward. In addition, any workers compensation staff who are on return to duty assignment in the wards should be assessed to identify if their activities should be included in the NHPPD count, for example undertaking observations or providing patient medications so it is consistently applied across the LHD.

Table 10: MLHD Additional hours above NHPPD FY 23/24

Weeks	Hours over	Hours under	Total Additional Hours	Total additional FTE	Cost- based on average Cost of FTE
1	918.3	0.5	917.8	24.1	$55,615
2	887.4	43	844.4	22.22	$51,277
3	797.8	1.5	796.3	20.9	$ 48,231
4	433.5	134.5	299	7.9	$18,231
5	398.5	176.5	222	5.8	$13,385
6	467.3	179.7	287.6	7.6	$17,539

7	326.1	274.2	51.9	1.3	$3,000
8	289.2	316.4	-27.2	-0.7	($1,615)
9	382.3	220	162.3	4.3	$9,923
10	323.8	58.5	265.3	6.9	$15,923
11	279.5	232.5	47	1.23	$2,838
12	375.3	218	157.3	4.1	$9,462
13	320	199.5	120.5	3.17	$7,315
14	129.5	260.7	-131.2	-3.45	($7,962)
15	205.8	117	88.8	2.3	$5,308
16	297.8	130	167.8	4.41	$10,177
17	312.3	210	102.3	2.69	$6,208
18	369	88	281	7.39	$17,054
19	256.5	215.8	40.7	1.07	$2,469
20	241.5	78	163.5	4.3	$9,923
					$294,300

Graph 13: MLHD Hours above or below NHPPD FY 23/24 by site



11. Nursing Specials

Nursing Specials have increased markedly since FY2018, with over $2,500,000 spent last year, and although peer LHDs have reduced post the pandemic era, MLHD has not. Griffith Base Hospital reported that AINs are treated as supernumerary and coded as specials on HealthRoster. Although coded as specials they do still count towards nursing hours per patient day. This may be inflating the specials FTE and not be a true representation of actual specials provided.

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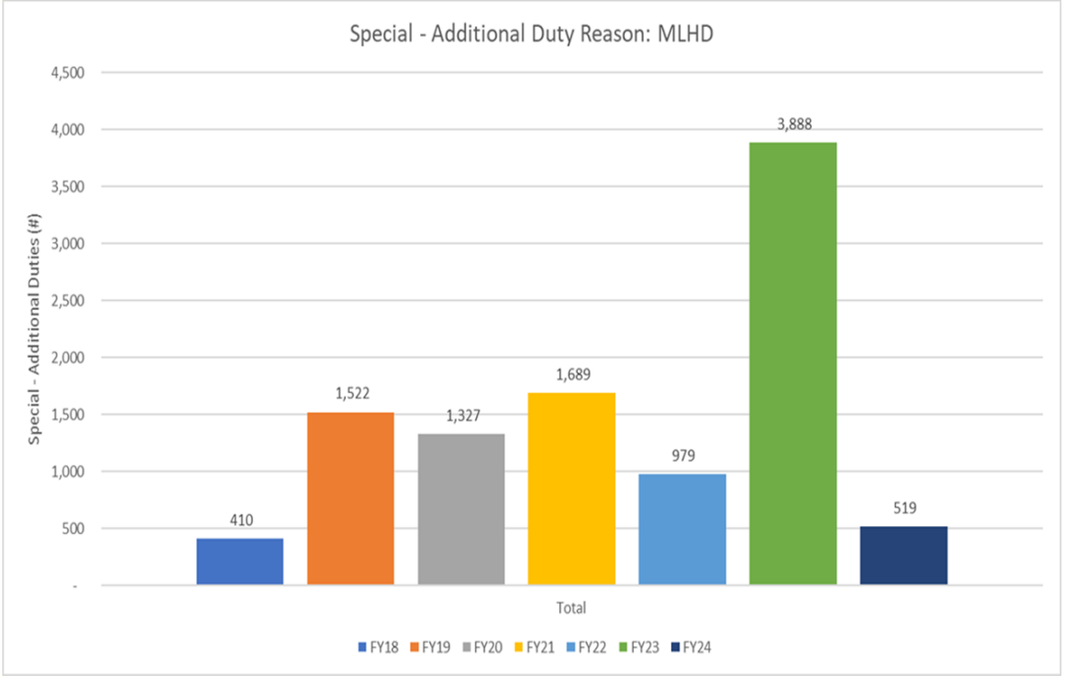
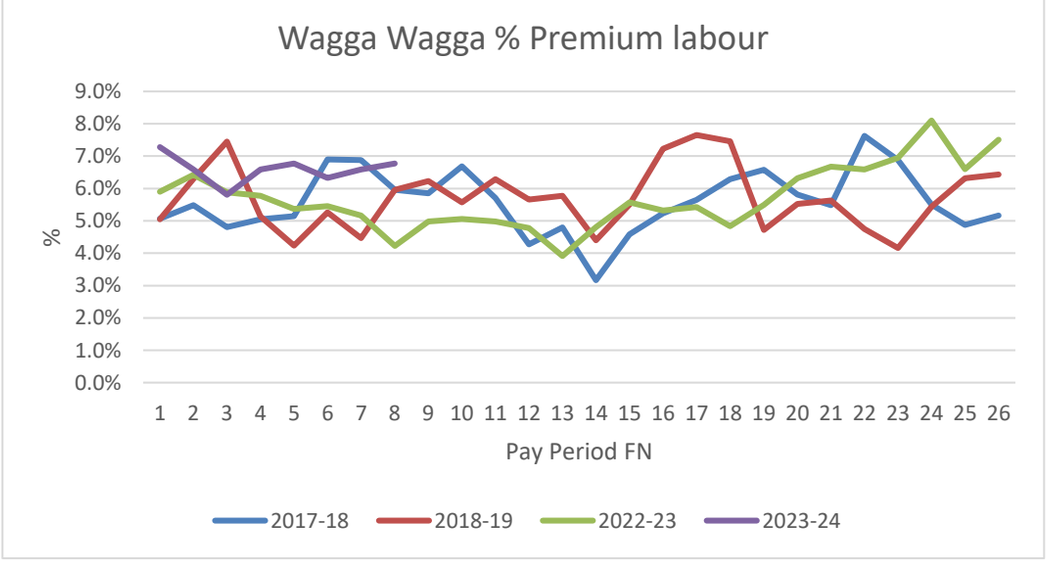
Table 11: Specials cost per year

Year	FTE	Av Cost
2018	1.86	$223,200
2019	6.6	$792,000
2020	5.8	$696,000
2021	7.4	$888,000
2022	4.2	$504,000
2023	21.06	$2,527,200
2024	3.1	$372,000

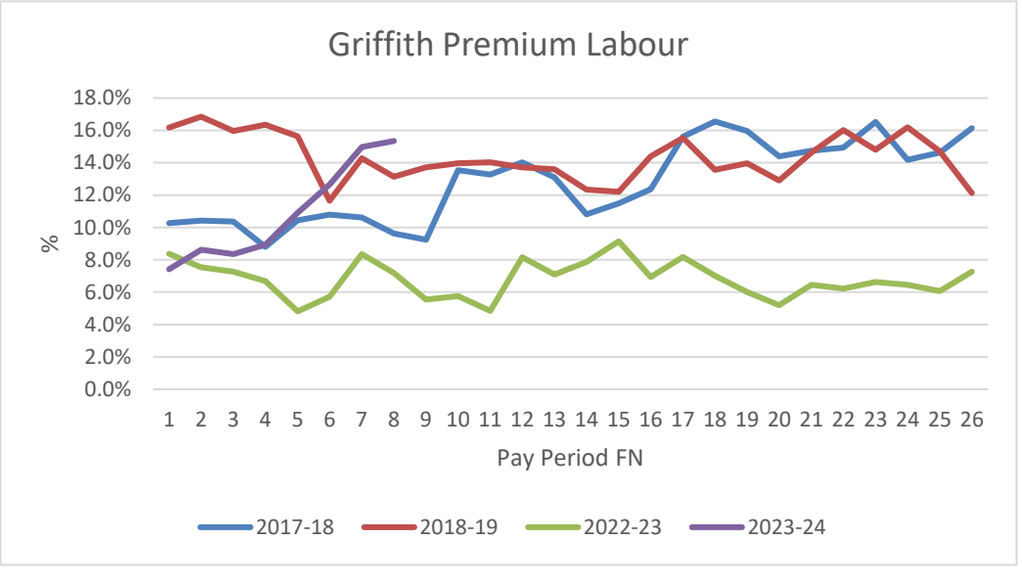
Graph 14: Specials by FTE per year



Graph 15: Wagga Wagga Base Hospital Nursing Specials % Premium Labour



Graph 16: Base Hospital Nursing Specials % Premium Labour



Although these graphs demonstrate the increase in premium labour, they do not capture the nursing and midwifery workforce that have been on boarded as 'contingent workers' and therefore premium labour will be higher than represented. The MLHD advised that this was now occurring, which can be seen it the growth in the last 4 FNs of 2023-24. It is important that all agency nursing are employed as agency nurses, allowing the hours to feed into NHPPD and also for FTE and costs to be accurately reflected. It is recommended that the Nursing and Midwifery District Directorate provide clear procedural advice and monitor to ensure compliance.

The LHD must aim for a 50% reduction in the use of specials from the FY23 baseline. This would provide approximately $1.735m in savings. In future years the LHD should return to the FY18 baseline and include these savings in their future EIP program.

12. Overseas Recruitment

It is recognised that a critical strategy to reducing nurse agency/premium labour costs is the recruitment of 94 overseas Nurses and Midwives. It should be noted that it was reported to the MoH review team that the vacancy rate is currently 145 FTE.

13. CNC Roles

The LHD should review CNC positions which have increased by 27% since 2017/18. 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.

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.

For recovery the LHD should target returning toward FY19 CNC staffing levels bringing it in line with peers. A target reduction has been initially set of 6 CNC FTE which would provide $793k in savings.

Table 11: 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

14. CNE Roles

Review CNE positions - these positions have grown 55% since 2017/18, which is higher than the State growth for this period of 47%, 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 towards FY22, providing $636K in savings (6 FTE).

Table 12: 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

15. Additional nursing workforce opportunities

1. Review all additional positions created since 2018/19 and determine if there is a return on investment.
2. 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 is an additional $40K per position without shift penalties and on-costs).
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. 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.
5. Ensure excess leave is managed in line with policy and ADOs are taken where possible in the month accrued.
6. Models of care change opportunities which could also result in lower FTE expense. Currently there is an 86:14 % RN to non-RN workforce, there is opportunity to provide an 80:20 RN to non-RN workforce, reducing costs.
7. Review opportunities to employ Acute Care AINs with the appropriate HLT3315 Acute care certificate existing and the MOH guidance can assist with this process https://www.health.nsw.gov.au/workforce/Pages/ain-acute-care.aspx
8. 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.
9. Monitor Nurse specials each shift, ensuring review and assessment occurs. Consider having the DONM be the approving manager at all times, run HealthRoster reports to look for patterns of specials by day and by area.
10. Review how overtime is approved to ensure the correct controls are in place, such as ensuring where possible the overtime does not incur a sleep day etc.
11. The reviewers were informed of a proposal to enhance the Griffith ED nursing model. However, given the level of ED activity this should not be supported in the financial recovery climate as it will add additional expense for limited ROI. This needs to be further monitored once the new redevelopment is commissioned to ensure any increased presentations are sustained and not the phenomenon that can be experienced when a new facility is opened where there is a short-term increase of presentations.
12. 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.

16. Review Health Service Management Positions/FTE

The LHD should look to reduce HSM FTE back to pre-Covid years (FY19). HSMs have grown by 33 FTE (16%) from FY18 211 FTE to a FY24 FTE of 244. This growth is lower than the State growth for this period of 25%. Returning to FY19 level, a reduction of 16 FTE, would provide the LHD with $1.914m 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 13: HSM FTE Growth since FY18 v Peers

Grade	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FTE FY18-24	%
HSM01	51	51	56	57	62	67	64	13	25%
HSM02	63	63	66	68	73	70	67	5	7%
HSM03	47	46	51	56	59	58	61	15	32%
HSM04	37	40	44	41	40	41	42	5	13%
HSM05	13	13	10	10	8	6	6	-7	-57%
HSM06	1	1	3	3	3	5	5	3	292%
	211	**215**	**229**	**235**	**247**	**247**	**244**	**33**	**16%**

Source MoH SMRS

17. Allied Health

Whilst less FTE than nursing, allied health FTE has grown by 20.4% (59 FTE) from FY18, which is the second highest growth experienced amongst peers and higher than the State growth of 13.2% growth for this period. A return to a FY22 benchmark would provide approximately $1.123m in savings (9 FTE)

Table 14: Allied Health FTE Growth since FY18 v Peers

	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY18 to FY23 FTE	FY18 to FY23 %	Avg Yearly
MNCLHD	315	317	315	339	349	372	387	57	18.1%	3.6%
MLHD	291	298	310	330	346	350	353	59	20.4%	4.1%
NNSWLHD	445	473	491	510	514	511	527	66	14.8%	3.0%
SNSWLHD	261	261	276	285	271	276	290	15	5.6%	1.1%
WNSWLHD	424	452	466	493	500	539	550	115	27.2%	5.4%

Source MoH SMRS

18. Hotel Services

Hotel Services FTE has grown by 19% since FY19 (13.8 FTE) The LHD should look to return towards FY19 benchmark levels with an initial reduction in 5 FTE which would provide approximately $405K in savings.

19. People and Culture

There has been significant FTE growth (96%) in this Directorate since FY18 with 37.3 FTE added to the FY18 baseline. The LHD should review this growth to ensure it is funded or aligned to/providing ROI benefits such as improved recruitment or workers compensation.

20. Other Affordable FTE Target

Outside of the Nursing and HSM targets the LHD should review all non-NHPPD staffing profiles to identify and meet a target reduction of 35 FTE. Based on an average MLHD FTE cost of $119K this will provide $4.187m 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.

21. 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 confirm that all Covid related FTE has been disinvested. If any roles are identified then these reductions in FTE and savings achieved will contribute towards the Affordable FTE target reduction.

22. 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. The LHD is currently one of the poorer performers against this KPI compared to a number of peers. Improvement will support JMO wellbeing and reduce cost.

Table 15: JMO ADO

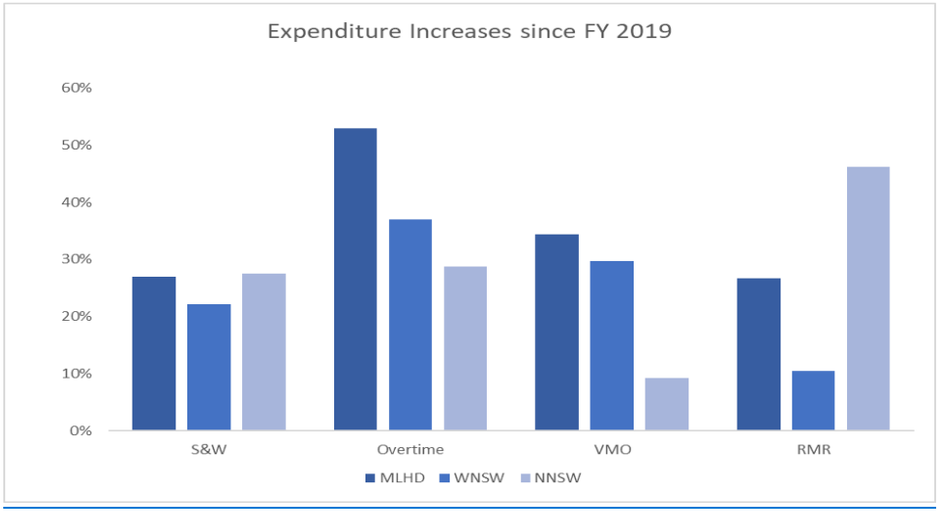
Row Labels	Sum of Sum ADO DAYS	Count	W/AVG
CCLHD	1150	560	2.053571
MLHD	715	183	3.907104
MNCLHD	877	305	2.87541
NNSWLHD	1030	363	2.839207
WNSWLHD	964	260	3.707692
SNSWLHD	94	23	4.086957

Source: MoH Medical Workforce

23. Overtime

Overtime spend has increased 5,363% since FY19, significantly higher than peers WNSW and NNSW (3,729% and 2,926% respectively) 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 overtime approvals.

Graph 18: MLHD Expenditure v Peers



Source MoH Finance

24. 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 MLHD prepare an initial submission to support recovery should a FY24 program be announced. The benefit of this program is that the LHD receives the benefit of the position saved in the financial year. It should be noted that VRs can be offered by the LHD without the MoH program, however, benefits will not be realised until 12-months after the position has been removed.

25. 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. This cost has been evident in a number of rural LHDs and contributes between a third and a half of these LHDs budget unfavourability. However, there are many other areas of expense identified in this review that are in the control of the LHDs and which can reduce expense unfavourability that are not related to agency costs (i.e. non-medical and nursing FTE growth). As well there are several strategies identified that if implemented will reduce the reliance of agency workforce (i.e., NHPPD, specials controls and maximising virtual care models).

The LHD has also implemented several strategies to address agency costs, including overseas recruitment and the renegotiation of agency contract fees. Since FY19 there has been a 207% growth in Net Cost of Agency. In particular significant costs were incurred in FY23 with an 84% increase on the previous year. Whilst medical agency costs have risen by 60% it is nursing agency costs that have significantly increased. In FY23 these costs grew by 375% in structural costs alone ($15m). 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. For example, controlling nursing specials, ensuring AINs are counted in NHPPD, removing contingent workers from rosters and improved rostering practices should assist in reducing the demand on agency. However, vigilance must be maintained on monitoring, reporting and ultimately reducing the reliance on agency.

Table 16: Agency Staffing Cost

MLHD Agency Staffing Cost $ Millions Actual Trend Analysis	FY19 YTD	FY20 YTD	FY21 YTD	FY22 YTD	FY23 YTD	MOV FY19 to FY23 ($M)	MOV FY19 to FY23 (%)
Nursing Agency costs A195165	4.0	4.0	4.0	4.0	19.0	15.0	375%
Med Agency Costs A195170	2.0	2.0	3.0	2.0	3.0	1.0	50%
Overtime	10.0	9.0	11.0	15.0	16.0	6.0	60%
Sick leave	4.0	5.0	5.0	6.0	6.0	2.0	50%
Staff Agency Accommodation/Travel costs	1.0	1.0	2.0	2.0	3.0	2.0	200%
Workforce Structural Costs #	**21.0**	**21.0**	**25.0**	**29.0**	**47.0**	**26.0**	**124%**
Agency S&W Medical & Nursing	23.0	24.0	22.0	21.0	32.0	9.0	39%
Total Agency Costs (Structural & S&W)	**44.0**	**45.0**	**47.0**	**50.0**	**79.0**	**35.0**	**80%**
Est costs of permanent staff to replace Agency	29.0	29.0	28.0	25.0	33.0	4.0	14%
(NET) Total Agency Costs (Structural & S&W)	**15.0**	**16.0**	**19.0**	**25.0**	**46.0**	**31.0**	**207%**

Source: MLHD Finance

26. Division/Service Vacancies

It was acknowledged that there are some services where vacancies are being held to deliver a needed underspend, for example Allied Health and Integrated Care. It is important that the LHD maintain these savings through vacancies and consider re-basing the FTE profile in order to return to a sustainable budget position. Recruitment to these vacant roles will only provide further expense and contribute to the UF position. Nursing should be excluded from this restriction up until Award level staffing requirements.

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 is provided in the appendices as a guide.

2. Virtual Care

While it was understood that virtual care (VC) was introduced as a complementary model of care in a number of the LHD service sites, given the rise on medical workforce costs the LHD should work with the MoH to transition to a substitutive model of care which could save the LHD significant financial relief through reducing locum/medical workforce costs by moving to a nurse led response supported by VC. Savings would be further enhanced if the LHD leverages off a VC model using NSW resourcing as opposed to private contracted services.

3. 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.

4. 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 approximately $637K in savings. For a 20-bed ward this would provide an approximate saving of 4.47 FTE and $472K.

5. Quinquennium Review/VMO standardisation

It is understood that a VMO quinquennial process has recently been completed. Despite this, given the significant number of VMOs and locum workforce used, the District should pursue the opportunity to standardise sessional payments where possible under the sponsorship of the District DMS should lead this process. In addition the reviewers were also provided with feedback that there may be a number of individual additional financial benefits provided to some VMOs as part of their recruitment and retention. The DMS review should identify any historical arrangements that may be in place used to attract individual medical officers to the LHD for removal and/or standardisation.

6. Non Inpatient Clinic Review

The LHD should expedite the review underway of non-inpatient clinics. Where this is not directly linked to the Clinical Services Plan and/or is providing low ROI, these clinics should be disinvested in.

7. District Patient Flow Model and Resources

The review identified that there was an opportunity for the LHD to review its District Patient Flow model and resources given the significant concentration of activity in Wagga Wagga Base Hospital with the exclusion of Mental Health, Renal and Cancer Services. MLHD total Patient Flow resourcing has increased by 22% over the analysis period (9.5 FTE). In addition the District Model is well resourced with x1 administration officer for admin duties; x1 admin for transportation bookings, x3 Nurse Manager (NM) grade 2 for district patient flow and critical care advisory roles (day shift – staggered start times) and x1 NM2 rostered overnight. The NM critical care advisory roles are 0.8 and must maintain 0.2 in either ICU or ED, and provide support to peripheral sites and support with flows into the hospital. However, this appears to be a lot of resources given the flow is concentrated into one site (which has its own flow team) and given the expertise of the critical care advisory roles may in fact provide small sites and GPs an easier referral pathway to Wagga Wagga. Of concern for the model is that reviewers were frequently advised of the struggle of Wagga Wagga to return patients back to the smaller sites once admitted.

8. 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.

9. Surge Beds Approvals and Reduction Plan

It is recommended that the LHD develop a planned approach to reduce the use of surge beds as well as ensure that the opening of these beds are approved by an LHD clinical or operations executive. On a number of occasions it was indicated that although there is a required approval pathway for the opening of surge beds requiring on-call executive approval, that this is not always followed. It is important that the LHD do not allow this process to be circumnavigated. As well, the executive should require the beds to be closed in a timely manner so as they are not left operating and generating additional cost when demand does not warrant.

10. Low Activity Plans

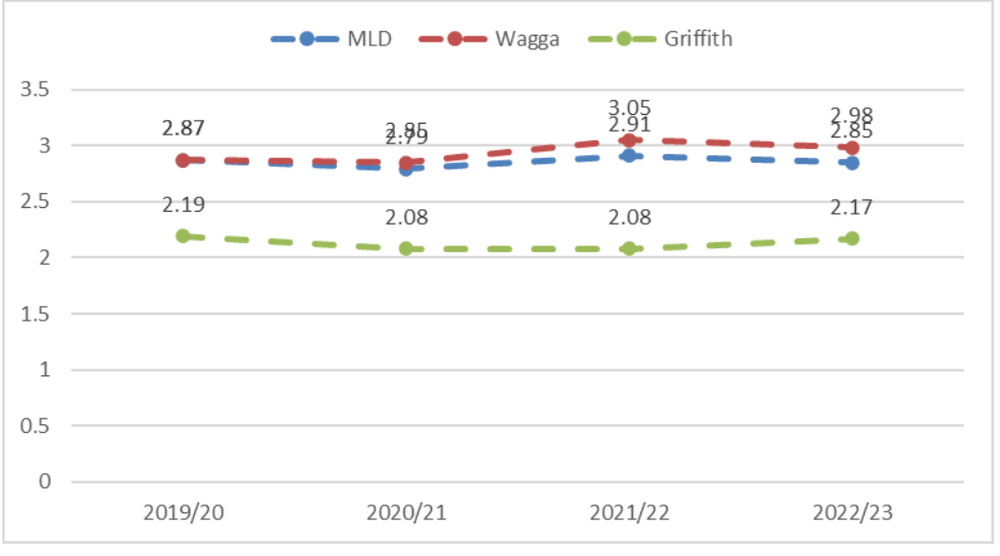
Management should use historical activity data patterns to identify periods of lower activity i.e. October school holidays and some parts of Xmas and New Year holidays. Plans should be developed in advance to ensure resourcing is reduced. This can include reducing ward bed stock in pods of four so as 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. During the reviews it was indicated that there was opportunity to implement greater lower activity plans for community-based services than had been in place for prior years. The LHD should develop a 12-month plan based on known activity and target $359K in total for the LHD (3.0 FTE).

11. Reduce Length of Stay

A review of LOS data reveals that there is some variance occurring particularly at Wagga Wagga 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 MLHD is $538.48.

Graph 19: 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 continue 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. The LHD has in place already a revenue committee with a mix of strategic and operational membership. Areas to address include:

- Although overall Private Health Insurance (PHI) conversion performance has historically been good, conversion rates have declined recently.
- Ensuring all medical staff onboarded are trained in revenue requirements and that relevant doctors are maintained in the Revenue Portal to ensure Clinician Billing report data is correct.
- Roll-out of VMO license agreements to maximise revenue opportunities through facility fees for privately referred non-inpatient activity (PRNIP) from VMO's exercising their rights of private practice (ROPP).

Graph 20: MLHD PHI Conversion and Patient Fees Revenue

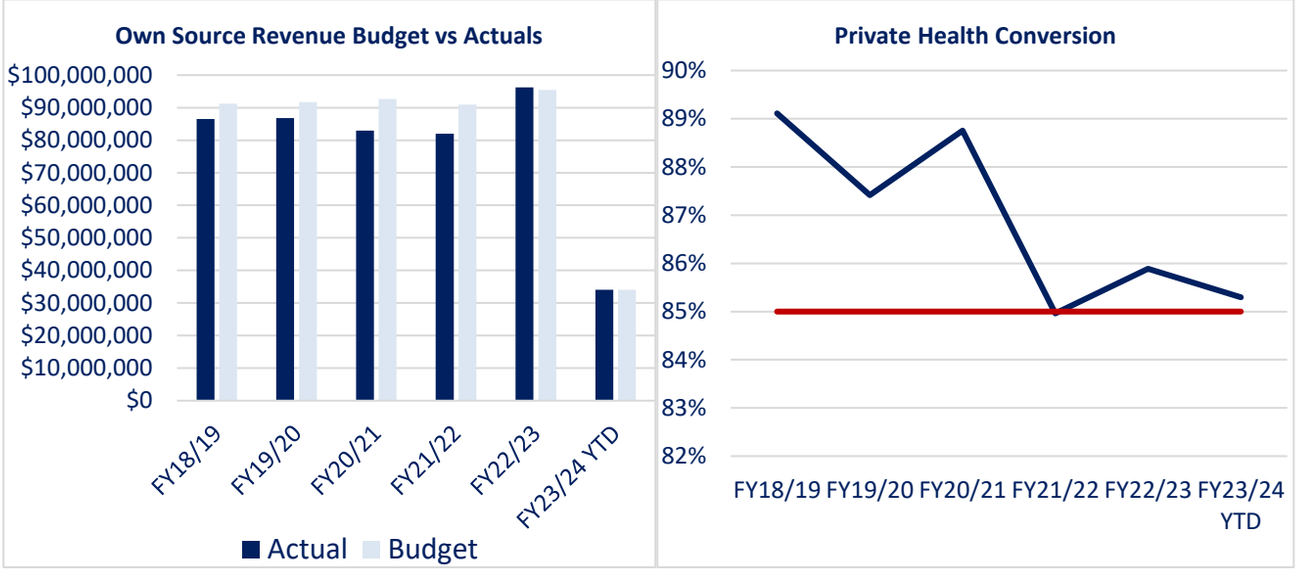


Table 17: MLHD Clinician Billing %

KPI	FY22	FY23	FY24 YTD
<10%	13%	7%	3.6%

Source: MoH Finance Revenue Team

2. Goods and Services Expenditure Benchmarking

While the largest part of the budget savings requirement should 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. In comparison to its peers, MLHD's 'Overtime,' 'G&S,' and 'RMR'

represent a higher percentage of overall expenses at 2.3%, 28.9%, and 2.4%, respectively. Aligning Overtime spend to a peer average of 2% translates to $3M in savings opportunity for MLHD.

It is also noted that MLHD has a lower proportion of S&W which may increase as it addresses the premium labour mix. During COVID, Agency Staff were hired as 'contingent workers' rather than as Agency Staff. This means that the as a contingent worker, they are not rostered in HealthRoster, or appear on Staff Link and as such the FTE is not visible in the reports. Instead, the contracted agency itself is paid from an account rather than payroll, and in turn pays the 'contingent' worker.

Similarly, savings opportunities present in G&S and RMR totalling $20M and $2M, respectively, with majority of G&S savings likely to be realised in 'Support,' 'Special Services,' and 'Outsourced Patient Care', in that order. If MLHD aimed to be the lowest of their peers (based on a comparison of RMR spend as a percentage of total budget) then a reduction in RMR would be $4.8M. However, a more conservative approach is to achieve the medium LHD reduction which would is a $2.7M savings target.

Table 18: Peer LHD Expenditure Analysis Key expense Categories FY23

Key Account Categories	NNSWLHD	% of total Expense	WNSWLHD	% of total Expense	MLHD	% of total Expense
Employee Related	$659,942	56.8%	$688,895	58.0%	$456,947	54.7%
Salaries and Wages	$440,245	37.9%	$467,339	39.4%	$302,116	36.2%
Overtime	$20,075	1.7%	$26,462	2.2%	$19,466	2.3%
Agency costs (Premium Labour)	$67,707	5.8%	$51,024	4.3%	$47,090	5.6%
VMO Payments	$92,299	8.0%	$91,857	7.7%	$61,902	7.4%
Goods & Services	$335,144	28.9%	$282,096	23.8%	$241,278	28.9%
Medical Consumable	$34,566	3.0%	$24,959	2.1%	$20,501	2.5%
Pharmaceuticals	$25,874	2.2%	$29,857	2.5%	$20,583	2.5%
Prostheses	$16,084	1.4%	$11,753	1.0%	$10,016	1.2%
G&S Special Services	$56,353	4.9%	$47,968	4.0%	$44,380	5.3%
Outsourced Patient Care	$5,055	0.4%	$5,355	0.5%	$9,299	1.1%
Support	$152,152	13.1%	$107,518	9.1%	$102,614	12.3%
Admin	$45,060	3.9%	$54,687	4.6%	$33,885	4.1%
Repairs, Maintenance & Renewals	$23,253	2.0%	$27,066	2.3%	$19,867	2.4%
Expenses	$1,160,963	100.0%	$1,186,869	100.0%	$834,967	100.0%
Revenue	-$98,076		-$138,820		-$119,440	
Net Cost of Services	**$1,063,593**		**$1,048,381**		**$715,928**	

3. VMoney Audit

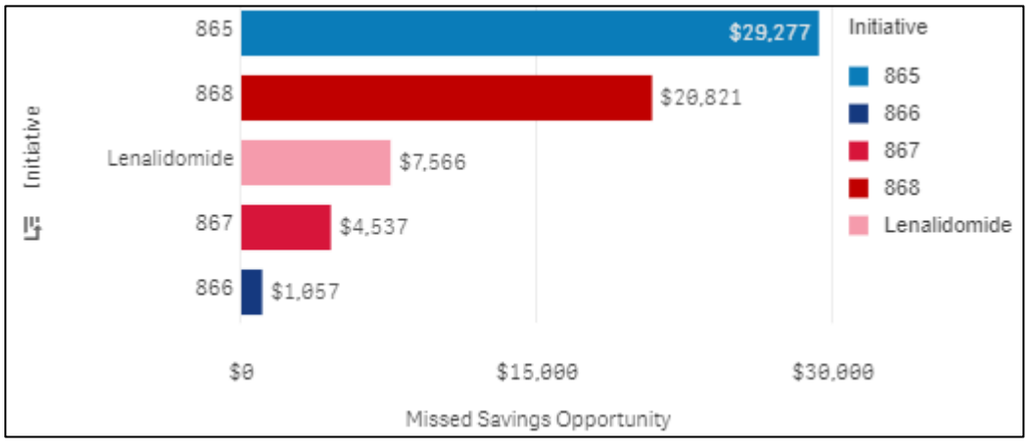
Given the scale of VMO utilisation and that there has recently emerged a number of issues with VMO claims the LHD should consider implementing a biennial internal audit of VMoney claims and payment system to ensure all claims are compliant with policy and Medicare. This audit should commence in early 2024.

4. Pharmacy Rebates and Cost Effective Medicines

The LHD is about to receive for the first time pharmacy rebates from the contracted service provider for the provision of chemotherapy drugs. There is also opportunity to ensure that the LHD is maximising the

introduction of cost-effective medicines through pharmacy purchasing arrangements. The MLHD PMO should work with Pharmacy to implement such savings opportunities.

Graph 21: Pharmacy Savings Tracker – MLHD missed Savings Opportunities



Source: HealthShare Pharmacy Tracker

5. Pathology

The LHD has incurred not insignificant pathology costs, which have grown by 48.4% ($5.759m) since 2018.

Table 19: MLHD Pathology Costs since 2018

	2018	2019	2020	2021	2022	2023
NSW Health Path	11,902,562	12,947,165	12,833,807	14,307,699	15,512,234	17,662,314

Source: MLHD

Of concern is the significant cost growth of pathology for the MLHD Rural Operations despite, with the exclusion of cancer services, there being negative NWAU growth in those sites. Furthermore, Mental Health costs have risen in the last year by 71% and rural operations by 17%.

Table 20: LHD Pathology Costs by major facility/service since 2018

	2018	2019	2020	2021	2022	2023	$ growth	% growth
Rural Operations	2,629,403	2,783,082	3,740,044	4,109,563	4,109,563	4,825,954	2,196,551	84%
Griffith	2,172,378	2,313,134	2,549,783	2,486,687	2,486,687	2,717,783	545,405	25%
Mental Health	183,055	149,945	156,239	183,604	183,604	313,883	130,828	71%
Wagga Wagga	6,741,911	7,470,371	7,156,423	8,477,311	8,477,311	9,593,975	2,852,064	42%

Source: MLHD

Four approaches to pathology should be considered, in partnership with NSW Health Pathology, to reduce costs:

- Establish a prospective review of all order claims where any errors or missing information that would otherwise result in a Medicare rejection, be addressed.
- Establish a working party with NSW Health Pathology to undertake a 'deep dive' review of all rejected claims over the last 22-months, correct these and resubmit to Medicare.
- Review use of point-of-care testing (POCT) and ensure that the mix of POCT and laboratory testing is maximising the most cost-efficient approach, especially for smaller sites.

- Implement a DMS led review of order sets in partnership with NSW Health Pathology to minimise diversity of order sets where possible and ensure authorisation steps are in place were required in order to minimise unnecessary and/or expensive order requests.

The prospective and retrospective recommendations have been successfully implemented in NSWLHD, CCLHD and recently WSLHD and provided those LHDs with significant savings. A conservative target of $250K in pathology expense reduction has been set as an outcome of implementing all four recommended strategies.

SUMMARY of RECOMMENDATIONS

Governance	Recommendation
FTE Realignment to Outputs	LHD should review the activity currently being undertaken at Wagga Wagga Base Hospital that could be transferred to other sites, particularly Griffith Base Hospital. This would assist Wagga Wagga with its flow and surge bed control as well as maximising use of resources invested in at the other sites. MLHD achieve a conservative reduction of 102 FTE ($15.089m) over an agreed recovery period negotiated with the NSW Health Chief Finance Officer. This is in addition to the LHDs FY24 EIP Program ($15.556m)
NWAU Reporting	Undertake a program of audit and education activities to improve NWAU coding.
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. The MLHD PMO should have oversight of all savings initiatives including those identified in this review report
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.
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.
Workforce Efficiencies	**Recommendation**
Staffing Profile Review	The LHD complete the commenced review of the staffing profile, to determine funded and unfunded FTE and alignment of profiles with StaffLink.
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 by the MLHD PMO 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.

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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. • Ensure staff are aware that AINs are included within the NHPPD award calculations. • Develop an assessment for any workers compensation staff who are on return to duty assignment and who are undertaking clinical activities that should be 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 who have clinical or operational experience. • 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. • 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	Return to benchmark through a conservative reduction of 6 FTE.
Nursing - Review of CNEs	Return to benchmark through a conservative reduction of 6 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: • Return to benchmark through a conservative reduction of 16 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.
Review Allied Health FTE	Return to benchmark through a conservative reduction of 9 FTE
Review Hotel Services FTE	Return to benchmark through a conservative reduction of 4 FTE
Review People & Culture FTE	Review the growth of 37.3 FTE to ensure it is funded or aligned to/providing ROI benefits such as improved recruitment or workers compensation

Other Affordable FTE Target	LHD should review all non-NHPPD staffing profiles to identify and meet a conservative target reduction of 35 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.
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 MLHD 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.
Virtual Care	Work with the MoH to implement VC as a substitutive model of care to onsite medical agency/locum use.
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.
Quinquennium Review/VMO standardisation	Pursue the opportunity to standardise sessional payments where possible under the sponsorship of the District DMS should lead this process. This also includes a review of any historical arrangements that may be in place used to attract individual medical officers to the LHD for removal and/or standardisation
Non Inpatient Clinic Review	Expedite the review underway of non-inpatient clinics. Where this is not directly linked to the Clinical Services Plan and/or is providing low ROI, these clinics should be disinvested in
District Patient Flow Model and Resources	Review LHD patient flow resourcing.
Workers Compensation	The LHD strengthen the current program of work with additional strategies that have proven successful in other LHDs.
Surge beds	Develop a planned approach to reduce the use of surge beds as well as ensure that the opening of these beds are approved by an LHD clinical or operations executive
Reduce Length of Stay	The LHD should review opportunities to reduce length of stay and closure of beds.
Low Activity Plans	Management should use historical activity data patterns to identify periods of lower activity i.e. Easter holidays, 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.

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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. A target of $2.7m has been recommended in RMR expense reduction.
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 and Cost Effective Medicines	The MLHD PMO work with Pharmacy on maximising the introduction of cost-effective medicines and obtaining of pharmacy rebates.
Pathology	The LHD work with NSW Health pathology to: • Establish a prospective review of all order claims where any errors or missing information that would otherwise result in a Medicare rejection, be addressed. • Establish a working party with NSW Health Pathology to undertake a 'deep dive' review of all rejected claims over the last 22-months, correct these and resubmit to Medicare. • Review use of point-of-care testing (POCT) and ensure that the mix of POCT and laboratory testing is maximising the most cost-efficient approach, especially for smaller sites. • Implement a DMS led review of order sets in partnership with NSW Health Pathology to minimise diversity of order sets where possible and ensure authorisation steps are in place were required in order to minimise unnecessary and/or expensive order requests.

STAKEHOLDERS CONSULTED

- Ms Jill Ludford, Chief Executive
- Ms Glynis Ingram, MLHD Board Chair
- Mr Kevin Lawrence, Director of Finance
- Mr Tony Kolbe, PRP MLHD Board Sub-Committee Chair
- Ms Carla Bailey, Executive Director Operations
- Mr Paul Templeton, Interim Director Mental Health, Drug & Alcohol
- Ms Sharlene Brown, MH Inpatient Manager
- Ms Tegan Reid, General Manager Rural Operations
- Ms Christine Stephens, District Director Nursing & Midwifery
- Prof Len Bruce, Executive Director Medical Services and General Manager WWBH
- Mr Bryce Addison, MLHD PMO
- Ms Anne McLeish, Interim Director of People and Culture
- Ms Kate Woodward, Interim Director Nursing & Midwifery, WWBH
- Ms Kristy Watson, Acting Deputy Director Nursing & Midwifery, WWBH
- Ms Alyssa Nesire, Orthopaedic ward, Nurse Unit Manager, WWBH
- Dr Denis Smith, Director Medical Services WWBH
- Ms Katrina Smith, Finance Manager, WWBH
- Mr William Pleming, Senior Management Accountant Operations, WWBH
- Mr Justin Curran, Interim Manager Corporate and Business Services, WWBH
- Ms Emma Field, Director Integrated Care & Allied Health
- Ms Joanne Garlick, General Manager, GBH
- Ms Beck Kelly, Business & Operational Performance Manager GBH
- Dr Sunil Adusumilli, Director of Medical Services GBH
- Ms Kat Schwerin, Director of Nursing & Midwifery GBH
- Ms Debbie Charles, Acting Deputy Director Nursing & Midwifery, GBH
- Ms Callie Macklin, Medical & Rehabilitation ward, Nurse Unit Manager, GBH

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Appendix 1 – Financial Literacy Program

Current Financial and Way Forward

Matthew Daly
Principal Consultant
MD Consulting

February 2021

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Where is CCLHD positioned financially as an organisation?

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Current financial forecast

As at January 2021:

	GEN exc. COVID			COVID			TOTAL GEN		
	Jan-21 Full Year (Forecast)			Jan-21 Full Year (Forecast)			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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What makes up the current financial position?

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Whichever way you cut it:

- Financial
- FTE
- ABF inefficiencies

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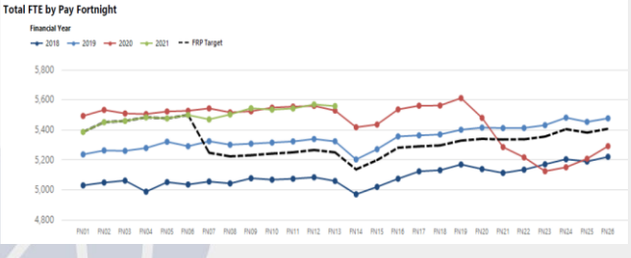
CCLHD



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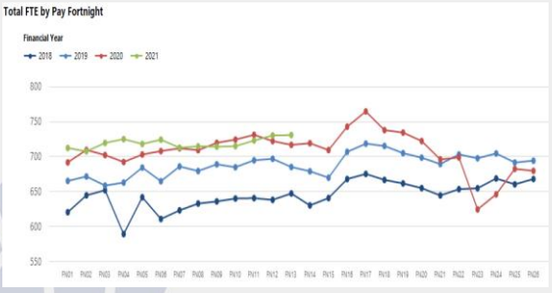
Medical



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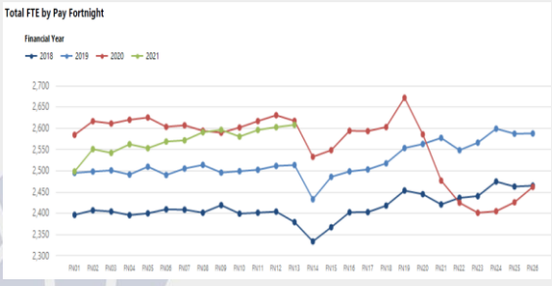
Nursing



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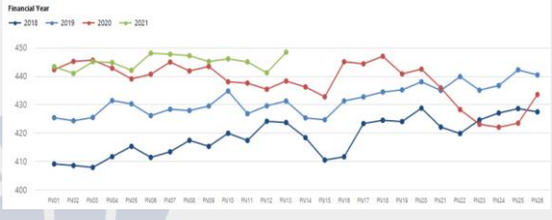
Allied Health



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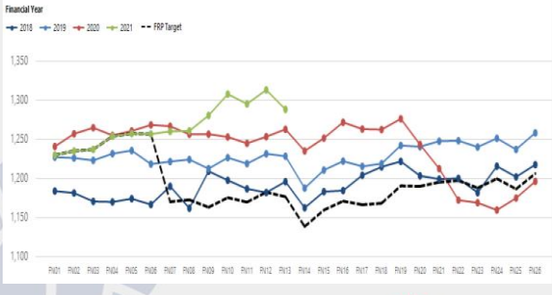
Wyong



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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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Budget Worst Case Scenario

CCLHD needs to transition from an unfavourable forecast variance to a balanced budget by 2022/23

2020/21 $30.0 million

2021/22 $15.0 million

2022/23 On Budget

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Cash Savings Plan

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

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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

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- 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

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Average cost per NWAU 2019-20

Results for 2019-20 — Show Movement

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	701,847	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	706,911	132,472	$5,058	$670,093,395
NS	1,141,811	188,020	$5,325	$1,001,289,175
SCHN	693,327	106,888	$5,221	$553,046,285
SES	1,335,688	255,620	$5,127	$1,310,664,353
SNSW	338,045	55,347	$5,892	$326,091,931
SWH	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	$5,622	$1,187,774,678
WNSW	668,286	100,968	$5,076	$511,883,599
WS	1,483,666	264,378	$4,987	$1,318,447,394

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Major Findings and Opportunities: ABF

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 Surg	$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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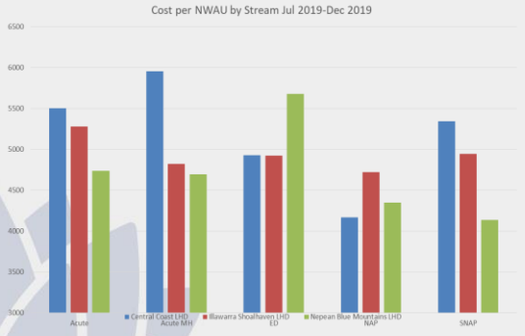
Major Findings and Opportunities: ABF



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Your Role as Leaders

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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 - 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

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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.