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Hunter New England LHD Review

February 2024

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Executive Summary

Hunter New England Local Health District (HNELHD) covers a region of 131,785 square kilometres and extends from Belmont to Urbenville in the north. In 2021 the estimated population was 962,390 residents and over the decade to 2031 the population is projected to increase to 1,038,920. Services are provided across 26 hospitals, 12 multi-purpose services, 40 community health services. The LHD employs over 16,033 staff.

HNELHD is focussed on innovative, safe and high-quality care to a diverse population over a large geographical area. As well, the LHD is focused on improving the effectiveness and efficiency of its hospital-based services and ensuring that our community receives care in the most appropriate setting, be that hospital, in the community or in their home.

Financial Position

HNELHD 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 forecast delivery of an unfavourable (UF) end of year variance to budget of 3.56% in 2023/2024, in both expenditure ($52.72m) UF against a budget of $2.889m, and own source revenue ($5.59m) UF. This result follows the delivery of an UF budget in 2022/23 of $20.8m. Given the year to date actual, the LHD should review if this full year projection is achievable.

Table 1: HNELHD FY24 Forecast January 2024

Expenditure YTD Variance		FY FC Variance		Revenue YTD Variance		FY FC Variance		NCOS		Perf Lev
$M	**% Var to Budget**	**$M**	**% Var to Budget**	**$M**	**% Var to Budget**	**$M**	**% Var to Budget**	**$M**	**% Var to Budget**	
-50.53	-2.91%	-52.72	-1.79%	1.99	0.00%	-5.59	0.00%	-58.36	-3.56%	1

Source: MoH Finance submitted January 24 results

HNELHD	FY24 $M	FY24 % Var to Budget	MoH Budget Support $M
Expenditure	-52.72	-1.79%	$7.0M 1,112 FTE funding for Safe Staffing Level $3.40M Rural Health Workforce Incentive (additional funding) $1.95M Gas Price Increase $1.56M COVID-19 Antiviral Pharmaceutical Stockpile $0.72M TMF APA adjustment $17.585m for 134 FTE Workforce Resilience - recurrent
Own Source Revenue	-5.59	0.00%	$1.45M Waived Car Parking Fee for Staff
Other Items	-0.06	-3.44%	
Net Cost of Service	-58.36	-3.56%	

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Table 2: HNELHD FY23 Result & MoH Budget Support

HNELHD	FY23 $M	% Var to Budget	MoH Budget Support $M
Expenditure	(24.2)	-0.9%	$5.8M Deferred Care (One off) $36M COVID Response (Jul 22- Dec 22) (One off) $18M R&R Building and Sustaining the Rural Health Workforce Initiative Strategy Funding (One off)
Own Source Revenue	3.6	1.0%	
Other Items	(0.2)	-13.0%	
Net Cost of Service	(20.8)	-0.8%	

Source: MoH Finance

It is recognised that the LHD has historically delivered on-budget results and strong focus on efficiency. However, contributing to this position has been a growth in FTE which has outpaced the increase in funded activity. Unlike other LHDs experience financial challenge through COVID and where significant increases in FTE were experienced from FY20 onwards, HNELHD has experienced over 97% of its significant FTE growth over the last two financial years.

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, several recommendations, which provide savings and efficiency opportunities, 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

Note it is the intention of the review recommendations to provide a platform from which the LHD can develop a more expansive financial recovery program. Recommendations made reflect successful efficiency initiatives implemented in other LHDs and any targets have been set based on a conservative assessment of the data. It is the responsibility of the LHD to consider and implement the recommendations, however, there may be some recommendations that the LHD chooses not to action. This is the prerogative of the LHD, however, the LHD must find other strategies of equal of greater savings to implement as a substitution.

FTE Growth

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 by 1,379 FTE or 11.62%. However, the majority of that growth experienced was from FY22 to FY24 – 1,344 which is equivalent to a 97.5% growth as a proportion of the total growth over the period. 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.

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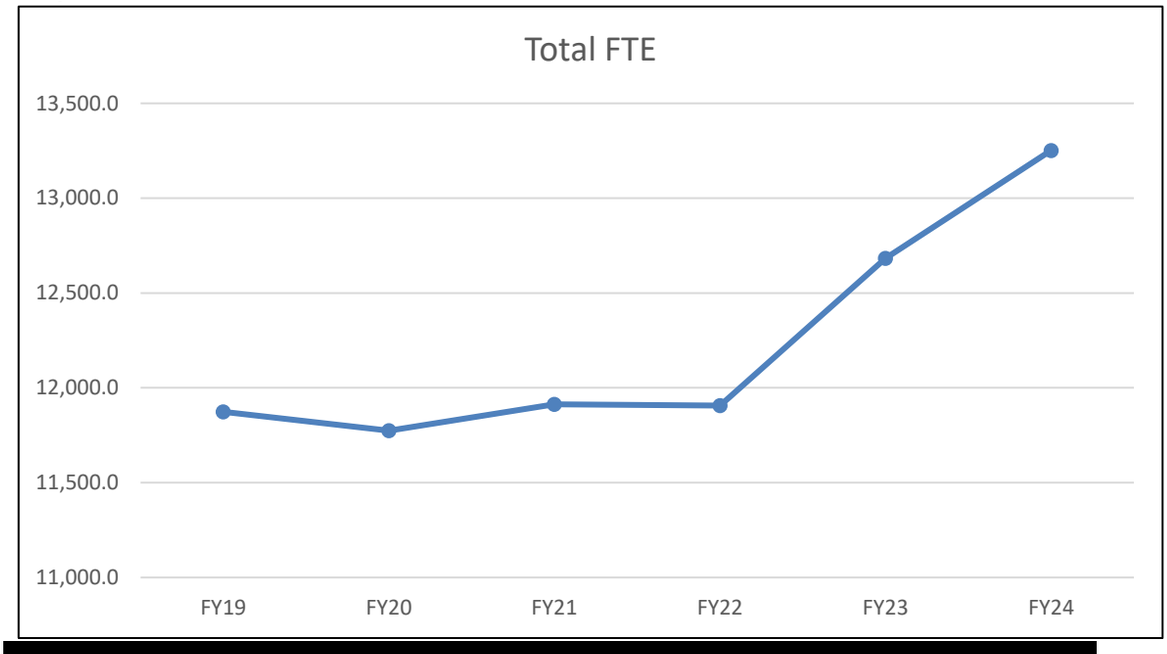
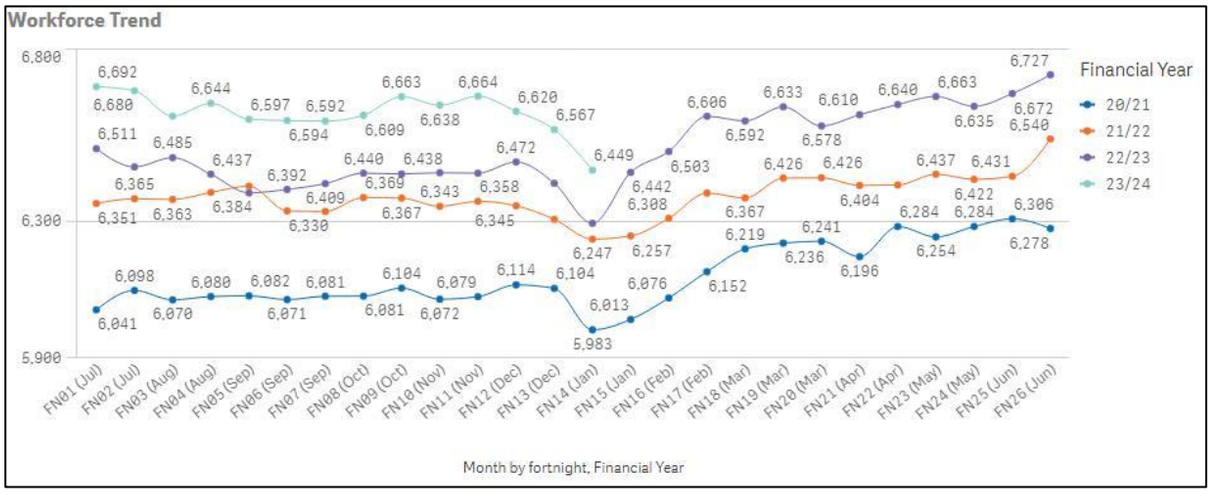
Graph 1: Growth in FTE



	FY19	FY20	FY21	FY22	FY23	FY24*
Total FTE	11,872.6	11,774.1	11,912.3	11,907.3	12,682.5	13,251.7

*Source: HNELHD (*FY24 YTD December)*

Graph 2 Demonstrates the year-on-year FTE growth



- Of the LHD's major hospitals John Hunter Hospital experienced the most growth in FTE 32%, followed by Maitland Hospital 19% growth in FTE, and both Manning Base and Tamworth Hospital with 11% growth.

Table 3: FTE growth by facility

Hospital	FTE Growth
John Hunter Hospital	440.8
Manning Base Hospital	154.5
Armidale Hospital	91.4
Tamworth Hospital	153.4
Maitland Hospital	260.0
Other Facilities/Services	277.3

Source: HNE LHD

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Table 4: FTE Growth by Award

Average FTE Growth FY2018/19 to FY2023/24 By Award	John Hunter Hospital		Manning Base Hospital		Tamworth Hospital		Armidale Hospital		Maitland Hospital		Other Facilities		Average % increase
Allied Health	28.3	14%	8.9	32%	6.4	11%	10.3	45%	16.2	49%	100.0	11%	25.3%
Corporate Services & Hospital Support	32.8	9%	8.3	9%	8.5	8%	15.9	40%	13.3	19%	3.1	0%	14.2%
Hotel Services	35.4	305%	31.0	2344%	15.1	252%	8.2	256%	15.0	1500%	30.3	20%	779.5%
Maintenance & Trades	0.1	0%	-2.0	-22%	-0.5	-5%	0.8	25%	0.0	0%	-21.1	-24%	-6.5%
Medical	58.2	10%	35.5	50%	22.0	15%	4.6	11%	27.9	20%	71.1	16%	20.3%
Nursing	198.5	12%	69.5	23%	76.4	15%	40.8	24%	168.7	44%	80.0	3%	20.2%
Oral Health Practitioners & Support Workers	0.0	0%	0.0	0%	0.0	0%	0.0	0%	0.0	0%	4.5	3%	0.5%
Other Prof. & Para Professionals & Support Staff	74.8	505%	-2.3	-66%	22.7	309%	7.8	403%	18.3	822%	1.2	1%	329.0%
Other Staff	9.4	994%	3.4	1592%	1.5	135%	0.5	53%	-0.4	-12%	-3.4	-7%	459.2%
Scientific & Technical Clinical Support Staff	0.6	0%	3.9	14%	-0.9	-3%	0.0	0%	6.4	25%	6.2	5%	6.8%
Total	**438.1**	**15%**	**156.17**	**30%**	**151.1**	**18%**	**88.8**	**31%**	**265.3**	**40%**	**271.8**	**4%**	**164.9%**

Source: HNE LHD

- From a LHD Division/Directorate perspective, the highest proportion of the 1,379 FTE service growth was in Children Young People & Families (99 FTE), followed by Finance (59.1 FTE) and Medical Workforce (30.7 FTE). This growth corresponds with growth in Employee Related Expense (ERE) for these Directorates since FY19 of $11.88M for Children Young People & Families ERE, $7.09M for Finance ERE and $3.68M in Medical Workforce ERE.
- All staff Awards have increased their % of FTE except Maintenance and Trades which has decreased. Nursing and Medical have increased in proportion to each other approximately 20%, with allied health increasing slightly more by approximately 25%.
- Hotel Services, other professional and paraprofessional/support staff and other staff have increased substantially. There may be clear reasons for this, but there is the opportunity to review the wide-ranging difference in the increase in staff.

Activity - District level

A key source of funding is through activity funding. It should be recognised that LHD activity initially declined at the beginning of COVID but has now increased since 2019 to 2023 by 5.15%. Acute activity almost mirrors this with an increase of 6.48%. Non-Admitted activity for HNELHD has increased since FY18 by 627,697 OOS or 24.2%. HNELHD total NWAU per FTE has decreased from FY2018/19 to FY2022/23 by 2.2%.

Whilst the MOH through the service agreement, provides the total activity for the LHD, it is the decision of the LHD where to allocate within its services this activity. The NWAU funding remains consistent wherever the services are being provided. The LHD overall average cost per NWAU ($5,625) is below the State average of $5,756.

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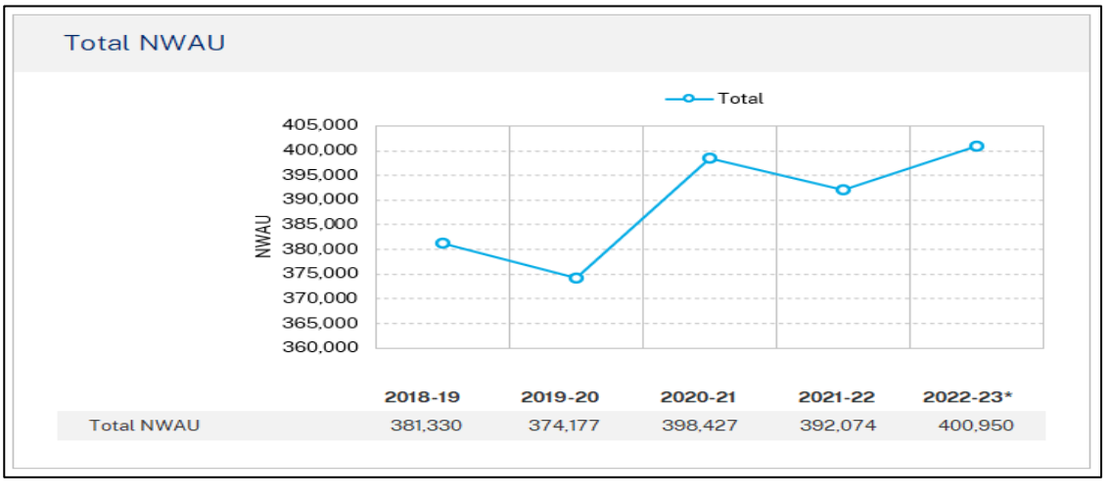
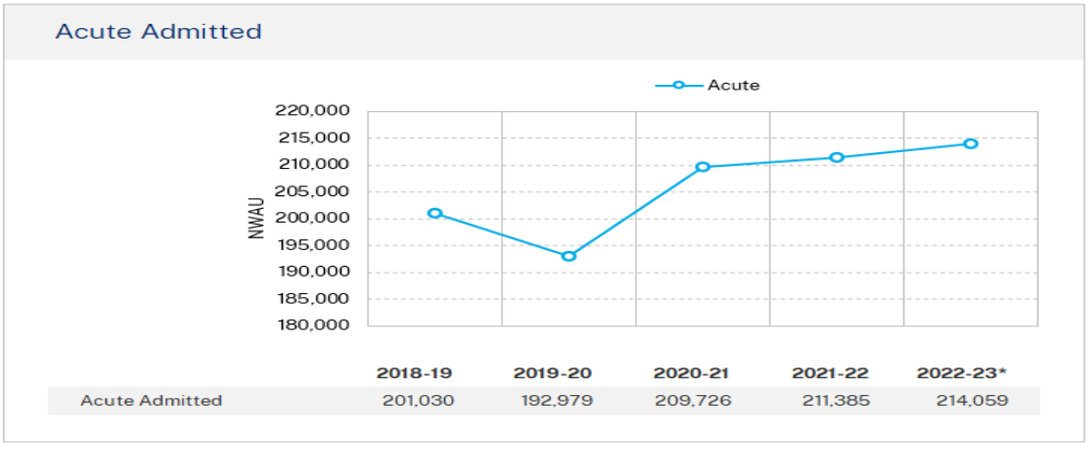
Graph 3: Total NWAU



	2018-19	2019-20	2020-21	2021-22	2022-23*
Total NWAU	381,330	374,177	398,427	392,074	400,950

Source: MoH SIA

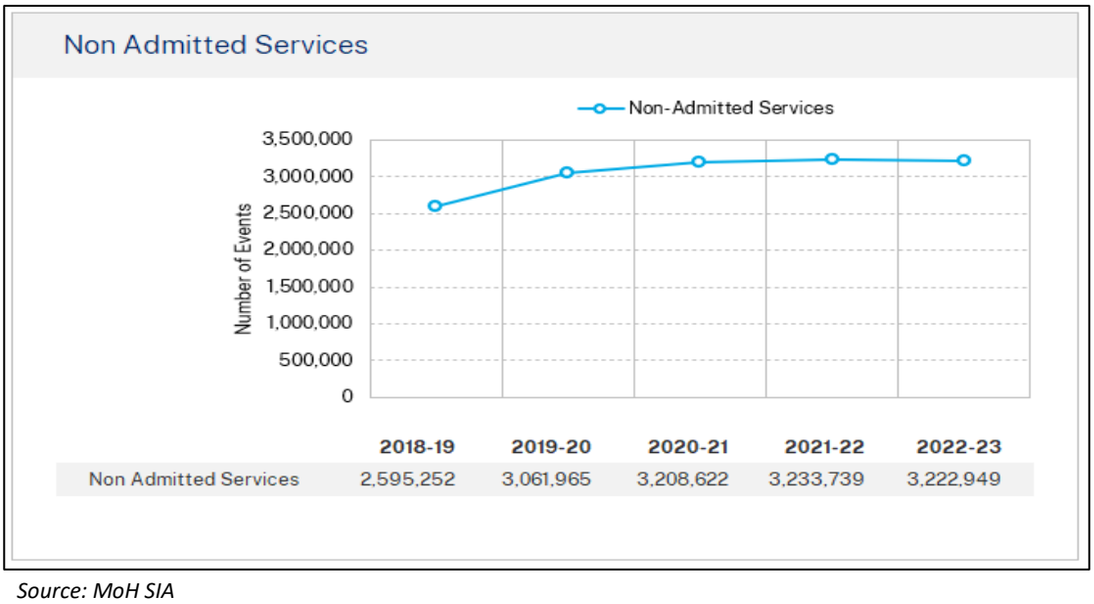
Graph 4: Acute Admitted NWAU



	2018-19	2019-20	2020-21	2021-22	2022-23*
Acute Admitted	201,030	192,979	209,726	211,385	214,059

Source: MoH SIA

Graph 5: Non-Admitted Services



	2018-19	2019-20	2020-21	2021-22	2022-23
Non Admitted Services	2,595,252	3,061,965	3,208,622	3,233,739	3,222,949

Source: MoH SIA

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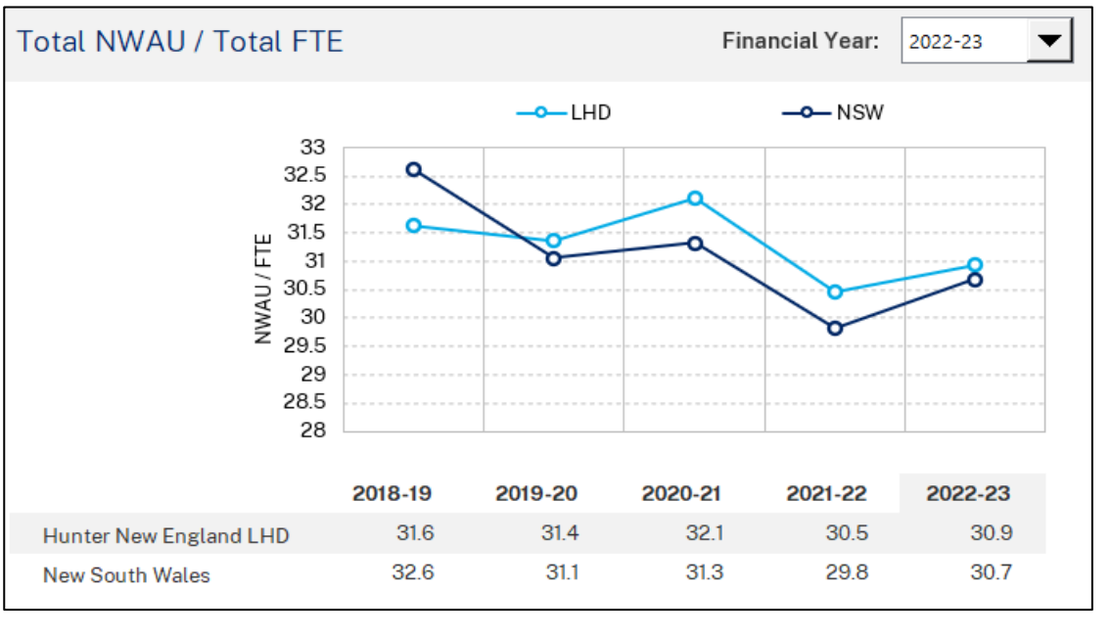
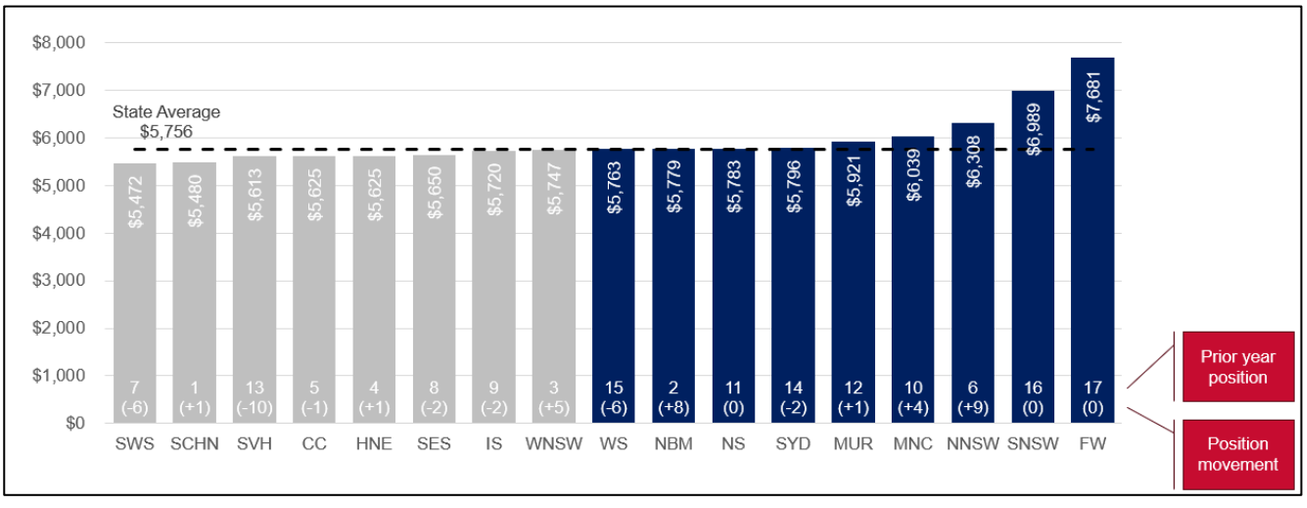
Graph 6: Total NWAU / Total FTE



	2018-19	2019-20	2020-21	2021-22	2022-23
Hunter New England LHD	31.6	31.4	32.1	30.5	30.9
New South Wales	32.6	31.1	31.3	29.8	30.7

Source: MoH SIA

Graph 7: Average cost per NWAU23 (2022-23 District and Network Return (DNR) results)



Source: MoH SIA

Activity – ED

Overall, ED activity for the LHD has increased by 5.02% since FY19. This is inclusive of only a 0.1% increase in presentations across the LHD in the past year. JHH has declined by 5.4% and Manning has increased by 6.8%.

From FY2019 to FY2023 Triage Category 1 has been at consistent levels, however, Triage Category 2 and 3 has seen an increase in the number of presentations. Triage Category 3 saw an increase in over 19,000 presentations, a growth of 17.13%. From FY2019 to FY2023 Triage Category 4 saw an increase of 3,076 presentations, a 1.5% growth. However, Triage Category 5 has seen a decline in the number of presentations (-12,368) equating to a decline of 18.5%.

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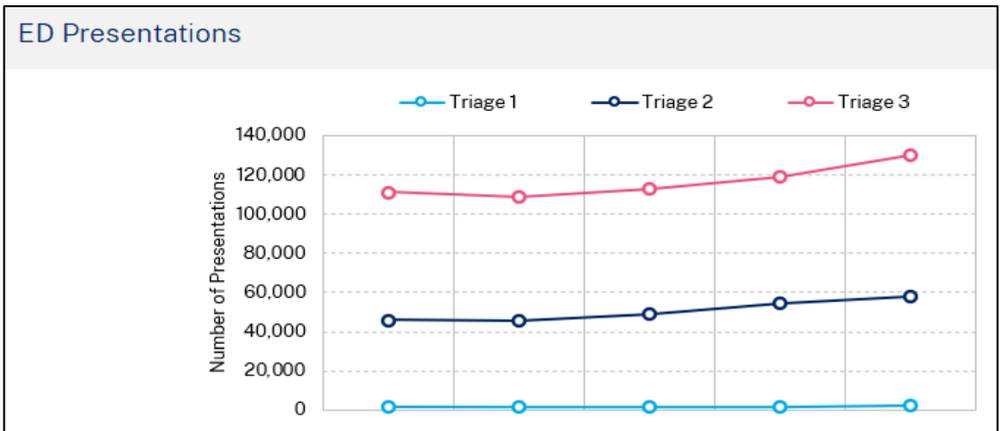
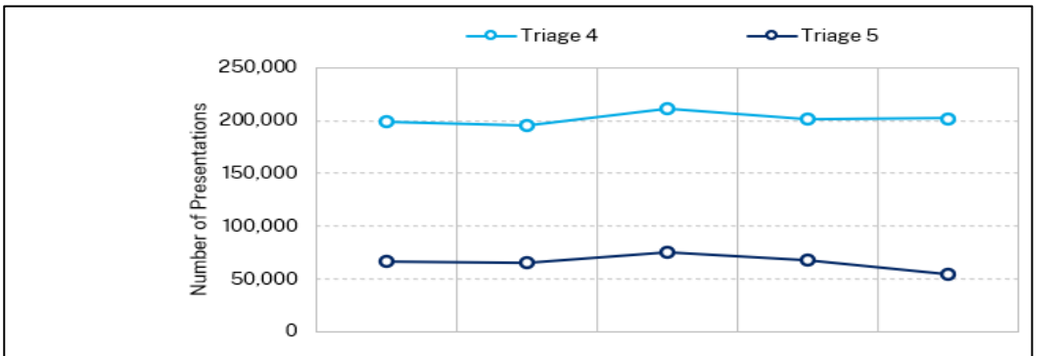
Graph 8: ED Presentations T1-T3 FY18-19 to FY22-23



Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 1	1,609	1,739	1,748	1,806	2,159
Triage 2	45,876	45,824	48,780	54,345	57,928
Triage 3	111,152	109,017	113,121	118,820	130,187

Graph 9: ED Presentations T4-T5 FY18-19 to FY22-23



Triage Category	2018-19	2019-20	2020-21	2021-22	2022-23
Triage 4	199,002	195,103	211,454	201,269	202,078
Triage 5	66,851	65,944	74,892	68,299	54,483

Source: MoH SIA

Table 5: ED Activity

Emergency Department Activity

Hospital	ED Attendances			Admitted to ward/ICU/Operating Theatre			Transfer of Care		
	Nov 2023	FYTD Nov-23	Change on LY-YTD	Nov 2023	FYTD Nov-23	Change on LY-YTD	Nov 2023	FYTD Nov-23	Change on LY-YTD
Armidale and New England Hospital	1,597	8,332	6.3 %	298	1,563	0.1 %	76.1 %	81.4 %	-3.2
Tamworth Base Hospital	3,344	18,340	5.4 %	868	4,536	11.0 %	74.2 %	73.0 %	1.9
Manning Base Hospital	2,948	15,310	6.8 %	623	3,263	7.7 %	56.8 %	63.0 %	-17.7
Maitland Hospital	4,296	22,040	3.9 %	732	3,760	9.7 %	76.9 %	72.4 %	-7.3
Calvary Mater Newcastle	3,166	16,267	-0.4 %	922	4,641	-1.1 %	62.3 %	63.7 %	-1.2
Belmont Hospital	2,337	11,875	-2.4 %	340	1,788	6.1 %	82.8 %	80.7 %	5.3
John Hunter Hospital	6,548	34,367	-5.4 %	2,076	10,815	-0.3 %	70.2 %	69.2 %	-8.4
All Other Hospitals (peer group C2 and below)	11,214	58,188	-1.3 %	671	3,392	-8.8 %	94.0 %	94.1 %	-1.7
Hunter New England LHD	**35,450**	**184,719**	**0.1 %**	**6,530**	**33,758**	**2.1 %**	**74.3 %**	**74.2 %**	**-5.1**
NSW Health	**244,120**	**1,273,846**	**1.2 %**	**59,893**	**313,646**	**5.2 %**	**79.9 %**	**79.0 %**	**2.0**

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NDIS and RACF patients

The length of Stay across HNELHD is 3.22 days, however the LHD has significant numbers of NDIS and RACF patients staying over their estimated date of discharge (EDD). As of February 2024, 39% of NDIS patients (22) and 78% of RACF patients (61) exceeding their EDD currently 6,280 days costing the organisation an estimated $3.89m. Overall HNELHD has 13% of the NSW Health total of NDIS patients and 15% of RACF patients in their acute care beds.

Table 6: NDIS and RACF inpatients NSW

07FEB2024	NDIS			RACF			Total		
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
CCLHD	12	9	473	26	20	565	38	29	1,038
FWLHD	.	.	.	13	13	344	13	13	344
HNELHD	57	22	1,399	78	61	2,138	135	83	3,537
ISLHD	17	10	567	87	86	2,635	104	96	3,202
MNCLHD	8	6	404	18	11	158	26	17	562
MLHD	10	2	49	6	5	213	16	7	262
NBMLHD	26	18	1,041	23	15	586	49	33	1,627
NNSWLHD	5	4	176	48	26	847	53	30	1,023
NSLHD	57	19	2,172	27	18	2,287	84	37	4,459
SESLHD	29	16	1,296	40	30	519	69	46	1,815
SWSLHD	51	28	2,047	65	43	1,039	116	71	3,086
SNSWLHD	7	3	139	5	.	.	12	3	139
SVHN	19	6	98	1	.	.	20	6	98
SLHD	62	16	1,326	28	17	930	90	33	2,256
WNSWLHD	19	8	1,047	26	21	356	45	29	1,403
WSLHD	54	32	2,619	20	13	647	74	45	3,266

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FTE Realignment to Outputs

Over the last five financial years FTE growth has out-paced activity. It is therefore recommended that HNELHD achieve a conservative reduction of 283 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 $35.9M in expense relief, the equivalent of 2% reduction of the LHDs underlying ERE expense budget of $1.75B, based on an average salary of $127,000. These FTE reductions will be achieved through implementing, commencing in FY24, the recommendations in this review report particularly those focused on ERE. Failure to realise benefits from the LHDs FY24 Efficiency Improvement Plan and planned strategy to reduce reliance on nursing and medical agency staff and locums will require additional FTE to be added to this recovery target to bridge the gap. If the LHD chooses not to implement the recommended strategies, then alternate ones must be implemented that achieve the same result.

Table 7: Affordable FTE

Existing FTE Profile	Required FTE Reduction Target	End of recovery Plan Affordable FTE
13,251.7 FTE	283FTE	12,968.7FTE

Table 8: Strategy by FTE Reduction and Targeted Savings

HNE Strategy Summary (HSM JE)	Target FTE Q4 FY24	Target Savings Q4 FY24	Target FTE FY25	Target Savings FY25
Reduction in Nursing OT	25	$3,175,000	75	$9,525,000
Reduction in JMO overtime	15	1905000	45	$5,715,000
Return to Peer Senior Management (HSMs)	8	$1,016,000	12	$1,524,000
Health Roster Improvement	5	$635,000	5	$635,000
Managing NHPPD to Award – Mental Health	2	$254,000	0	
Return to Peer Supernumerary Nursing - CNCs	5	$635,000	15	$1,905,000
Return to Peer Supernumerary Nursing - CNEs	4	$508,000	8	$1,016,000
Reduction in specials	3	$381,000	1	$127,000
Affordable FTE Reprofile of non-NHPPD wards and all District Services	2	$254,000	8	$1,016,000
Reduction in Allied Health	5	$635,000	20	$2,540,000
Reduction in other services	10	$1,270,000	10	$1,270,000
Total	**84**	**$10,668,000**	**199**	**$25,273,000**
			283	**$35,941,000**

Efficiency Improvement Plans

There is a robust EIPs process embedded across NSW Health which provides transparency of savings and benefits achieved to both the LHD executive and to MoH. Whilst it is understood that not every savings achieved will be reported through this process it is particularly important for LHDs with significant financial challenges to maximise their submission and reporting of EIPs. This provides visibility to the LHD CE, Board and Executive when monitoring savings as well as the MoH. For FY24 the LHD has a total of 10 EIPs, of which four are mandated Whole of Government (WofG) Savings EIPs, targeting $39.468m. A clear challenge for HNELHD will be to not only deliver on the FY24 EIP program but increase the focus of the savings program on reducing ERE, especially when ERE accounts for between 60-70% of an LHDs total expenditure. Currently the

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LHDs EIP program is targeting only 13.7% ERE, in comparison the NSW Health wide average is currently 46.5% of all EIPs being ERE focussed and therefore the LHD needs to address this deficit of ERE focus.

Table 9: HNELHD EIP Program Summary

HNELHD EIP Program Summary	EIP category	Account category	Planned value $m
Overtime Reduction FY 2023-24	Expenses	ERE	$1,884
Corporate Overhead budget reduction 2023-24	Expenses	ERE	$2,744
Increase in savings from Salary Packaging FY 2023-24	Expenses	ERE	$514
Savings Leadership program FY2023-24	Expenses	G&S	$6,365
Part year VR benefit from FY23	Expenses	ERE	$290
Cessation of collaborative care FY 2023-24	Expenses	G&S	$25,000
WofG Reduction in Advertising Costs FY 2023-24	Expenses	G&S	$311
WofG Reduction in Consultant Costs FY 2023-24	Expenses	G&S	$779
WofG Reduction in Legal Costs FY 2023-24	Expenses	G&S	$158
WofG Reduction in Travel Costs FY 2023-24	Expenses	G&S	$1,603

Table 10: HNELHD EIP Program Focus Areas

EIP Focus	# of EIPs	Sum of Planned value ($m)	% Of Planned Value
Employee Related Expenses	4	5,432	13.7%
Goods & Services	6	34,216	86.3%
Grand Total	**10**	**39,648**	**100.0%**

It is therefore recommended that the LHD ensure for FY25 that financial recovery strategies implemented are where possible reported through the NSW Health EIP program.

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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. 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. Executive Leadership Team

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

- Consider implementing a regular and specific ELT member-based meeting focused entirely on financial recovery. This will ensure dedicated time is focused on this objective and enable the usual ELT to maintain its BAU focus. As the LHD returns toward an on-budget position this meeting can be scaled-back and eventually dissolved. This meeting should include:
    - Updates from recovery project manager (if implemented) or the DOF on:
        - Verified savings v target performance
        - Number of new savings verified since last meeting
        - New issues and risks (for sustainability risk log)
    - Update from members on initiatives that they are sponsoring and/or leading (including any working groups being chaired – i.e. pathology, discretionary food etc.)
    - A central point for the reporting and monitoring all savings initiatives being undertaken across the LHD.
    - 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 HNELHD at a service or ward level.

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

    - Identification of initiatives not progressing and mitigation actions
    - Committee identification of new savings concept ideas for investigation.
- Identify and agree on conservative FTE reduction targets and/or limiting growth in cost and allocate financial efficiency outcomes across the services and facilities to be delivered and factored in to FY24 and out year projections.
- Ensure return-on-investment (ROI) is well understood on any service enhancement or FTE request and furthermore that benefits realisation is appropriately evaluated in a well understood framework.
- Monitor closely the implementation steps of EIPs to ensure they are implemented on time and that any risks are mitigated. ELT sponsors should report on progress and mitigations they have implemented to address any 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**
   - The Board understand the approach and communicates support for the CE and ELT in achieving the required savings.
   - The CE provides a regular update on recovery activity and achievements as part of the CE Board report.
   - The DOF provides the F&P Committee with a regular report on all recovery activity.
   - That services or directorates consistently not performing to budget (i.e. UF ⩾4% to budget if previous Performance Framework example used) be required to present to the Finance and Performance Board Sub-committee on their approach to mitigate their budget position.
3. **Dedicated Recovery Project Officer**

   Consider developing a senior project officer role which is responsible for leading and supporting Executive with the recovery plan. Consideration should be given to this role reporting to the CE. Where this has previously occurred, the role is required to work closely with the DOF, however, the reporting line to the CE provides the role with a CE mandate when engaging with stakeholders and the role is not seen as simply 'finance'.
4. **Monthly Accountability Meetings (MAMs)**

   With many competing service issues which staff and managers need to discuss, it is common 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 agendas. This should commence with senior leadership down and include discussion on cost centre performance review, savings identification, and achievement against the affordable FTE target/re-profiled FTE profile.
5. **Recovery Communication Plan**

   Throughout stakeholder engagement it was clear that staff outside of the leadership team were not aware of the financial situation. A key to creating a strong culture and discipline around budget performance and identification of savings will be to engage all service staff. A communication plan should be developed which:
   1. Informs staff of the current financial position and need to recover.
   2. Steps being undertaken to mitigate the financial unfavourability.
   3. Encourages staff to identify efficiencies and which recognises/celebrates savings identified.
6. **Recovery Initiative Tracking Tool**

   It is recommended that a tracking tool be used that details all strategies being implemented and identifies who the key sponsors are, target savings (if known) and whether these savings are recurrent or once off, key milestones and timing of savings. This tool can be used for governance committee reporting and rolling up savings into MoH efficiency roadmaps. A number of LHDs have implemented a similar tool. Contact the Efficiency Improvement Team MoH for options.
7. **Concept Development/Capture**

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

WORKFORCE EFFICIENCIES

The fundamental issue to be addressed in order to recover to an on-budget and sustainable position is the growth of FTEs over multiple financial years. Whilst patient safety will always remain the priority in the decision making on position retention or otherwise, the LHD has quality data at its disposal which identifies clearly where this growth has occurred over the last five years, and this should be utilised to inform the decisions made in the return to sustainability.

Recommendations

The following recommendations are made:

1. Affordable FTE Profile

It is imperative that HNELHD 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 the LHD at $127,000 with the initial FTE target requiring a reduction of 283 FTE ($35.9M). Transition to Affordable FTE targets may need to occur over 12-18 months, however, this recovery timeframe must be negotiated with the NSW Health Chief Finance Officer. As strategies are implemented and employee related expense is reduced, the Affordable FTE profile will need to be revisited as some FTE will be at higher salary cost (i.e. medical, senior nursing) and some FTE lower than this average (i.e. support and admin staff). This profile needs to be understood by all managers, monitored, and met by services within the timeframe of the recovery plan. Whilst additional budget supplementation or other own source income come with obligations for additional service delivery and advancing patient outcomes that must be met, each should be looked at as an opportunity to close the gap on Affordable FTE.

2. Approval of positions

Delegations

The CE consider removing recruitment delegations (except for nursing frontline positions), for a six-to-twelve-month period with only the DOF/ CE being able to approve. Once the situation is stable consider implementing an Approval to Fill (ATF) committee (or equivalent), whose members are senior ELT, which have been effective in other LHDs.

Cost Centre Status

It was reported that in many cases requests for recruitment approval did not include or require a documented assessment of the favourability or unfavourability of the positions cost centre. It is recommended that the relevant Finance Business Partner provide this documented assessment so that where a budget is unfavourable the delegate is in a position to make an informed decision on whether to approve or not.

Project Roles

A number of district officers advised of project or new roles being advertised that caused the front-line positions to be depleted further, causing increasing agency and overtime use. An example would be the position of a hyperemesis midwife, although this is an important role, there is a critical shortage of midwives especially in the more rural settings. Use of front-line staff in project positions need to be considered within the bigger picture and context and potential impact on the requirement of overtime back-fill using agency staff.

3. Unfunded Enhancements

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 or hospital 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), however, it was agreed there was no systematic approach to evaluate the ROI and ensure that benefits were realised. Another example was the transfer of Hotel Services staff from HealthShare to the LHD, where initial agreement between the entities was for a cost-neutral transfer through a reduction in goods and services expense (incurred by the LHD through the HealthShare pass-through cost charge) off-set by an increase salary and wages expense by the same amount. However, after completing the staff transfer the budget transferred from HealthShare has not covered the cost of the FTE and the LHD has incurred the additional cost. As such it is recommended that a register of these expenditure commitments be developed and regularly reviewed by the ELT 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.

4. Position Regrades

The LHD should ensure the process for regrading requires Finance determination that budget is available. It is recommended that it is an obligation for a proponent of any regrade to not only establish industrial obligations and service needs but to identify the funding source for any successful regrading. Approval of new positions or increasing gradings must reside only with the Chief Executive

5. HSM Band Increases via PDR.

Currently within Stafflink, a manager can increase a HSM's salary up to 5% if it is within their band. It is recommended the LHD review and consider rescinding the delegations and policy allowing this increase during financial recovery with exception only upon CE approval.

6. 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. Given the situation in HNELHD has only occurred in the past 2 years, consider reviewing all positions that have commenced at that time and review for ROI. Opportunities may exist to return these staff to the frontline easing pressure on overtime and agency.

7. 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.

8. Removal of Favourable Service Budgets

It was reported that there are some services within the LHD achieving budget and/or who have a level of favourability generally through not recruiting to vacancies. The LHD should remove the level of favourability and re-baseline the budget and FTE profile for FY25 accordingly. This will ensure that this level of savings is quarantined and minimises risk that it is eroded in next financial year if positions are recruited to. Where this favourability has been significant the LHD could consider providing that service with a lower adjusted efficiency target for future year savings.

9. 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), reduce unnecessary FTE, improve compliance with the Nursing Award and improve flow through freeing up shifts to flexibly meet high demand times or weekend requirements.

It is strongly recommended that as a priority HealthRoster upskilling commences immediately with nursing workforce NHPPD and roll-out across organisation in a planned approach. Once the revision of the staffing templates is completed, this should be reflected in Stafflink, and approval of new FTE must be restricted to the Chief Executive. Addressing the HealthRoster knowledge gaps and improving workforce demand templates would deliver an estimated 10 FTE. This 10 FTE can be saved through a variety of ways, ensuring the staffing profile, matches the budget, ensuring that NHPPD and non NHPPD departments are well governed, reducing retrospective pays and monitoring supernumerary hours. It is recommended a plan be developed with the support of the MOH Rostering Best Practice Team. The LHD is ideally positioned to address this recommended as there are currently 5 positions in the HealthRoster Service. It is recommended that they develop an agreed remediation plan-based benefits and risks and travel to the identified priority sites and assist with their knowledge and outcomes.

Unfilled Demand and Additional duties

Unused contracted hours are 25.25% and additional duties added 4.67% indicating demand templates may be inaccurate or that additional duties are being assigned and should be reviewed. Unused contracted hours indicates 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

32% 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 Rostering Best Practice 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 team. 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.

Forced Finalisation and Payroll Backdated Adjustments

Force finalisation in HealthRoster is when a roster or timesheet is finalised for pay by the Local Roster Administrator rather than the roster approver for payroll transfer. Where this happens, the roster may not have been reviewed by the roster manager meaning appropriate governance and assurance of the information being sent for pay has not occurred. Ineffective review of shifts/rosters and e-timesheets in HealthRoster increases the risk of inaccurate roster entries being approved, staff claiming, and being paid for hours not worked as well as leave not being recorded. In accurate rosters require backdated adjustments which incur the LHD as cost. In FY23 backdated changes cost the LHD $364,000 and in the first half of FY24 this has cost the LHD $194,000. Increased knowledge and education on HealthRoster could dramatically reduce this cost to the LHD. In addition the LHD has been identified as having a rate of forced finalisation of rosters (as opposed to Managers reviewing and correctly approving the roster on time) that is

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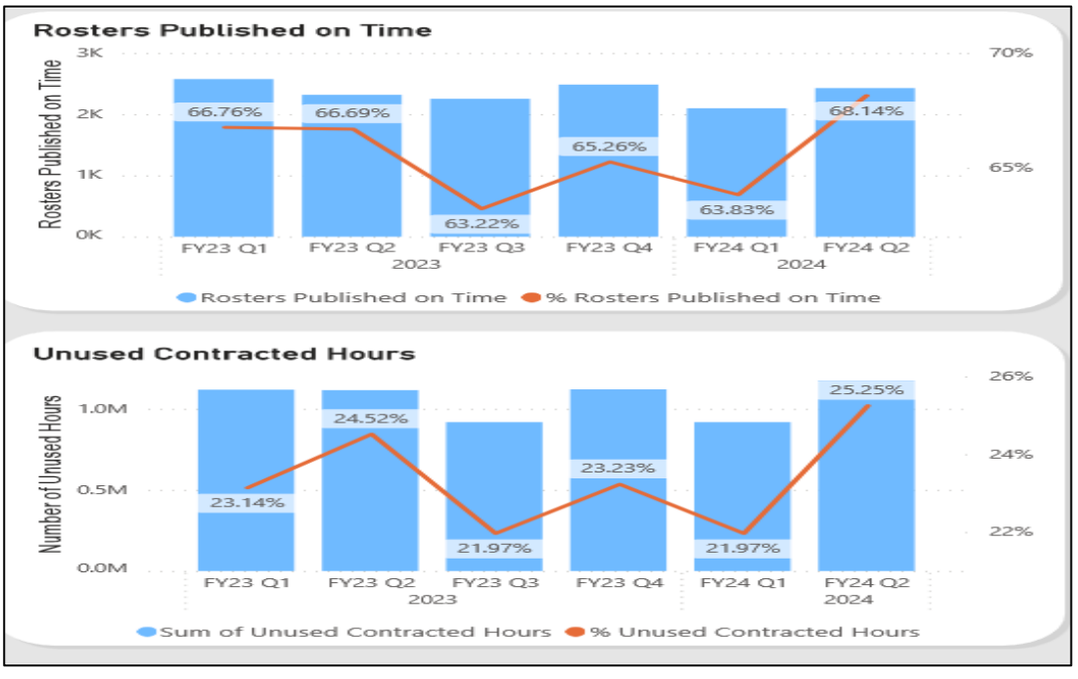
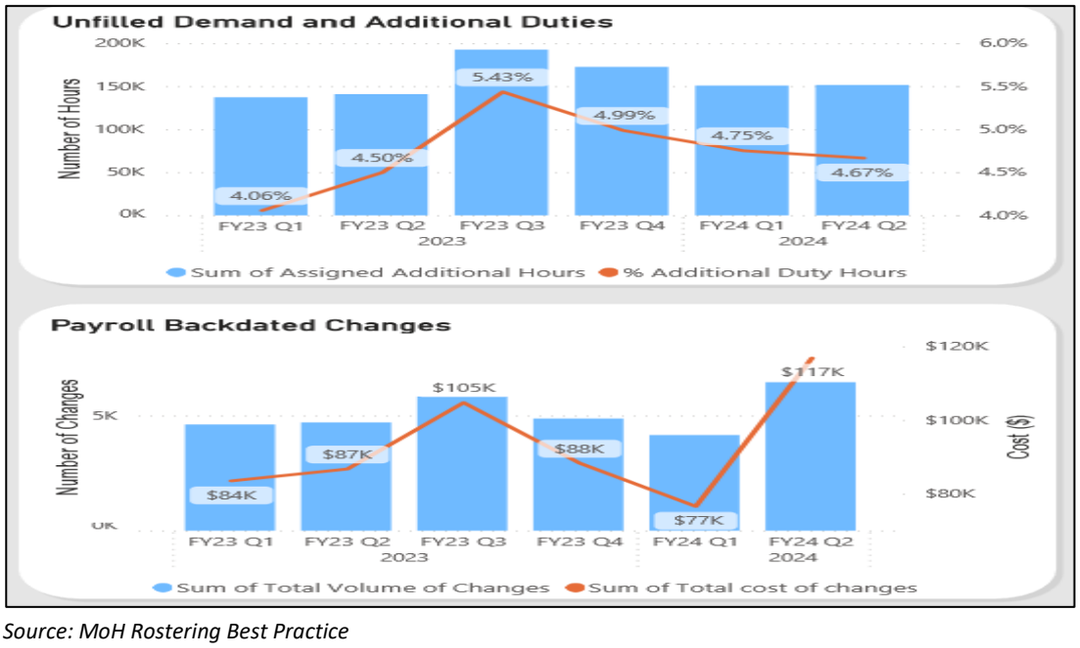
significantly above LHD peers. In FY23 the average forced finalisation rate for NSW health was 4.8%, whereas HNELHDs rate was 11.1%.

Graph 10: Rostering Best Practice Metrics





Source: MoH Rostering Best Practice

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. These reports can be used to monitor NHPPD, the see specials and supernumerary rostering and sick leave and overtime management. As part of the strategy to increase knowledge management Executive staff should be trained in running and accessing required reports or be provided to them for review.

10. Nursing Workforce Efficiencies

There has been a 14% growth since FY18 in Nursing FTE (811 FTE) which is equivalent to the state average. The largest increase in FTE occurred from FY20 to FY24 – a jump of 671FTE, representing 82% of their total

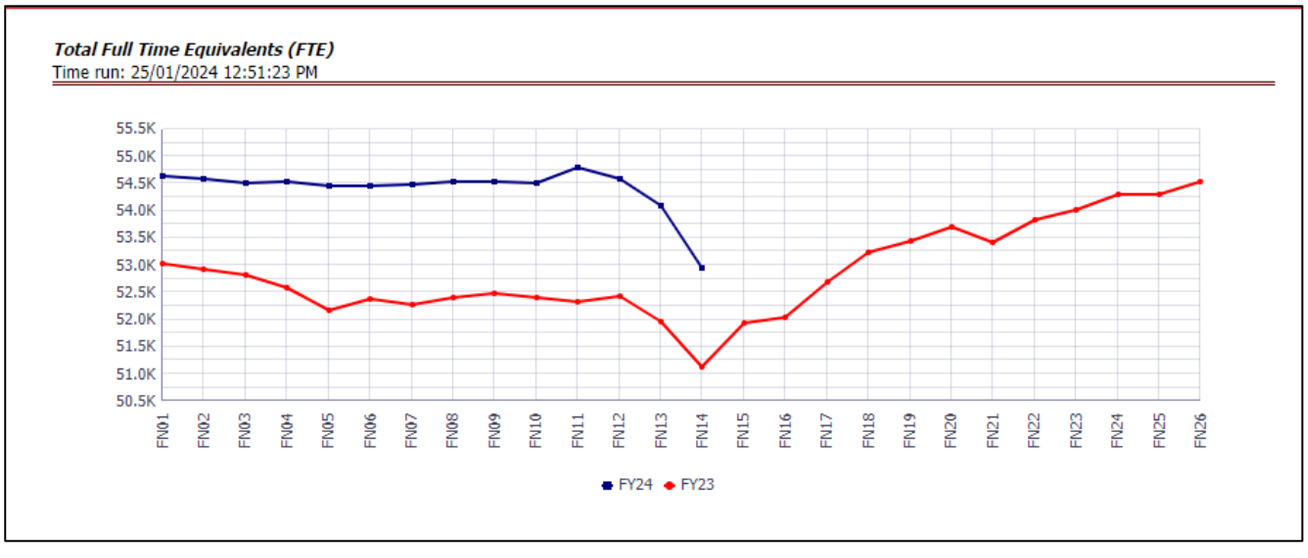
increase in FTE over that period. John Hunter received the most FTE (198.5FTE) whereas Maitland Hospital experienced the highest % growth from their FY18 base (44% 260 FTE) followed by Manning Hospital (23% 154.5 FTE).

Table10 Comparison increase in FTE

LHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	FTE Growth FY18-24	%
CCLHD	2,466	2,572	2,652	2,692	2,646	2,674	2,724	259	10%
FWLHD	295	308	299	303	309	306	328	34	11%
HNELHD	5,798	5,948	5,938	6,116	6,342	6,479	6,609	811	14%
ISLHD	2,606	2,660	2,735	2,817	2,876	2,881	2,953	347	13%
MNCLHD	1,741	1,791	1,827	1,918	2,011	2,029	2,049	308	18%
MLHD	1,760	1,827	1,857	1,908	1,926	1,953	2,006	247	14%
NBMLHD	2,050	2,088	2,148	2,242	2,281	2,345	2,449	400	19%
NNSWLHD	2,198	2,280	2,332	2,445	2,488	2,394	2,532	334	15%
NSLHD	4,132	3,901	3,709	3,841	3,895	3,849	3,958	- 175	-4%
SESLHD	4,565	4,747	4,753	4,861	4,884	4,902	5,016	451	10%
SNSWLHD	1,150	1,171	1,201	1,276	1,264	1,245	1,310	160	14%
SWSLHD	4,815	5,088	5,148	5,394	5,457	5,610	5,887	1,073	22%
SLHD	4,173	4,254	4,338	4,706	5,006	4,653	4,680	507	12%
WNSWLHD	2,437	2,469	2,484	2,557	2,597	2,628	2,695	257	11%
WSLHD	4,434	4,509	4,700	4,875	4,962	5,126	5,476	1,042	24%
All LHDs	**44,619**	**45,613**	**46,121**	**47,950**	**48,943**	**49,074**	**50,673**	**6,054**	**14%**

Source: MoH SMRS & HNE Data

Graph 11 Nursing FTE growth FY23- FY24 comparison



Other key observations on nursing workforce is that agency usage has remained stable, although the cost has increased substantially by $6.87 M, however, nursing overtime has increased by 357% ($23.43M) since 2018/19.

Nursing Hour per Patient Day

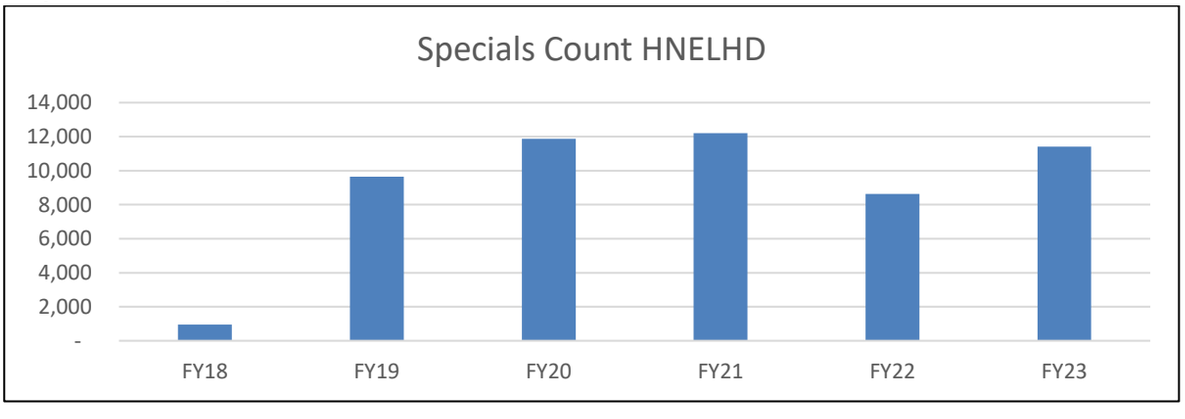
The LHD should continue to monitor NHPPD usage and ensure that the award requirements are met but not exceeded. This monitoring needs to be daily and along with other recommendations outlined on improving HealthRoster literacy and Nursing Special policy compliance, this will be integral to available savings. The NHPPD should be discussed/monitored and adjusted at the daily staffing meeting with accountability at the Executive huddles. NHPPD looks to be contained across the District at 6.0-6.3 NHPPD. However, Mental

Health looks to have an increased and sustained overrun of NHPPD and should be urgently reviewed. Managing to the Award is an effective approach to returning to an Affordable FTE without loss of positions. 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 patient observations or providing patient medications. Managing Mental Health back to the Award in line with the Districts NHPPD performance (6-6.3 NHPPD) would provide 2 FTE in savings ($254,000) and free up nursing resources.

Nursing Specials

Nursing Specials have increased 1096.1% since FY18 and shows no decrease from the pandemic era, whereas some LHDs have managed to return to pre-pandemic levels. The LHD should as a priority review and update the LHDs policy on use of nursing specials, in particular the approval steps which should be well communicated to NUMs and routinely audited for compliance (a weekly specials report can be generated from HealthRoster). Through tighter monitoring, education, and compliance with the revised policy the LHD should aim for a 50% reduction from FY23. Achieving this reduction target should provide 3 FTE in savings ($381,000), with a further 1 FTE saving in the FY25 ($127,000 in savings). To assist with controlling specials the LHD should consider that the Executive On-Call must make after-hours approval. The reduction in specials expenditure should form a routine component of the LHDs reporting on recovery at the recommended recovery governance meeting. During the review it was asserted that the high special count was a major contributing factor in the fall levels across the LHD positioning HNELHD as the leader in the State for this important quality of care KPI. However, this assertion is not underpinned by NSW Health data as other LHDs (SWSLHD, FWLHD and WNSWLHD) have a low rate of falls with a fraction of the specials usage.

Graph 10: HNELHD Specials Use FY18-FY23



Source: HealthRoster

Overseas Recruitment and vacancy rates

It is recognised that a critical strategy to reducing nurse agency/premium labour costs is the recruitment of a large cohort of overseas Nurses and Midwives (139FTE). The LHD should consider collating the vacancy rates, weekly or monthly to identify areas of need and to inform strategy. At the time of the review senior ELT staff were unable to identify the vacancy rate for the District. The vacancy rate should be agreed to between the DOF and District Director of Nursing.

CNC Roles

HNELHD has seen a 36% growth in CNC FTE (68) since FY18. The percentage increase of 36% is in line with the state average of 33%. However, it should be noted that the LHD baseline FTE numbers in FY18 were significantly higher than peer rural LHDs. In addition, 80% of this growth in FTE has occurred since FY21 (55FTE).

Table 11: CNC FTE Growth since FY18

LHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	Growth FY18-24	%
CCLHD	78	81	81	86	87	84	80	2	3%
FWLHD	13	13	13	16	19	19	22	9	73%
HNELHD	187	199	195	200	219	241	255	68	36%
ISLHD	93	97	108	114	113	122	127	34	37%
MNCLHD	64	66	73	76	81	85	91	27	41%
MLHD	48	49	46	48	52	60	61	13	27%
NBMLHD	58	65	72	76	81	79	82	25	43%
NNSWLHD	45	46	43	51	55	62	67	22	49%
NSLHD	138	140	148	153	165	185	190	52	38%
SESLHD	234	247	251	264	273	282	288	54	23%
SNSWLHD	43	45	46	49	50	57	53	10	24%
SWSLHD	171	181	190	197	203	217	234	63	37%
SLHD	207	208	224	245	265	280	289	82	40%
WNSWLHD	77	80	82	81	84	83	87	9	12%
WSLHD	154	154	167	180	188	203	217	63	41%
All LHDs	**1,610**	**1,671**	**1,737**	**1,836**	**1,934**	**2,059**	**2,144**	**534**	**33%**

Source: MoH SMRS

Although some growth may be attributable to TNP roles that have been funded, a review should be undertaken to ensure historical positions are still meeting the needs of the organisation and that staff are meeting their job descriptions and the Award domains, with opportunity to identify positions to change or be deleted. NP are an expensive staff resource ($135,127-$144,684.8 with no shifts/ or oncosts) and therefore in the LHD's current financial position employing NPs where their scope of practice is not fully utilised, should be reconsidered. Where the TNP/ NP is employed, the LHD should look for opportunities to cease medical coverage, rather than the TNP/NP be in addition to the medical coverage.

Consideration when reviewing senior nursing roles is to utilise the CNS2 grading which allows a skilled experienced nurse to provide care, advise and undertake policy reviews without having to achieve the domains of a CNC such as research or a Masters qualification. Adopting this approach also reduces the cost by over $15K (CNC1 to CNS2). The CCLHD framework for review of CNCs is attached and should be localised by the LHD. This includes identifying roles that needed to change from a CNC to a CNS2, so the LHD moves to regrade these roles as staff resign and not automatically recruit. The LHD should target returning toward FY19 CNC staffing levels bringing it in line with peers. A target reduction has been initially set of 20 CNC FTE which would provide $2.54M in savings.

CNE Roles

There has been a 55% growth in CNE FTE (43) since FY18 which is in line with the state average of 47%. However, their overall CNE FTE is still much larger due to the baseline of 79FTE being almost double some peers. In addition, 90% of that growth has taken place since FY22 (39FTE). It is recommended that the LHD review CNE positions. The LHD should determine if the New Graduates/ overseas nurses can be supported for the first 3 months and once acclimatised, the affordable CNE FTE can be reverted to which is recommended to be FY19, providing 12 FTE in savings ($1,524,000).

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Table 12: CNE FTE Growth since FY18 v Peers

LHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	Growth FY18-24	%
CCLHD	56	57	59	55	56	57	57	1	2%
FWLHD	4	4	3	4	4	3	5	2	44%
HNELHD	79	80	82	82	83	102	122	43	55%
ISLHD	41	42	46	48	52	54	59	18	43%
MNCLHD	30	33	34	36	35	40	41	11	37%
MLHD	29	32	36	34	35	40	45	16	55%
NBMLHD	39	43	48	47	48	56	57	18	46%
NNSWLHD	31	40	46	44	47	52	53	22	70%
NSLHD	76	71	67	68	79	81	86	10	13%
SESLHD	84	93	97	98	103	110	120	36	44%
SNSWLHD	21	24	23	26	27	39	43	22	105%
SWSLHD	93	96	98	105	104	129	156	63	68%
SLHD	59	57	56	62	73	77	88	30	51%
WNSWLHD	43	45	43	46	51	55	68	25	59%
WSLHD	82	83	88	92	95	110	126	44	54%
All LHDs	**766**	**799**	**826**	**847**	**891**	**1,005**	**1,126**	**360**	**47%**

Source: MoH SMRS – FY2023/24 YTD Average up to FN06

CNSs

HNE has seen a growth of 24% in CNS (113 FTE) since FY18 with majority of that growth occurring since FY19 – 87% (99FTE). The growth is higher than the state average of 18FTE since FY18 and a significant increase in comparison to peer LHDs.

Table 13: CNS growth since FY 2018 vs peers

LHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	Growth FY18-24	%
CCLHD	**243**	**244**	**255**	**253**	**240**	**235**	**240**	- 3	-1%
FWLHD	**34**	**38**	**37**	**45**	**49**	**53**	**54**	20	60%
HNELHD	**476**	**490**	**526**	**541**	**558**	**582**	**589**	113	24%
ISLHD	**222**	**227**	**231**	**236**	**224**	**223**	**228**	6	3%
MNCLHD	**196**	**188**	**168**	**149**	**146**	**142**	**144**	- 52	-26%
MLHD	**93**	**101**	**103**	**103**	**102**	**100**	**100**	7	8%
NBMLHD	**152**	**151**	**173**	**179**	**170**	**171**	**178**	27	17%
NNSWLHD	**253**	**246**	**247**	**247**	**223**	**211**	**214**	- 39	-15%
NSLHD	**378**	**364**	**363**	**371**	**362**	**361**	**366**	- 12	-3%
SESLHD	**532**	**527**	**529**	**551**	**534**	**506**	**506**	- 25	-5%
SNSWLHD	**80**	**88**	**83**	**95**	**103**	**99**	**111**	31	39%
SWSLHD	**272**	**277**	**274**	**293**	**282**	**270**	**274**	2	1%
SLHD	**371**	**386**	**382**	**381**	**363**	**345**	**352**	- 20	-5%
WNSWLHD	**150**	**148**	**148**	**148**	**149**	**145**	**140**	- 10	-7%
WSLHD	**368**	**364**	**355**	**350**	**347**	**337**	**339**	- 29	-8%
All LHDs	**3,819**	**3,838**	**3,874**	**3,942**	**3,851**	**3,780**	**3,837**	**18**	**0%**

Source: MoH SMRS – FY2023/24 YTD Average up to FN06

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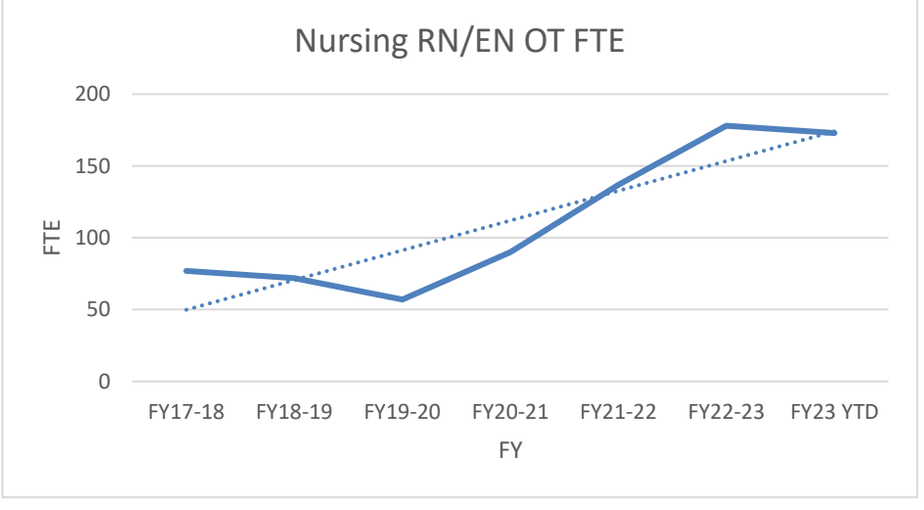
There is opportunity to revise and update the CNS policy to ensure that the CNS's are meeting the Award conditions. Consideration should be given to placing the CNS's on higher grade duties for 12 months to allow compliance of the annual portfolio review by the DONM therefore ensuring that CNSs prepare and submit their required supporting documentation for continuance of HGD payment and mitigate continued payment where achievement of the Award has not been assessed but payment continues. Where CNS are not meeting the Award they can be returned to their substantive grade which will provide savings for the LHD.

Additional nursing workforce opportunities

There are a number of additional strategies that should be implemented that will reduce nursing and midwifery ERE.

- Nursing overtime has doubled in 5 years and as the 2023 data is only 6 months into the financial year, it appears that Nursing OT will be well in excess of 300 FTE if it is not contained. It is suggested that reports are run, looking for patterns and key staff (as it is important to look after the staff wellbeing to prevent burnout). During the review visit discussion with key staff indicated that such monitoring was inconsistently applied. It is recommended a procedure be introduced to ensure all OT has to be approved by the DONM in hours and the Executive on call afterhours. The Overseas Nurses (139 FTE arriving soon) will assist in the savings, but other strategies will need to be considered.

Graph 11: Nursing Overtime



- Ensure that nurse/ midwife staffing is in line with the allocated budget i.e. RNs are not against EN/AIN lines etc. (average base cost is an additional $37K per position without shift penalties and on-costs).
- Ensure excess sick leave is monitored in line with policy and have a procedure to stop staff picking up overtime if they have excess sick leave. This approach will assist in reducing daily staff shortages.
- Ensure excess leave is managed in line with policy and ADOs are taken where possible in the month accrued.
- Across the district, it was expressed at numerous facilities that Emergency Nurses were hard to find, it is suggested that the ED Network look at a plan to train ED nurses to supply across the district.

11. Review Health Service Management Positions/FTE

Looking at the overall HSM FTE numbers, the growth HNE has seen since FY18 of 6% (40 FTE). The largest increase (29 FTE) occurred from FY23 to FY24, representing 72.5% of the overall increase in FTE within the review period. The largest increases in HSM FTE numbers have occurred in the HSM3 grade (29 FTE) followed by the HSM1 grade (27 FTE). Contrary to peers, HNE has seen a decline in both HSM2 and HSM4 FTE. Where the HSM role is not patient facing (where it is in place as a substitute for another award i.e. Allied Health), the

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LHD should look to reduce HSM FTE back towards pre-Covid years (FY19). A reduction of 20 FTE would provide the LHD with $2.54Min savings.

It was understood that the Chief Executive intends to implement a restructure that will identify opportunities for FTE reductions in Management. The delivery of the restructure would contribute to meeting this target (not in addition). Also there has emerged 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 14: HSMs FTE

LHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	FTE Growth FY18-24	%
CCLHD	**260**	**270**	**274**	**276**	**284**	**284**	**304**	**44**	**17%**
FWLHD	**71**	**66**	**66**	**69**	**68**	**76**	**82**	**11**	**16%**
HNELHD	**628**	**657**	**631**	**608**	**622**	**639**	**668**	**40**	**6%**
ISLHD	**288**	**305**	**322**	**336**	**356**	**387**	**401**	**113**	**39%**
MNCLHD	**202**	**207**	**212**	**217**	**230**	**240**	**257**	**55**	**27%**
MLHD	**211**	**215**	**229**	**235**	**247**	**247**	**244**	**33**	**16%**
NBMLHD	**258**	**275**	**285**	**298**	**316**	**324**	**329**	**71**	**28%**
NNSWLHD	**231**	**258**	**261**	**272**	**295**	**302**	**317**	**87**	**38%**
NSLHD	**528**	**554**	**557**	**600**	**607**	**631**	**651**	**124**	**23%**
SESLHD	**588**	**592**	**589**	**598**	**638**	**647**	**660**	**73**	**12%**
SNSWLHD	**209**	**213**	**203**	**201**	**216**	**233**	**244**	**35**	**17%**
SWSLHD	**431**	**471**	**499**	**506**	**492**	**525**	**558**	**127**	**30%**
SLHD	**494**	**526**	**563**	**628**	**696**	**753**	**800**	**306**	**62%**
WNSWLHD	**316**	**344**	**349**	**352**	**369**	**372**	**376**	**60**	**19%**
WSLHD	**572**	**585**	**605**	**626**	**640**	**661**	**699**	**128**	**22%**
All LHDs	**5,286**	**5,538**	**5,648**	**5,823**	**6,073**	**6,320**	**6,592**	**1,306**	**25%**

HNELHD	FY18	FY19	FY20	FY21	FY22	FY23	FY24 FN06)	FTE Growth FY18-24	%
HSM1	192	210	202	194	190	207	219	27	8%
HSM2	219	219	215	201	201	199	209	- 10	-9%
HSM3	128	135	126	130	145	153	158	29	19%
HSM4	54	55	53	49	49	44	44	- 11	-19%
HSM5	24	27	24	23	25	25	27	3	5%
HSM6	10	11	10	11	12	12	12	2	12%
Total	**628**	**657**	**631**	**608**	**622**	**639**	**668**	**40**	**2%**

Source: MoH SMRS – FY2023/24 YTD Average up to FN06

12. Allied Health

Not insignificant FTE growth has occurred in Allied Health FTE since FY18. The LHD has added 196 FTE. Most of this growth has been in social worker (64.87 FTE), radiographer (44.38 FTE), pharmacists (26.45 FTE) and

Dietitians (23.18 FTE). The LHD should review use of Allied Health FTE with a target reduction of 25 FTE. This would provide the LHD with an estimated $2.5m in savings.

Table 21 HNELHD Allied Health FTE by category

Award Tier	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY18 to FY24 FTE	Growth %
Play Therapist	1.50	2.00	1.85	2.20	2.30	3.45	4.65	3.15	211%
Podiatrist	11.48	12.14	12.20	12.78	12.96	12.94	14.02	2.53	22%
Speech Pathologist	86.84	85.82	84.49	84.43	82.88	85.42	87.53	0.70	1%
Social Worker	233.08	254.01	257.36	270.69	265.89	282.61	297.95	64.87	28%
Orthoptist	1.00	1.00	1.00	1.00	1.00	0.99	1.00	-	0%
Physiotherapist	159.35	162.93	165.25	164.55	167.61	173.51	177.65	18.30	11%
Nuclear Medicine	20.20	20.28	20.58	20.38	21.96	23.10	23.08	2.88	14%
Radiographers & Trainees	223.53	226.82	233.83	249.57	258.69	263.40	267.91	44.38	20%
Audiologist	1.24	1.24	1.31	1.36	1.52	1.99	2.44	1.20	97%
Welfare Officer	7.37	7.08	6.87	6.66	6.68	5.14	4.12	- 3.25	-44%
Exercise Physiologist	1.49	1.29	1.66	2.19	2.45	1.43	1.60	0.10	7%
Pharmacists (Incl. P/T)	74.48	76.94	80.63	82.09	86.06	91.40	100.94	26.45	36%
Psychologists	115.67	110.78	109.91	112.94	112.44	111.55	115.64	- 0.02	0%
Counsellor	18.20	18.82	18.24	16.23	15.09	17.22	17.37	- 0.83	-5%
Dietitian	86.16	89.28	90.90	98.70	97.88	104.31	109.34	23.18	27%
Diversional Therapist	1.00	0.92	1.21	1.40	1.52	1.52	1.50	0.50	50%
Genetics Counsellor	7.22	6.95	7.18	8.17	8.15	8.85	9.38	2.16	30%
Music Therapist	0.73	0.70	0.73	0.82	0.41	0.83	1.21	0.48	67%
Occupational Therapist	193.63	194.26	196.41	198.28	194.24	197.09	203.42	9.79	5%

13. Other Affordable FTE Target

Outside of the Nursing and HSM targets the LHD should review all non-NHPPD staffing profiles, PSA, security, hotel and administration roles to identify and meet a target reduction of 35 FTE. Underachievement on other identified FTE targets will require higher achievement in this strategy. In addition, developing a comprehensive surge bed plan will provide further affordable FTE relief. Any staff profiles vacant for more than 6 months should be deleted.

14. 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. cleaners. The LHD should identify these roles and as a high priority disinvest in them. Reductions in FTE and savings achieved will contribute towards the Affordable FTE target reduction.

15. JMO ADO and Overtime Management

The JMO (OT) spend has increased dramatically this year and if not controlled could be double last years expenditure on overtime. Strategies implemented to reduce the reliance on this medical workforce, JMO un-rostered OT and ADO should be strictly controlled. Where possible the LHD should ensure no overlap of JMO shifts and ensure Heads of Department / Senior Medical Officers ensure that JMOs hand-over their patient work to reduce un-rostered overtime. This control also applies to ADO management. ADOs form an important part of ensuring the wellbeing of our JMOs and they should not be able to cancel scheduled ADOs. If cancelled these ADOs are paid-out with penalty rates. MoH Medical Workforce have identified that the goal state is for JMOs to have no more than 2 accruing ADOs. While the LHD has improved in this KPI compared to a number of peers, it still needs improvement and should be in line with CCLHD where the forementioned strategies have been implemented.

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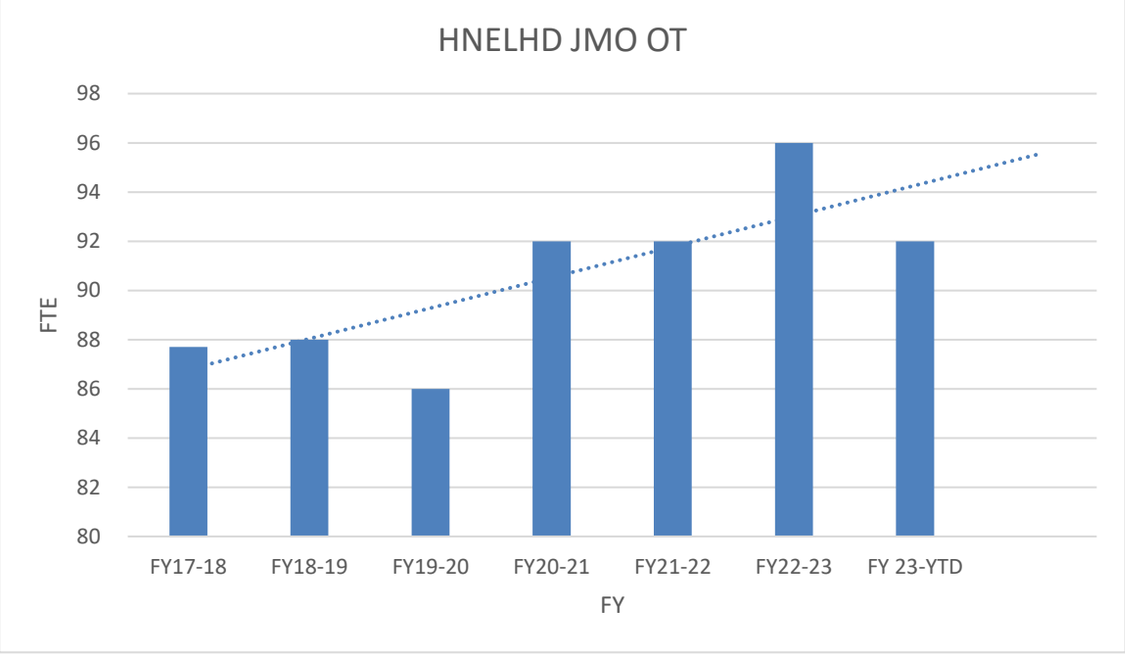
Table 22: JMO ADO

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
HNELHD	3025	1133	2.669903

Source: MoH Medical Workforce

Graph 12 HNELHD JMO Overtime



16. Annual Leave and ADO liability

For FY23, the LHD was provided with $17m in Workforce Resilience funding (134 FTE) with one key aim of this funding to assist in reducing the Annual Leave liability. However, despite this funding annual Leave has rather increased by 0.6% in FY24. There has been a reduction in ADO liability by 0.4% compared to FY23, however, it remains 66% higher than the ADO liability carried in FY19. The LHD should implement strategies to reduce this liability.

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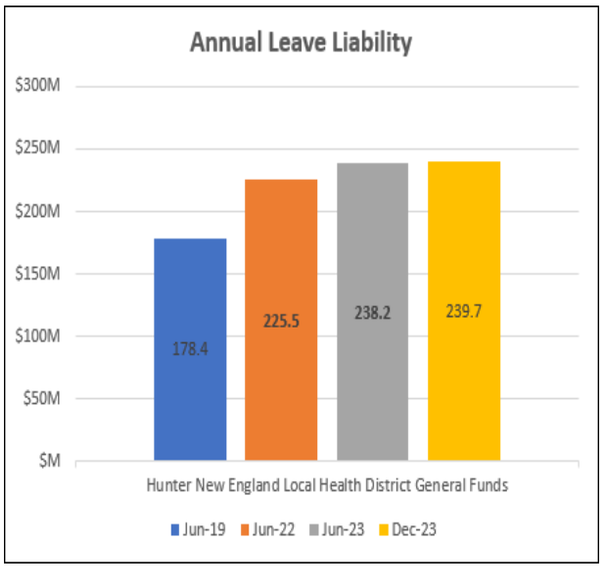
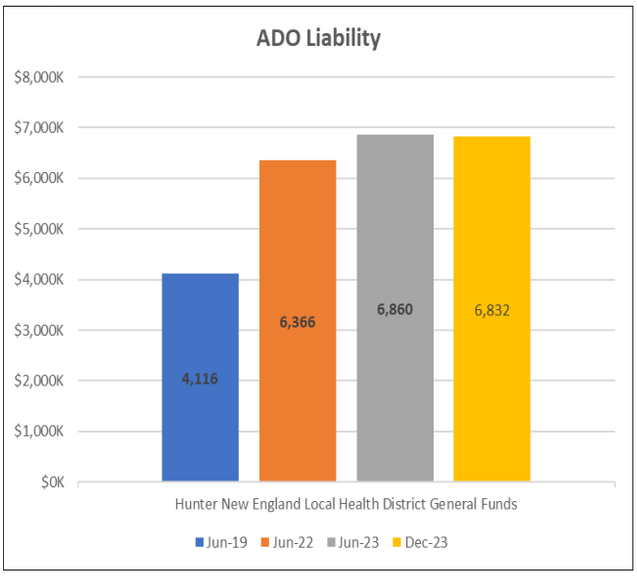
Graphs 13 and 14 HNELHD leave liability and ADO liability.





17. Expenditure

Of note for Hunter, increases in G&S clinical operating (49.9%) and Overtime (66.3%) were the most significant (and concerning) compared with the other LHDs.

Any programs with current favourable variances, it is recommended that these cost centres be capped at current expenditure levels.

Graph 16 HNELHD Expenditure increases since FY 2019

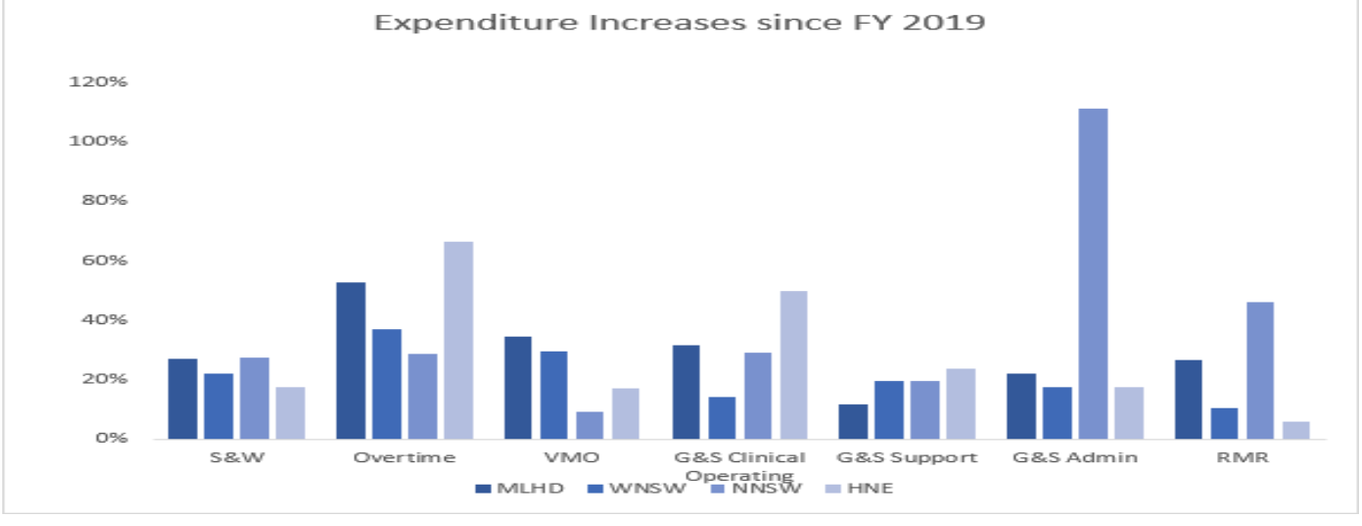


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Table 23: Comparison of Peers expenditure

Comparison of Peers for Key Expense Categories - Values in 000's								
Key Account Categories	HNELHD	% of total Expense	NNSWLHD	% of total Expense	WNSWLHD	% of total Expense	MLHD	% of total Expense
Employee Related	$1,636,911	57.4%	$659,942	56.8%	$688,895	58.0%	$456,947	54.7%
Salaries and Wages	$1,218,715	42.7%	$440,245	37.9%	$467,339	39.4%	$302,116	36.2%
Overtime	$63,134	2.2%	$20,075	1.7%	$26,462	2.2%	$19,466	2.3%
VMO Payments	$124,658	4.4%	$92,299	8.0%	$91,857	7.7%	$61,902	7.4%
Goods & Services	$718,047	25.2%	$335,144	28.9%	$282,096	23.8%	$241,278	28.9%
Medical Consumable	$91,265	3.2%	$34,566	3.0%	$24,959	2.1%	$20,501	2.5%
Pharmaceuticals	$104,606	3.7%	$25,874	2.2%	$29,857	2.5%	$20,583	2.5%
Prostheses	$29,161	1.0%	$16,084	1.4%	$11,753	1.0%	$10,016	1.2%
G&S Special Services	$134,772	4.7%	$56,353	4.9%	$47,968	4.0%	$44,380	5.3%
Outsourced Patient Care	$4	0.0%	$5,055	0.4%	$5,355	0.5%	$9,299	1.1%
Support	$34,986	1.2%	$152,152	13.1%	$107,518	9.1%	$102,614	12.3%
Admin	$323,254	11.3%	$45,060	3.9%	$54,687	4.6%	$33,885	4.1%
Repairs, Maintenance & Renewals	$49,470	1.7%	$23,253	2.0%	$27,066	2.3%	$19,867	2.4%
Expenses	$2,853,121	100%	$1,160,963	100.0%	$1,186,869	100.0%	$834,967	100.0%
Revenue	-$360,233		-$98,076		-$138,820		-$119,440	
Net Cost of Services	**$2,492,888**		**$1,063,593**		**$1,048,381**		**$715,928**	

Source: MoH Finance and SMRS

18. Voluntary redundancy program opportunities

Each year the MoH write to LHDs outlining the approval process for VR programs. Stage one of a three stage process requires LHDs to provide an indicative estimate. Whilst no VR program has yet to be approved it is recommended that HNELHD prepare an initial submission to support recovery should a FY24 program be announced.

19. Agency Utilisation

It is recognised that a contributor to the LHDs financial unfavourability has been the cost in the agency supply of medical and nursing workforce. The LHD has implemented a number of strategies to address this, including overseas recruitment and renegotiation of agency contract fees. Whilst these market determined costs are challenging to address, the LHD must focus on returning to sustainability in the areas of service where it has greater influence and control. Developing a clinical services plan, with consideration of virtual services and utilising Nurse Practitioners should assist with reducing agency costs.

- Nursing agency costs have increased by $6.87m since FY19 or 581%
- Medical Agency costs have increased by $0.41m since FY19 or 14%
- Overtime has increased by $23.43m since FY19 or 357%

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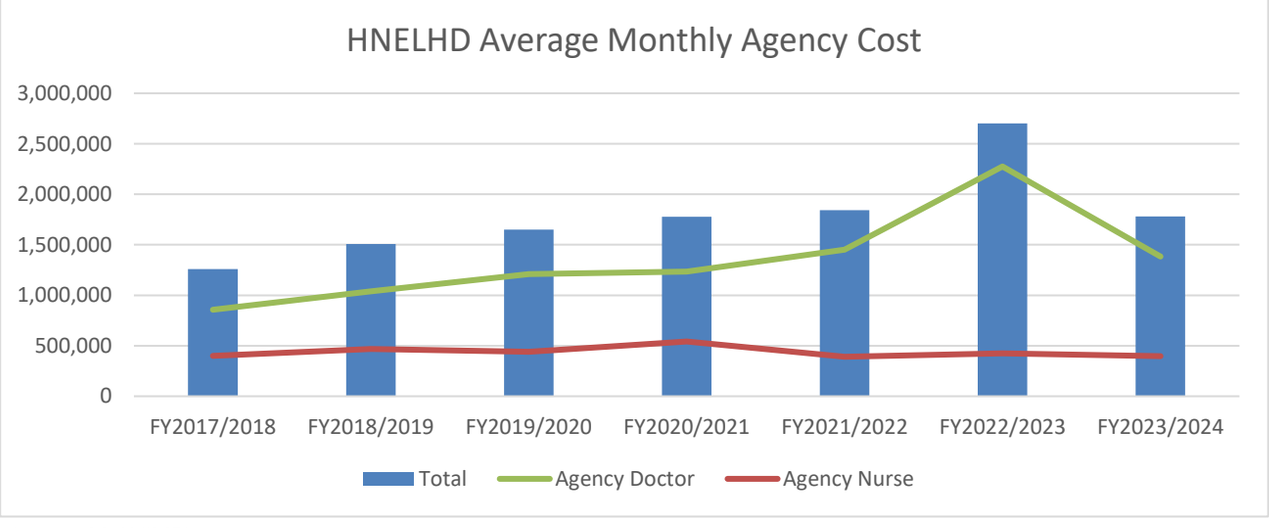
Table 24 HNELHD Agency costs

HNELHD Agency Staffing Cost ($ Millions)	FY19 YTD	FY20 YTD	FY21 YTD	FY22 YTD	FY23 YTD	MOV FY19 to FY23 ($M)	MOV FY19 to FY23 (%)
Nursing Agency costs	1.18	1.40	1.60	1.30	8.06	6.87	581%
Med Agency Costs	2.88	4.12	3.91	3.50	3.29	0.41	14%
Overtime	6.57	3.79	11.01	21.76	30.00	23.43	357%
Sick leave	6.47	8.26	10.32	14.09	15.05	8.58	133%
Staff Accommodation costs	2.18	2.47	2.25	2.58	3.80	1.62	74%
Workforce Structural Costs Total	**19.28**	**20.05**	**29.09**	**43.24**	**60.19**	**40.92**	212%
Agency S&W Medical & Nursing	24.48	27.01	29.42	29.99	39.13	14.65	60%
Total Agency Costs (structural & S&W costs)	**43.76**	**47.06**	**58.51**	**73.23**	**99.33**	**55.57**	**127%**
Est costs if permanent staff were employed rather than Agency	20.74	21.48	23.11	22.87	28.58	7.83	38%
(NET) Workforce Structural & Agency Costs	**23.02**	**25.58**	**35.40**	**50.36**	**70.75**	**47.73**	**207%**

Source: HNEHD

Graph 17 HNELHD Average Monthly Agency Cost



Source: MoH SMRS

QUALITY IMPROVEMENTS and MODEL OF CARE INITIATIVES

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

1. **Financial Literacy and Leadership Education**

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

2. **Map DRGs to Beds**

   Opportunities exist to map DRGs to beds and reconfigure beds into current requirements ensuring efficient use of nursing staff on both a day-to-day basis and when surge is required. Consideration should be given to reduce the bed base to reduce length of stay and nursing premium labour.

3. **Ward Consolidation of NDIS /Nursing Home type patients**

   The LHD should review the number of these patient types (currently 139 patients) and consider consolidating NDIS/nursing home type patients onto one ward or more wards (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, but it will also provide productivity efficiencies for services (i.e. social work) who can maximise their time on the one ward and not have to track down these patients who are outliers on a number of different wards. Consolidating a 28-bed ward at one hospital would provide savings of 6.3 FTE and $637K. For a 20-bed ward this would provide a saving of 4.47 FTE and $472K.

4. **Workers Compensation**

   Claims are continuing to steadily increase, although the graph 18 appears to depict a decreasing. However, this line graph represents only 6 months of data rather than full YTD. If the rate of claims continues the rates will be similar to last year, and although this includes COVID claims, this is not the case at other LHDs. The LHD should consider evaluating the program and also consider successful initiatives undertaken at other LHDs and NSW Health Pathology 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.

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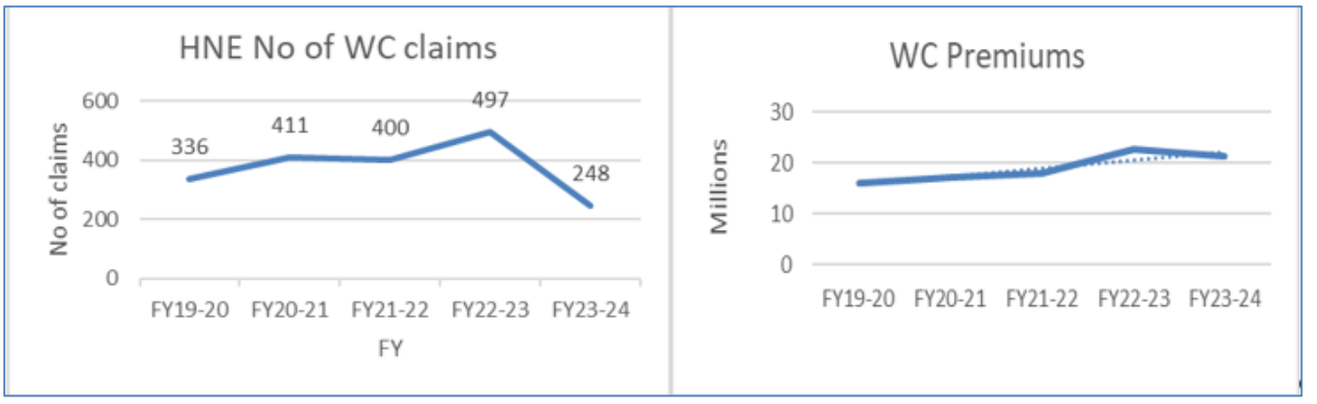
Graph 18: HNE WC Claims and Premiums



5. Low Activity Plans

Management should use historical activity data patterns to identify periods of lower activity i.e. October school holidays and some parts of Xmas and New Year holidays. Plans should be developed in advance to ensure resourcing is reduced. This can include reducing ward bed stock in pods of four so as to still maintain services but ensure staffing is lower if closing wards is not an option. Minor refurbishment of wards (i.e. painting) can also be undertaken to maximise non-use of these beds as well as providing an improved environment for patients and staff when activity returns to BAU. Opportunities include considering either closure of a single ward or pods of 4-beds across multiple wards. Wyong hospital in CCLHD has used the 4-bed reduction approach and consistently delivered approx. $300-400K per annum, whereas Gosford hospital due to its size has frequently closed entire wards.

The LHD should develop a 12-month plan based on known activity and target $840,000 in total for the LHD (7 FTE). Low activity plans should be extended to include community and integrated care services. During COVID these services were frequently reduced and/or ceased over holiday periods and therefore there is an opportunity to assess the opportunity to increase the low activity periods for these services in future plans. Doing so will provide additional savings as well as assist in reducing the LHDs annual leave liability. Note savings will only be achieved if the low activity plan is at an increased level/scope than prior years. If less, then there is a risk that overall expenditure is increasing.

6. Reduce Length of Stay

A review of LOS data reveals that there is some variance occurring between John Hunter and some of the other sites. Average LOS for John Hunter was 3.36 whereas Manning was 2.67 and Tamworth 3.00. The state average LOS for FY22/23 was 2.95 whilst for HNELHD the average was 3.14. 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 HNELHD is $417.29.

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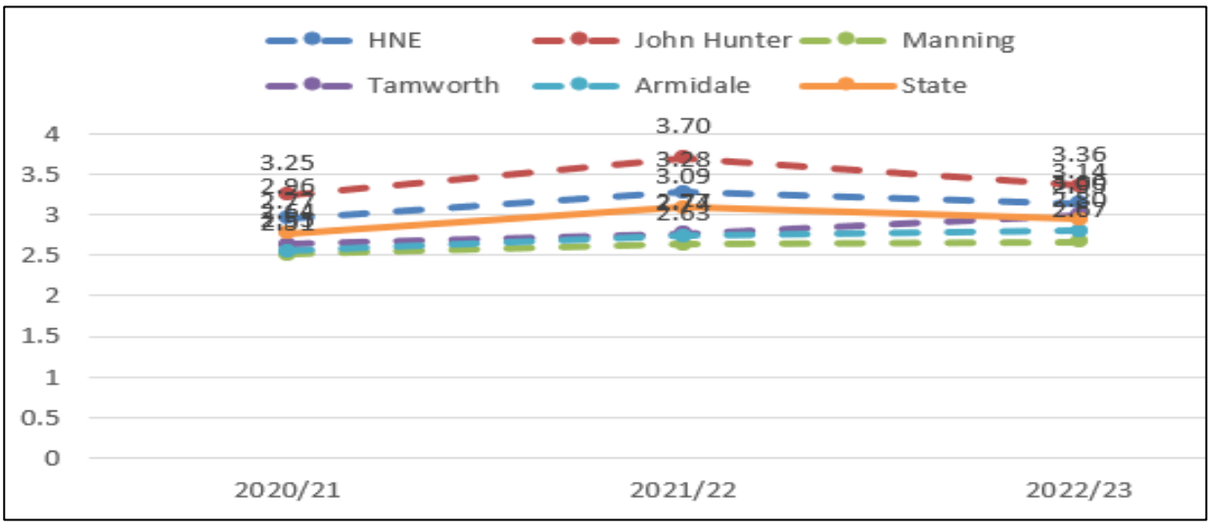
Graph 20: LOS HNELHD by facility



7. Clinical Services Plan

It is recommended the Clinical Services Plan (CSP) is reviewed and updated. Feedback provided to the Review Team indicated that the CSP has not been updated in some time and in past years has primarily focused on redevelopment only. A CSP will guide the LHD and the community on the types of services provided across the District and future development opportunities. Without an updated plan some community areas have ended up with a hybrid model with sometimes a Nurse/ Nurse Practitioner, sometimes a doctor if available and some virtual care. It is recommended decisions are made of what services are provided where, given the resources available i.e. if Nurses Practitioners are present, Drs are not, or vis a versa. Another example would be the reestablishment of a Maternity Service (including theatres) at Glen Innes after it has been closed for 18 months, where alternative services are available and where they are struggling to staff the Maternity Services in the region.

8. Occupational Therapists

The District may wish to consider the allegedly mandated strategy direction given to hospitals with Emergency Departments to appoint occupational therapists (OTs) dedicated to those EDs as there was considerable feedback given that OTs skills would be better used in other parts of the service.

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NON-WORKFORCE EFFICIENCIES

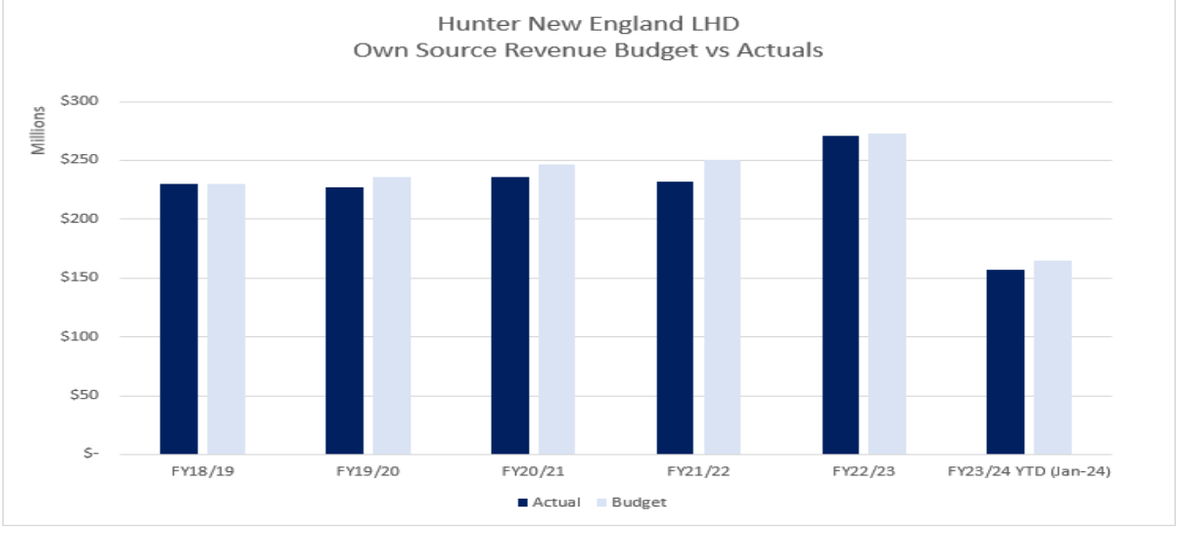
Whilst the reviewers were not provided a scope to review the structure of the organisation in identifying barriers to achieving efficiencies some considerations have been put forward.

1. Revenue

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

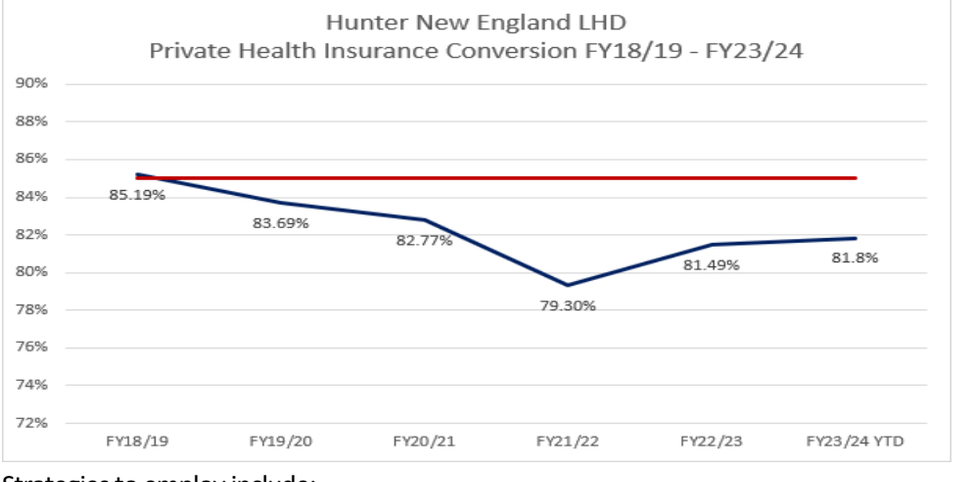
- Private Health Insurance Identification rate. Budget vs Actuals (Patient Fees) YTD Jan 24 – variance against budget - $8M (-4.9%).

Graph 21 HNELHD revenue budget vs Actuals



- Identification – slight increase in identification in January 2024, 0.2% from previous month.
- Conversion – slight decrease in conversion rates in January, 0.3%, from previous month. Year to date performance is 81.8% which is 3.2% under KPI (85%).

Graph 22 HNELHD Private Health Insurance Conversion



Strategies to employ include:

- Develop a district wide VMO out-of-pocket list and review annually.
- Improve staff onboarding and training in revenue opportunities and requirements,

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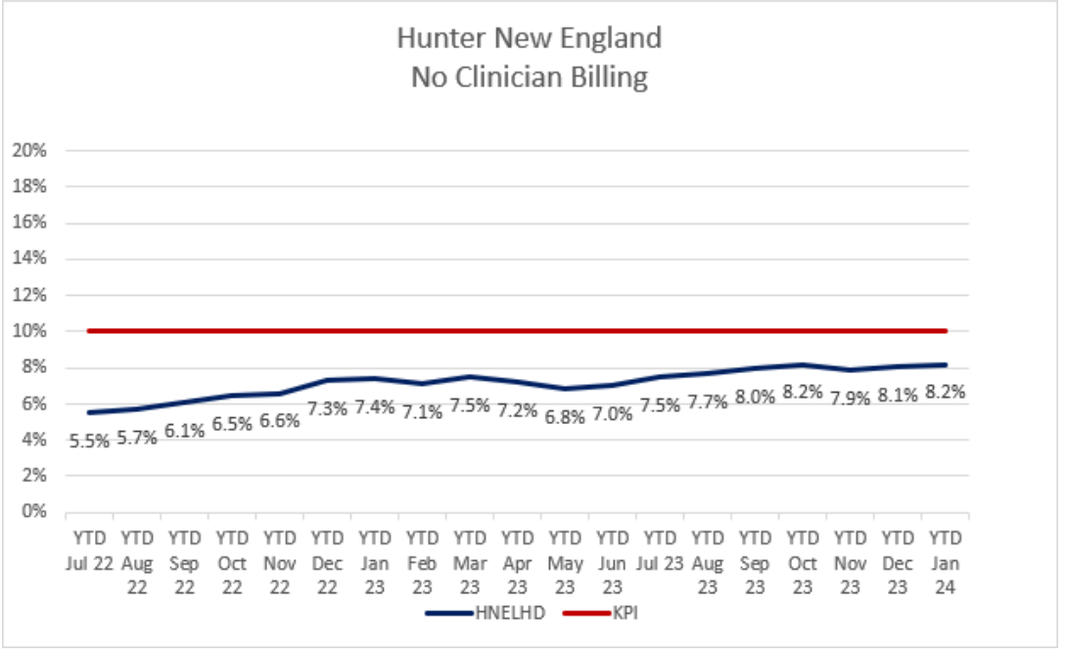
- Increase the usage of the relevant Doctors tables in the NSW Health Revenue Portal,
- Facilitate patient liaison officer interview, training, and upskilling,
- Review PLO structure, onboarding, and location. Ensure they are not being utilised for other administrative tasks outside of their revenue scope,
- Maximise pharmacy rebate revenue received,
- Ehealth, Bill of IT- LHD to seek savings opportunities,

YTD Jan-24 performance for no clinician billing is 8.2%, achieving KPI (<10%). However gradual decrease in performance has been identified during this financial year.

Graph 23 HNE Clinician billing



2. Goods and Services Expenditure Benchmarking

While the largest part of the budget savings requirement will be obtained through workforce efficiencies all opportunities for savings in non-salary areas should be undertaken. MoH Finance provided a benchmark analysis of expenditure against peer LHDs. The LHD should explore opportunities to reduce expenditure to peer levels in G&S medical and surgical supplies, drugs, prosthetics and RMR which are at higher levels than peers. While the state average increase for RMR is 32.8%, the HNELHD has experienced an increase of 23.5% RMR spend since FY19 and 36.2% increase in G&S. Opportunity should be explored to reduce the outsourcing of patient care. Year on year December reporting indicates that Outsourced Patient Care has increased by $6.7M (40%).

3. Review of Contracts for Major Medical Equipment

Often specialised equipment (such as MRI's or Catheter Lab equipment) is serviced by a contractor and a premium is paid for a high response rate to get the equipment repaired. The LHD should review its contracts and look for opportunity to negotiate down the service response times for non-urgent services or services with multiple machines - from 1hr to next day and uptime guarantees from 98% to 95%. The reality is that even if a MRI has a 1hr response by the time the issue sis known and repair work commences patients are either scheduled into other multiple machines available or rescheduled for another day.

4. VMoney Audit

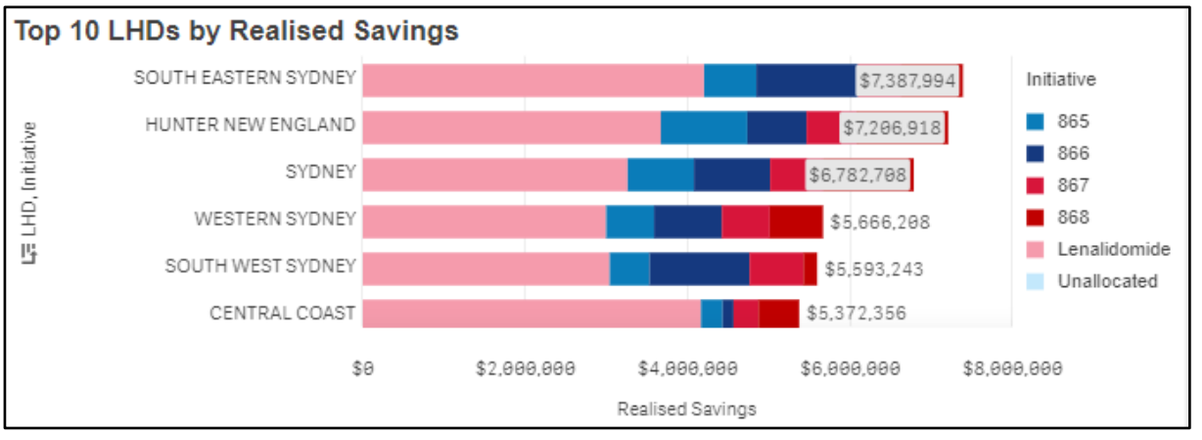
The LHD should consider implementing a biennial internal audit of VMoney claims and payment system to ensure all claims are compliant with policy and Medicare. Given the size of the VMO workforce this audit

should be scheduled for FY24. Experience in other LHDs has indicated that these audits will realise some savings through immediate improved compliance with billing.

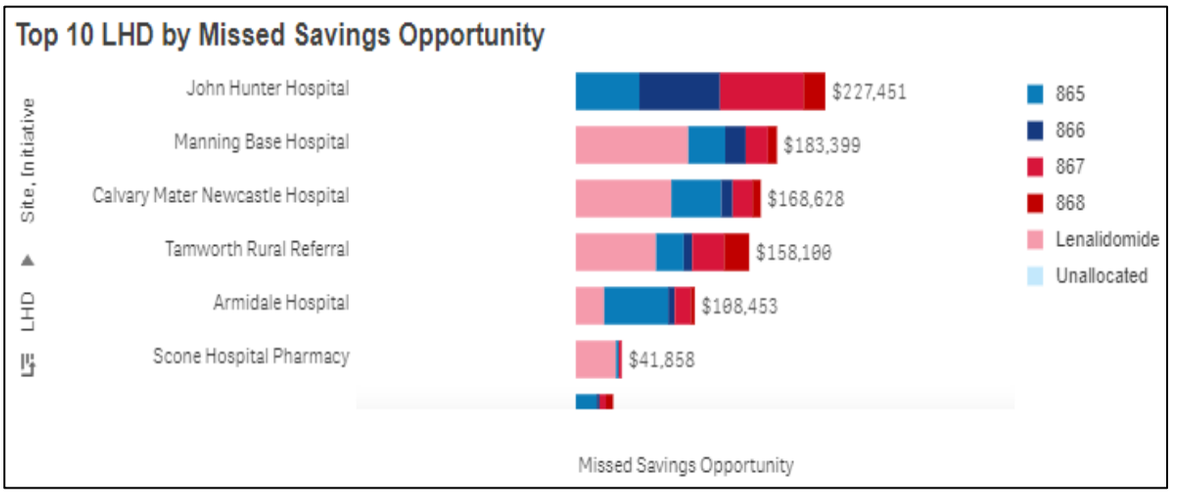
5. Pharmacy

Pharmacy services play a critical part role in financial sustainability through ensuring the LHD is maximising the opportunity introduce cost-efficient medicines via statewide formulary and through the agile uptake of generic and biosimilar medicines. The John Hunter Hospital Pharmacy is ensuring cost-effective medicines are available and that clinical trials work is full-cost recovery.

Graph 24 LHD Pharmacy realised savings



Graph 25 LHD Pharmacy Missed saving opportunities



Further opportunities for the District to consider with pharmacy include:

- Implementing a district-wide pharmacy service which can leverage of the John Hunter service. In addition to workforce coverage for smaller sites this would provide the opportunity for a District-wide approach to procuring cost effective medicines and related strategies i.e. review of imprest sock holdings and wastage return strategies. Centralised procurement would mean faster implementation of NSW Health state contracts which would reduce that number of missed savings opportunities.
- Tender for a preferred wholesaler model. CCLHD is in the finalisation of a market tender for this, and early indications is that this will provide CCLHD with significant expense savings and revenue increases through rebates. This strategy builds upon a successful model implemented by Victorian Health in many of its regional health services.

- Prior to the commissioning of the new build pharmacy production unit that the LHD Finance complete a cost-benefit review of in-house production verse out-source production. This will provide the LHD with a baseline on ensuring that it is maximising outsourcing where a supplier rebate or PBS revenue is received off-setting purchase cost over in-house manufacturing where there is little opportunity for rebate or revenue. An example of this was undertaken at CCLHD which identified at the time that chemotherapy drugs wee much more cost-effective to be outsourced than manufactured in-house when you consider the in-house labour costs, raw materials and maintenance of sterile equipment etc. This enabled CCLHD to increase outsourcing of all chemo to 85% from 72%, realising an additional 180K per annum in revenue and reduction of $150K in expense.

Table 25: In-house and Outsourced Production by Drug Group

		Gosford	Wyong	Cytotoxics/Chemo	Sterile	Non-Sterile	Trials	Other	Total
In House	Units produced	7,212	2,380	5,654	922	252	1,916	848	**9,592**
	Mean revenue per unit	(10)	(12)	(12)	0	0	(16)	0	**(10)**
	Mean cost per unit	187	141	206	410	23	50	53	**176**
									(100,196)
	Net cost per unit	177	130	193	410	23	34	53	**165**
	PBS Only items for inhouse	2,073	986	3,059	0	0	0	0	**3,059**
	PBS Avoided cost	5,955,258	4,032,499	9,987,757	0	0	0	0	**9,987,757**
	Average avoided cost per PBS item	2,873	4,090	3,265	0	0	0	0	**3,265**
Outsourced	Units produced	8,840	5,688	14,528	0	0	0	0	**14,528**
	Mean revenue per unit	(123)	(134)	**(123)**					**(123)**
	Mean cost per unit	67	71	69					
									(1,850,978)
	Net cost per unit	(56)	(63)	(59)					
	PBS Avoided cost	27,850,706	24,315,823	52,166,529					
	Average avoided cost per item	3,151	4,275	3,591					

- Review opportunity to implement a trial of pharmacy dispensing discharge medicines direct from select wards to assist in improving discharge times. At CCLHD this has reduced the wait for discharge medicines at Gosford Hospital by approximately 45-minutes. This strategy also reduces pharmaceutical waste as there is improved stock rotation on the selected wards.

6. Medical Imaging

The LHD operates a district-wide medical imaging (MI) service. The service has successfully minimised/eliminate MI reporting backlogs through the establishment of an innovate provider panel through open market tender. As part of the pathway to financial recovery the LHD should assess the cost-effectiveness of this model to ensure it is not adding additional expense compared to peers (as seen in the ABF cost bucket reports) as the flexibility of the farming out of reports to the private sector all hours of the day could be contributing to higher costs in eliminating backlogs. It also may be coming at an opportunity loss of revenue as there are stringent Medicare requirement on what constitutes a Medicare eligible report. In most cases reports sent to private reporting companies are not eligible, and why many LHDs only use private arrangements sparingly and in out of hours emergency situations. A review of ABF cost-buckets indicate that the LHDs MI service cost are higher than some peers.

Version Final

Table 26:MI ABF Cost Buckets – Acute Care Costs

LHD/SHN	Allied	Med	Nurse	Critical Care	Imag	OR	Path	Pharm	Pros	SPS	Ward&ED Supplies	Non Clinical	On Cost	Exclude	Covid	PatTrans	Avg Cost / Enct	Encounter Volume
	$ 211.3	**$ 804.1**	**$1,168.2**	**$ 520.9**	**$ 142.6**	**$ 826.5**	**$ 194.0**	**$ 189.6**	**$ 181.0**	**$ 66.7**	**$ 564.6**	**$ 609.6**	**$ 387.8**	**$ 179.8**	**$ 23.0**	**$ 67.4**	**$6,137.2**	**1,656,631**
Western NSW LHD	$ 172.8	$ 800.7	$ 872.2	$ 415.6	$ 82.7	$ 711.8	$ 138.3	$ 179.3	$ 160.9	$ 59.8	$ 422.4	$ 530.8	$ 310.0	$ 116.3	$ 11.3	$ 115.3	$5,100.2	71,106
Southern NSW LHD	$ 116.0	$ 948.2	$1,210.9	$ -	$ 58.6	$ 810.9	$ 123.1	$ 117.2	$ 126.0	$ -	$ 473.3	$ 651.9	$ 270.1	$ 143.2	$ 5.8	$ 135.7	$5,191.0	42,912
Murrumbidgee LHD	$ 111.7	$ 773.6	$1,034.8	$ 216.5	$ 103.5	$ 901.8	$ 130.8	$ 98.6	$ 183.7	$ 46.4	$ 551.8	$ 538.6	$ 288.5	$ 125.5	$ 50.8	$ 129.7	$5,286.4	52,896
South Western Sydney LHD	$ 189.9	$ 729.1	$1,094.0	$ 469.7	$ 79.7	$ 632.1	$ 145.4	$ 146.0	$ 134.4	$ 4.7	$ 603.6	$ 509.7	$ 347.5	$ 165.3	$ 24.3	$ 46.6	$5,322.1	222,787
Central Coast LHD	$ 144.1	$ 608.9	$1,201.9	$ 318.9	$ 98.0	$ 631.1	$ 124.9	$ 196.3	$ 105.3	$ 48.0	$ 565.2	$ 716.2	$ 435.9	$ 116.6	$ 10.4	$ 57.2	$5,378.9	89,857
Mid North Coast LHD	$ 130.6	$ 824.8	$1,010.3	$ 462.9	$ 60.5	$ 875.6	$ 124.7	$ 152.4	$ 116.3	$ 112.2	$ 627.6	$ 530.6	$ 348.0	$ 163.7	$ 13.1	$ 70.6	$5,623.9	69,024
Northern NSW LHD	$ 126.9	$ 866.9	$1,370.9	$ 481.7	$ 72.7	$ 912.0	$ 105.0	$ 210.3	$ 180.4	$ 65.6	$ 389.3	$ 514.3	$ 345.7	$ 146.9	$ 17.6	$ 48.0	$5,854.3	87,688
South Eastern Sydney LHD	$ 207.1	$ 670.1	$1,160.8	$ 573.1	$ 142.6	$ 850.0	$ 189.2	$ 192.9	$ 195.9	$ 102.2	$ 542.0	$ 588.1	$ 392.4	$ 174.9	$ 15.3	$ 48.3	$6,045.0	163,259
Hunter New England LHD	$ 192.8	$ 829.0	$1,266.4	$ 418.6	$ 120.6	$ 857.6	$ 144.3	$ 177.4	$ 153.8	$ 59.9	$ 595.5	$ 624.7	$ 377.0	$ 147.2	$ 10.3	$ 105.5	$6,080.6	192,856
Illawarra Shoalhaven LHD	$ 187.1	$ 802.7	$1,254.0	$ 340.2	$ 104.8	$ 766.1	$ 224.0	$ 204.0	$ 163.1	$ 11.7	$ 954.2	$ 639.9	$ 377.9	$ 131.1	$ 36.6	$ 63.2	$6,260.7	87,558
Far West LHD	$ 299.4	$ 711.5	$1,176.5	$ 378.9	$ 78.7	$1,163.7	$ 79.1	$ 114.2	$ 44.0	$ -	$ 734.3	$ 859.1	$ 394.4	$ 141.0	$ 16.4	$ 87.3	$6,278.4	7,848
Nepean Blue Mountains LHD	$ 222.2	$ 825.6	$1,195.6	$ 622.7	$ 147.4	$1,049.3	$ 200.5	$ 146.9	$ 202.2	$ 36.9	$ 429.5	$ 642.3	$ 432.5	$ 163.5	$ 7.6	$ 64.5	$6,389.3	68,213
Sydney LHD	$ 272.1	$ 758.4	$1,059.3	$ 724.6	$ 208.5	$ 907.5	$ 269.7	$ 157.1	$ 241.6	$ 86.0	$ 599.5	$ 645.9	$ 403.1	$ 188.9	$ 74.3	$ 50.0	$6,646.5	144,863
Western Sydney LHD	$ 285.5	$ 943.0	$1,143.6	$ 689.3	$ 252.8	$ 786.7	$ 338.3	$ 219.6	$ 201.9	$ 138.8	$ 474.0	$ 630.0	$ 448.9	$ 216.3	$ 18.6	$ 71.1	$6,858.3	157,451
Northern Sydney LHD	$ 316.8	$ 849.2	$1,331.7	$ 636.4	$ 284.0	$ 967.6	$ 249.5	$ 275.3	$ 285.3	$ 47.7	$ 465.8	$ 763.3	$ 436.9	$ 164.6	$ 16.8	$ 50.8	$7,141.8	100,762
St Vincent's Health Network	$ 313.4	$ 905.4	$1,076.9	$ 720.8	$ 196.1	$ 860.2	$ 225.3	$ 294.1	$ 350.7	$ 278.4	$ 863.4	$ 649.1	$ 406.9	$ 231.3	$ 26.3	$ 36.5	$7,434.7	40,739
Sydney Children's Hospitals Network	$ 309.8	$1,077.5	$1,390.9	$1,021.0	$ 214.6	$1,027.0	$ 328.3	$ 358.1	$ 179.8	$ 46.9	$ 486.0	$ 649.5	$ 535.5	$ 654.8	$ 14.5	$ 39.0	$8,333.3	56,812

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Table 27:MI ABF Cost Buckets – ED Costs per Encounter

LHD/SHN	Allied	Med	Nurse	Critical Care	Imag	OR	Path	Pharm	Pros	SPS	Ward&ED Supplies	Non Clinical	On Cost	Exclude	Covid	PatTrans	Avg Cost / Enct	Encounter Volume
	$ 10.8	**$ 218.0**	**$ 188.9**	**$ -**	**$ 115.7**	**$ 0.1**	**$ 68.0**	**$ 13.8**	**$ 0.2**	**$ 0.1**	**$ 81.4**	**$ 86.5**	**$ 60.1**	**$ 18.4**	**$ 10.2**	**$ 26.6**	**$ 898.8**	**2,743,657**
Sydney Children's Hospitals Network	$ 5.6	$ 208.2	$ 182.7	$ -	$ 28.0	$ 0.0	$ 35.1	$ 8.9	$ -	$ -	$ 59.1	$ 75.1	$ 54.5	$ 11.4	$ 6.0	$ 5.4	$ 680.0	105,676
Western NSW LHD	$ 2.1	$ 190.9	$ 165.6	$ -	$ 102.8	$ -	$ 66.1	$ 14.1	$ 0.0	$ -	$ 74.3	$ 69.8	$ 47.6	$ 17.4	$ 6.1	$ 57.1	$ 813.8	141,135
South Eastern Sydney LHD	$ 6.3	$ 197.6	$ 186.2	$ -	$ 103.3	$ 0.0	$ 73.5	$ 10.5	$ 1.3	$ 0.2	$ 72.9	$ 79.9	$ 60.4	$ 17.2	$ 3.0	$ 8.5	$ 821.0	236,317
Hunter New England LHD	$ 6.4	$ 210.8	$ 177.1	$ -	$ 135.7	$ 0.1	$ 55.5	$ 14.1	$ 0.1	$ -	$ 72.3	$ 69.9	$ 49.9	$ 15.0	$ 6.8	$ 34.2	$ 848.0	374,584
Far West LHD	$ 4.9	$ 231.2	$ 131.8	$ -	$ 122.7	$ -	$ 40.7	$ 41.3	$ -	$ -	$ 105.0	$ 95.2	$ 52.9	$ 10.5	$ 6.7	$ 9.1	$ 852.1	20,403
Illawarra Shoalhaven LHD	$ 8.7	$ 218.5	$ 178.6	$ -	$ 119.5	$ 0.1	$ 48.3	$ 11.1	$ -	$ -	$ 69.8	$ 94.3	$ 54.4	$ 17.5	$ 12.3	$ 40.0	$ 873.1	167,045
Mid North Coast LHD	$ 2.3	$ 190.0	$ 175.2	$ -	$ 118.4	$ 0.2	$ 47.9	$ 17.1	$ 0.0	$ 0.3	$ 102.5	$ 86.4	$ 61.8	$ 29.4	$ 5.8	$ 46.4	$ 883.7	134,867
Northern NSW LHD	$ 8.4	$ 206.5	$ 246.3	$ -	$ 93.0	$ 0.1	$ 59.8	$ 11.9	$ 0.0	$ -	$ 74.6	$ 78.9	$ 51.9	$ 15.7	$ 4.2	$ 39.9	$ 891.0	210,619
Murrumbidgee LHD	$ 5.6	$ 214.4	$ 189.9	$ -	$ 84.4	$ -	$ 80.3	$ 10.0	$ -	$ -	$ 99.7	$ 87.2	$ 55.7	$ 16.6	$ 14.5	$ 37.8	$ 896.2	81,056
Central Coast LHD	$ 36.7	$ 245.8	$ 192.9	$ -	$ 80.8	$ 0.0	$ 54.1	$ 11.9	$ 0.0	$ 0.0	$ 83.9	$ 76.4	$ 74.8	$ 16.9	$ 12.1	$ 17.0	$ 903.3	151,388
Southern NSW LHD	$ 8.0	$ 238.5	$ 166.3	$ -	$ 80.2	$ 0.1	$ 70.3	$ 10.9	$ -	$ -	$ 111.0	$ 97.2	$ 50.9	$ 18.6	$ 4.1	$ 66.9	$ 922.9	107,089
South Western Sydney LHD	$ 18.9	$ 197.1	$ 185.7	$ -	$ 143.7	$ 0.3	$ 70.5	$ 14.7	$ 0.1	$ -	$ 79.4	$ 97.9	$ 66.2	$ 25.5	$ 14.9	$ 14.5	$ 929.3	306,117
Northern Sydney LHD	$ 11.1	$ 242.2	$ 184.4	$ -	$ 112.5	$ 0.0	$ 87.2	$ 12.4	$ 0.0	$ 0.0	$ 71.2	$ 114.0	$ 64.9	$ 19.4	$ 21.1	$ 12.9	$ 953.4	162,059
Sydney LHD	$ 12.7	$ 245.0	$ 200.8	$ -	$ 102.7	$ 0.1	$ 89.7	$ 11.5	$ 0.0	$ 0.1	$ 91.3	$ 90.7	$ 66.7	$ 17.5	$ 25.3	$ 18.8	$ 972.8	176,152
Nepean Blue Mountains LHD	$ 11.5	$ 247.8	$ 206.1	$ -	$ 136.3	$ 0.0	$ 86.4	$ 21.4	$ 0.8	$ 0.0	$ 89.6	$ 86.2	$ 68.2	$ 23.5	$ 4.3	$ 22.7	$1,004.9	109,720
St Vincent's Health Network	$ 13.9	$ 240.6	$ 183.2	$ -	$ 99.2	$ 0.0	$ 114.1	$ 11.6	$ 0.0	$ 0.6	$ 124.2	$ 156.4	$ 64.2	$ 10.5	$ 10.6	$ 4.5	$1,033.5	51,116
Western Sydney LHD	$ 12.3	$ 244.5	$ 195.6	$ -	$ 185.4	$ 0.5	$ 88.3	$ 21.1	$ 1.0	$ 0.1	$ 87.6	$ 83.9	$ 73.7	$ 17.8	$ 12.2	$ 12.6	$1,036.5	208,314

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Table 28: MI ABF Cost Buckets – SNAP

LHD/SHN	Allied	Med	Nurse	Critical Care	Imag	OR	Path	Pharm	Pros	SPS	Ward&ED Supplies	Non Clinical	On Cost	Exclude	Covid	PatTrans	Avg Cost / Enct	Encounter Volume
	$1,369.1	**$1,722.0**	**$4,017.8**	**$ 51.0**	**$ 78.4**	**$ 18.9**	**$ 138.3**	**$ 336.4**	**$ 5.9**	**$ 2.6**	**$1,490.1**	**$2,245.7**	**$ 965.9**	**$ 229.6**	**$ 50.8**	**$ 137.5**	**$12,860.1**	**77,795**
South Eastern Sydney LHD	$1,244.7	$ 868.9	$2,345.6	$ 28.1	$ 45.4	$ 14.9	$ 72.4	$ 256.4	$ 4.8	$ 1.9	$ 793.2	$1,181.3	$ 451.1	$ 120.1	$ 14.8	$ 48.0	$ 7,491.8	15,764
Western NSW LHD	$ 645.8	$1,730.7	$2,101.0	$ 23.5	$ 66.4	$ 9.7	$ 77.8	$ 224.1	$ 0.5	$ -	$1,080.4	$1,497.9	$ 626.1	$ 162.0	$ 20.7	$ 104.9	$ 8,371.3	3,608
Central Coast LHD	$1,040.6	$1,569.7	$3,726.3	$ 81.9	$ 76.8	$ 31.0	$ 132.2	$ 268.6	$ 6.4	$ 3.4	$1,079.8	$2,584.2	$1,384.8	$ 238.4	$ 25.7	$ 112.1	$12,361.8	5,511
Murrumbidgee LHD	$1,106.5	$1,133.8	$4,890.6	$ 20.0	$ 66.0	$ 25.8	$ 84.0	$ 197.1	$ 0.2	$ 1.0	$1,369.0	$2,704.3	$ 814.9	$ 142.4	$ 87.3	$ 111.9	$12,754.7	2,772
South Western Sydney LHD	$1,351.1	$1,974.0	$4,127.5	$ 15.7	$ 65.9	$ 24.4	$ 172.8	$ 319.4	$ 6.8	$ 0.1	$1,522.3	$1,826.7	$1,017.8	$ 271.9	$ 80.0	$ 136.4	$12,912.8	8,323
Hunter New England LHD	$ 896.1	$1,839.6	$4,583.8	$ 3.5	$ 86.7	$ 17.0	$ 104.8	$ 320.3	$ 8.3	$ 10.2	$1,698.7	$2,162.0	$ 963.3	$ 273.3	$ 33.3	$ 250.0	$13,251.0	4,910
St Vincent's Health Network	$1,726.6	$2,245.3	$3,990.5	$ 5.6	$ 53.9	$ 16.7	$ 104.1	$ 506.2	$ 2.0	$ 9.6	$1,519.8	$1,932.0	$1,031.6	$ 180.3	$ 59.1	$ 95.3	$13,478.5	2,402
Northern Sydney LHD	$2,123.7	$1,860.8	$4,124.2	$ 1.2	$ 119.0	$ 19.4	$ 201.2	$ 358.6	$ 5.9	$ 2.0	$1,484.6	$2,489.1	$ 997.7	$ 224.6	$ 36.2	$ 134.8	$14,182.8	7,544
Sydney Children's Hospitals Network	$2,211.4	$1,973.8	$3,988.1	$ 140.1	$ 53.9	$ 53.0	$ 29.5	$ 215.3	$ 2.9	$ -	$1,543.4	$2,428.8	$1,280.7	$ 310.7	$ 15.4	$ 41.8	$14,288.8	656
Illawarra Shoalhaven LHD	$1,406.4	$1,687.3	$4,513.1	$ 2.4	$ 60.5	$ 7.2	$ 138.3	$ 429.5	$ 1.8	$ -	$1,558.5	$3,335.6	$1,189.8	$ 243.0	$ 36.0	$ 223.9	$14,833.3	5,857
Mid North Coast LHD	$1,253.2	$2,568.1	$4,328.6	$ 96.7	$ 106.9	$ 20.3	$ 165.9	$ 315.6	$ 3.1	$ 4.4	$1,741.2	$2,659.1	$1,166.8	$ 423.3	$ 40.1	$ 263.5	$15,156.6	1,722
Southern NSW LHD	$1,307.7	$2,714.7	$4,822.1	$ -	$ 130.0	$ 13.9	$ 171.8	$ 259.5	$ 0.0	$ -	$1,474.9	$2,839.3	$ 971.7	$ 328.5	$ 19.1	$ 219.5	$15,272.6	1,657
Sydney LHD	$1,486.4	$2,071.2	$4,994.8	$ 31.4	$ 104.1	$ 14.1	$ 160.3	$ 239.8	$ 2.9	$ 2.5	$1,648.4	$2,932.0	$1,205.0	$ 257.9	$ 212.6	$ 106.3	$15,469.6	5,252
Nepean Blue Mountains LHD	$1,630.3	$1,679.6	$4,578.6	$ 0.6	$ 126.1	$ 28.5	$ 153.9	$ 434.3	$ 31.0	$ 1.6	$2,591.7	$2,905.2	$1,171.1	$ 285.4	$ 29.1	$ 180.3	$15,827.3	3,158
Western Sydney LHD	$1,806.9	$2,365.5	$4,664.1	$ 18.2	$ 87.7	$ 27.6	$ 257.5	$ 548.8	$ 12.1	$ 7.3	$3,053.2	$2,865.7	$1,265.5	$ 311.3	$ 73.1	$ 194.7	$17,559.4	4,762
Northern NSW LHD	$1,093.2	$2,521.1	$7,349.0	$ 604.2	$ 96.8	$ 13.1	$ 184.6	$ 589.0	$ 2.8	$ -	$1,675.1	$2,675.0	$1,290.0	$ 337.2	$ 38.2	$ 218.3	$18,687.3	3,677
Far West LHD	$1,592.3	$2,371.4	$8,804.0	$ 83.6	$ 116.5	$ 44.1	$ 118.4	$ 443.8	$ -	$ -	$3,586.8	$5,612.2	$2,054.4	$ 297.9	$ 4.8	$ 33.9	$25,164.0	220

Table 29 MI ABF Cost Buckets - NAP

LHD/SHN	Allied	Med	Nurse	Critical Care	Imag	OR	Path	Pharm	Pros	SPS	Ward&ED Supplies	Non Clinical	On Cost	Exclude	Covid	PatTrans	Avg Cost / Enct	Encounter Volume
	$ 53.2	**$ 32.9**	**$ 55.5**	**$ 0.0**	**$ 2.9**	**$ 2.5**	**$ 4.1**	**$ 6.7**	**$ 0.4**	**$ 3.6**	**$ 32.4**	**$ 32.9**	**$ 20.0**	**$ 30.2**	**$ 2.9**	**$ 0.4**	**$ 280.8**	**10,228,321**
Northern NSW LHD	$ 57.2	$ 17.9	$ 64.9	$ -	$ 1.7	$ 1.4	$ 1.6	$ 1.7	$ 0.0	$ 0.5	$ 32.6	$ 37.3	$ 22.1	$ 5.0	$ 0.6	$ 0.2	$ 244.7	452,234
South Western Sydney LHD	$ 41.4	$ 31.7	$ 49.0	$ -	$ 0.2	$ 0.5	$ 6.0	$ 7.2	$ 0.1	$ 0.7	$ 31.9	$ 28.9	$ 18.1	$ 27.0	$ 2.7	$ 0.6	$ 246.1	1,182,439
Mid North Coast LHD	$ 59.4	$ 19.4	$ 68.0	$ -	$ 1.3	$ 4.1	$ 1.8	$ 2.7	$ 0.1	$ 1.1	$ 27.1	$ 34.0	$ 20.6	$ 8.6	$ 2.4	$ 1.4	$ 252.1	406,541
Central Coast LHD	$ 48.2	$ 22.6	$ 61.0	$ -	$ 0.3	$ 0.6	$ 2.5	$ 4.6	$ 0.7	$ 11.5	$ 24.5	$ 29.8	$ 20.1	$ 24.5	$ 2.4	$ 0.6	$ 253.8	538,499
Murrumbidgee LHD	$ 63.8	$ 15.6	$ 63.2	$ -	$ 4.4	$ 6.9	$ 2.3	$ 0.4	$ -	$ -	$ 39.9	$ 31.1	$ 19.8	$ 5.5	$ 1.3	$ 0.9	$ 255.0	208,909
St Vincent's Health Network	$ 31.9	$ 40.6	$ 40.8	$ -	$ 7.2	$ 3.8	$ 4.4	$ 9.5	$ 0.0	$ 8.1	$ 18.0	$ 22.9	$ 14.1	$ 48.1	$ 9.7	$ 0.5	$ 259.6	174,968
Northern Sydney LHD	$ 39.6	$ 40.2	$ 51.0	$ -	$ 5.9	$ 1.1	$ 3.4	$ 8.4	$ 0.7	$ 5.8	$ 27.2	$ 34.0	$ 18.7	$ 24.5	$ 1.5	$ 0.9	$ 262.8	802,459
Southern NSW LHD	$ 68.0	$ 12.7	$ 68.8	$ -	$ 4.9	$ 6.4	$ 1.8	$ 3.1	$ -	$ -	$ 33.5	$ 33.0	$ 20.5	$ 7.5	$ 4.3	$ 0.2	$ 264.7	211,081
Western Sydney LHD	$ 56.3	$ 20.9	$ 48.0	$ -	$ 1.7	$ 3.3	$ 4.8	$ 6.4	$ 0.3	$ 0.4	$ 31.2	$ 27.9	$ 17.3	$ 42.1	$ 5.0	$ 0.3	$ 265.9	1,284,476
Far West LHD	$ 46.3	$ 21.5	$ 63.3	$ -	$ 0.2	$ -	$ 1.7	$ 1.5	$ -	$ -	$ 43.2	$ 57.0	$ 21.3	$ 11.0	$ 6.2	$ 0.1	$ 273.2	62,107
South Eastern Sydney LHD	$ 46.7	$ 39.3	$ 56.4	$ 0.3	$ 2.3	$ 3.2	$ 8.3	$ 4.8	$ 0.6	$ 5.5	$ 33.0	$ 33.7	$ 19.8	$ 27.2	$ 0.8	$ 0.1	$ 282.1	976,838
Hunter New England LHD	$ 54.1	$ 34.2	$ 61.7	$ -	$ 2.9	$ 3.6	$ 0.8	$ 9.9	$ 0.7	$ 0.7	$ 31.9	$ 29.8	$ 18.6	$ 33.8	$ 1.3	$ 0.3	$ 284.2	1,312,077
Western NSW LHD	$ 71.0	$ 30.7	$ 66.8	$ 0.0	$ 0.1	$ 0.0	$ 1.2	$ 2.3	$ 0.0	$ 2.5	$ 37.2	$ 38.8	$ 23.0	$ 7.7	$ 8.1	$ 0.0	$ 289.5	374,235
Nepean Blue Mountains LHD	$ 56.1	$ 29.4	$ 64.6	$ -	$ 3.9	$ 4.2	$ 4.0	$ 2.4	$ 1.2	$ 13.1	$ 37.0	$ 37.3	$ 23.6	$ 19.9	$ 1.6	$ 0.6	$ 299.0	527,058
Illawarra Shoalhaven LHD	$ 72.4	$ 24.0	$ 68.5	$ -	$ 1.2	$ 5.7	$ 2.0	$ 5.3	$ 0.5	$ -	$ 54.1	$ 33.8	$ 23.6	$ 14.6	$ 4.7	$ 0.7	$ 311.1	566,200
Sydney Children's Hospitals Network	$ 67.5	$ 76.2	$ 24.0	$ -	$ 5.2	$ -	$ 4.2	$ 18.1	$ -	$ 0.2	$ 19.7	$ 27.6	$ 21.6	$ 88.6	$ 4.3	$ 0.1	$ 357.4	423,525
Sydney LHD	$ 50.2	$ 56.5	$ 47.5	$ -	$ 9.9	$ 0.1	$ 9.5	$ 11.1	$ 1.0	$ 11.8	$ 34.7	$ 47.8	$ 24.2	$ 57.9	$ 2.9	$ 0.4	$ 365.6	724,675

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7. Coding

The LHD should undertake audit and education activities to improve NWAU coding. Increasing complexity reporting would enable HNELHD and the State to attract further ABF funding from the Commonwealth and lead to lower cost. An example would be missed opportunity with Mental Health coding as seen in the table below, where if coded with all phases complete the opportunity for a further $2.9m revenue would be available to the LHD.

Admitted Mental Health

2022-23 Lost Commonwealth Revenue Assessment ABF Admitted Mental Health with Unknown Phase

LHD/SHN	Total Phases	Total Unknown Phases	Additional NWAU	Cth Rev Opportunity
CCLHD	1,217	76	101.66	$235,724
FWLHD	113	77	102.71	$238,160
HNELHD	2,259	870	1,253.56	$2,906,749
ISLHD	1,403	584	329.62	$764,327
MNCLHD	862	292	31.53	$73,122
MLHD	475	479	195.40	$453,089
NBMLHD	1,333	324	576.07	$1,335,781
NNSWLHD	669	886	171.65	$398,020
NSLHD	2,219	347	686.25	$1,591,267
SESLHD	2,337	278	714.93	$1,657,770
SWSLHD	3,007	839	227.67	$527,912
SNSWLHD	608	207	218.14	$505,822
SVHN	370	585	1,097.42	$2,544,707
SCHN	243	866	5,255.94	$12,187,470
SLHD	2,142	751	2,920.15	$6,771,250
WNSWLHD	457	150	185.54	$430,233
WSLHD	1,394	180	170.16	$394,574
Total	21,108	7,791	10,620.08	$24,625,846

Source: ABM Portal, Activity Year = 2022-23, Pricing Inclusion Flag = Y, Stream = Admitted MH, WIP = N Data excludes Hawkesbury and Northern Beaches Hospitals

8. Discretionary Food

Review and reduce discretionary food expenditure. Establish a working party and identify food expenditure reduction opportunities. The working party should include cost-centre managers and a dietician/nutritionist. The working party should review their cost centre food expenditure reports to reduce unnecessary purchases, restrict food and water purchases being made via the stationary provider, restrict any food provided to staff for meetings, review patient discretionary food options i.e. ED and recovery and limit to set items, expensive desert options. CCLHD were able to achieve savings of over $500K in this area.

9. Bill of IT (BoIT)

The BoIT traditionally comes from eHealth in a one bulk cost item. This financial year it has been itemised with detail for different items, examples would be mobile phones and licences for software. There is opportunity to review all the different components of the BoIT and reduce costs. For example, Mobile phones no longer used, or have been lost etc, or licences such as acrobat that are costly and either now no longer needed or the person has resigned**.** There are potentially large savings to be gained. Feedback to the Review Team was inconsistent on the BoIT information being made available to FBPs or senior managers. The LHD should ensure this is consistently made available.

10. Pathology

The LHD has worked in partnership with NSW Health Pathology to identify opportunities to review claims to ensure they are eligible for Medicare reimbursement (retrospective claims). The LHDs should continue to work with the Pillar service provider by:

- Reviewing the 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.

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SUMMARY of RECOMMENDATIONS

Governance	Recommendation
FTE Realignment to Outputs	HNELHD achieve a conservative reduction of 283 FTE over an agreed recovery period negotiated with the NSW Health Chief Finance Officer.
Efficiency Improvement Plan Program	• It is recommended that the LHD ensure for FY25 that financial recovery strategies implemented are where possible reported through the NSW Health EIP program • FY25 EIPs should targeting employee related expense reduction should account for 60-70% of the LHDs total EIP program in FY25
ELT Governance	Maintain the ELT focus on the delivery of expense efficiencies and minimise wastage and monitoring and reporting on financial recovery activity and targets. Consider a dedicated meeting be held to focus on recovery activities so leadership are focused on these activities and not distracted by BAU.
Recovery Budget Performance Framework	Adopt a budget performance framework similar to the CCLHD recovery one, that is used at a service level to identify performing and under-performing services.
Board and Finance & Performance Committee	Ensure reporting on recovery plan and activity is in place.
Dedicated Recovery Project Officer	Consider establishing role.
MAMs	Ensure Efficiency and budget performance is part of all management staff MAMs
Communication Plan	Develop and enact a plan that ensures all staff are aware of the budget performance challenges and the need to reduce expenditure and eliminate wastage.
Recovery Initiative Tracking Tool	Implement a tracking tool for monitoring and reporting purposes.
Concept/Idea capture	Develop a simple approach that captures all ideas from managers for minimising wastage and reducing expense (or maximising revenue).
Workforce Efficiencies	**Recommendation**
Affordable FTE	The DOF to establish and report on an affordable FTE profile.
Approval of Positions	• The CE consider removing recruitment delegations (except for nursing frontline positions). Once the situation is stable consider implementing an Approval to Fill (ATF) committee, • It is recommended that the relevant Finance Business Partner provide this documented assessment so that where a budget is unfavourable the delegate is in a position to make an informed decision on whether to approve or not. • Review use of frontline staff in project roles.

	• Establish a register of enhancement approvals. Ensure all requests are regularly reviewed on ROI and have DoF approval and broader Executive review.
Position Regrades	• Ensure the process for regrading requires Finance determination that budget is available. • It is recommended that it is an obligation for a proponent of any regrade to not only establish industrial obligations and service needs but to identify the funding source for any successful regrading. • Approval of new positions or increasing gradings must reside only with the CE
HSM Band Increases via PDR	Recommend the LHD rescind the delegations and policy allowing a % increase for HSM salary band increases via PDR.
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.
Favourable Service Budgets	The LHD should remove favourability within any service and re-baseline the budget and FTE profile for FY25 accordingly. Where this favourability has been significant the LHD could consider providing that service with a lower adjusted efficiency target for future year saving
HealthRoster	• Priority should be given to ensure all HealthRoster demand templates for rostering are within affordable FTE and agreed upon staffing establishment/staff profile. Upon confirmation CE approval is required to alter. • Develop an annual plan for addressing rostering best practice with support from the MoH Rostering Best Practice Unit. • Develop an annual internal audit plan to measure the success of implementation and identify gaps to address. • Upskill and train staff in HealthRoster including awareness and use of reports.
Nursing - NHPPD	• Return Mental Health to NHPPD Award. • Ensure contingent worker and workers compensation staff (who are doing clinical duties) are included in the NHPPD count.
Nursing - Specials	• Expedite as a priority the review and update of the LHDs policy on use of nursing specials, including educating staff on the policy. • Authorisation after-hours must be made by the Executive On-Call. • Deliver 50% reduction on nursing specials in FY24 on the baseline of expenditure in FY23. Reporting specials reduction at the recommended recovery governance meeting.

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Nursing - Overseas Recruitment	• Monitor vacancy FTE numbers to ensure Strategies are developed to attract and retain staff such as the development a District wide Emergency Nurse education
Nursing - Review of CNCs	Target of 20 FTE through ensuring historical positions are still meeting the needs of the organisation and that staff are meeting their job descriptions and the Award domains, with opportunity to identify positions to change or be deleted.
Nursing - Review of CNEs	Target returning to FY19 CNE staffing levels once new graduates and overseas nurses have been supported for their first 3 months and acclimatised.
Nursing - Review of CNSs	• Review and ensure that the CNS's are meeting the Award conditions. • Consider use of HGD payment to ensure staff are not continuing in CNS roles without an annual assessment of performance to ensure meeting Award requirements.
Nursing - Overtime	• It is recommended a procedure be introduced to ensure all OT has to be approved by the DONM in hours and the Executive on call afterhours. • Reports are run to check patterns of sick leave post overtime approval. Ensure staff with excess sick leave are not offered overtime
Emergency Nurses	ED Network look at a plan to train ED nurses to supply across the district
Nursing - 80:20	Review and work towards achieving an 80:20 RN to EN/AIN workforce in acute facilities.
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	• Target returning to FY19 HSM staffing levels. Target reduction 20 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.
Allied Health	Review use of Allied Health FTE with a target reduction of 25 FTE.
Other Affordable FTE Target	LHD should review all non-NHPPD staffing profiles, PSA, security, hotel and administration roles to identify and meet a 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.

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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.
Annual Leave and ADO Liability	The LHD should implement strategies to reduce these liabilities.
Voluntary Redundancy program	It is recommended that HNELHD prepare a VR program to support recovery.
Medical and Nursing Agency Utilisation	Ensure vigilance is maintained on monitoring, reporting, and ultimately reducing agency staff use.
Quality Improvements & Model of Care Initiatives	**Recommendation**
Financial Literacy and Leadership Education	That the District introduce a compulsory Strategic Financial Management education program for all Executive, Managers and Leaders to raise the overall knowledge base of the LHD and develop a consistency of language across this group.
Map DRGs to Beds	Map DRGs to beds and reconfigure beds into current requirements ensuring efficient use of nursing staff on both a day-to-day basis and when surge is required.
Ward Consolidation of Nursing Home type patients	The LHD should review the number of these patient types and consider consolidating nursing home type patients onto one ward creating productivity and staffing efficiencies.
Workers Compensation	The LHD strengthen the current program of work with additional strategies that have proven successful in other LHDs.
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, particularly in community and integrated care settings.
Reduce Length of Stay	The LHD should review opportunities to reduce length of stay and closure of beds.
Clinical Services plan	It is recommended the Clinical Services Plan is reviewed and updated.
Occupational Therapists in ED	Consider redirecting this FR to other parts of the service
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.

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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.
Reviewing Service contracts for Major Medical equipment	review its contracts and look for opportunity to negotiate down the service response times for non-urgent services or services with multiple machines - from 1hr to next day and uptime guarantees from 98% to 95%.
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 Service	• Continue the strong approach to introducing cost-efficient medicines and full cost recovery of clinical trials work. • Consider implementing a District-wide service model so that the benefits and experience of John Hunter service model is implemented in other major sites. • Consider tender for a preferred wholesaler model. • Complete a cost-benefit review of in-house production verse out-source production and establish a baseline prior to commissioning of the redevelopment pharmacy production suite. • Review opportunity to implement a trial of pharmacy dispensing discharge medicines direct from select wards to assist in improving discharge times.
Medical Imaging costs	The LHD should assess the cost-effectiveness of the model utilised to ensure it is not adding additional expense compared to peers and assess loss of potential revenue.
Coding	Develop a plan to maximise coding, including reviewing mental health acute admitted coding to ensure complexity is accurately reported.
Discretionary food	Implement a working committee to look at reducing the cost of discretionary food
BoIT	Review BoIT and ensure information is made available to FBPs or senior managers to check for removal of all mobile phones and licences that are no longer utilised.
Pathology	• Review the 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.

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STAKEHOLDERS CONSULTED

- Tracy McCosker- Chief Executive
- Chris Mitchell- Executive Director, Information, Communication and Technology
- Kim Nguyen, Executive Director Workforce and Allied Health
- Elizabeth Grist, Executive Director, Clinical Services Nursing and Midwifery
- Paul Craven, Executive Director, Children Young people and Families
- Tony Gibertson, Executive Director of finance
- Christine Osborne, Acting Executive Director Mental Health
- David Quirk, Acting Executive Director, Rural and regional Health Services
- Julie Tait, Executive General Manager, John Hunter Hospital
- Paula Doherty, Director of Pharmacy
- Sally Milson- Hawke, Director of Nursing and Midwifery
- Sunbo Olalere, Director of Imaging
- Viv Thompson, Finance Manager
- Peter Choi, Director of Medical Services
- Angela Mears, ADONM Manning Hospital
- Aaron McLean, Finance Manager Manning Hospital
- Dr John Roberts, Locum Director of Medical Services, Manning Hospital
- Jenny Fishpool, Operational Manager Medical Services, Manning Hospital
- Paul Townsend, Acting General Manager Manning Hospital
- Stephen Joyce, Acting General Manager Armidale Hospital
- John Kim A/DONM Armidale Hospital
- Jodie Moore, Finance Manager
- Sundar Thavapalasundarum, Director Medical Services Armidale Hospital
- Yvonne Patricks, General Manager, Tamworth Hospital
- Michelle Keir, DONM Tamworth Hospital
- Karen Clark, Finance Manager Tamworth Hospital

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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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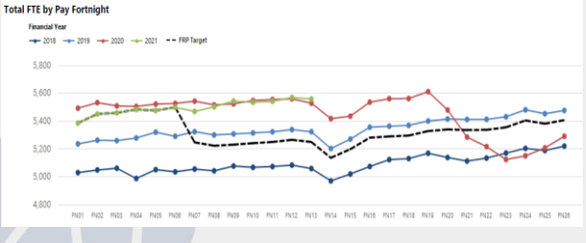
CCLHD



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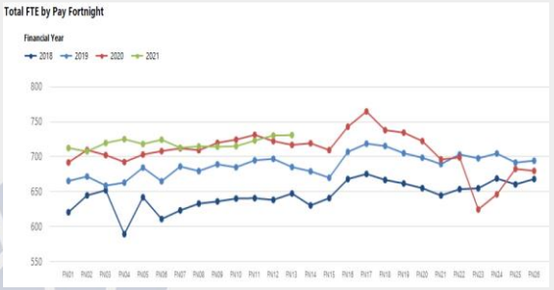
Medical



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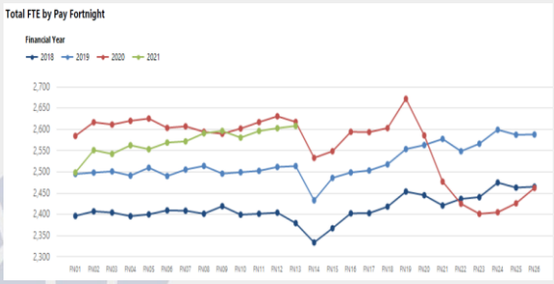
Nursing



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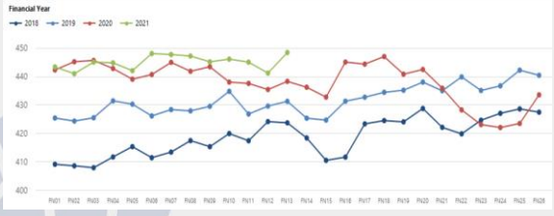
Allied Health



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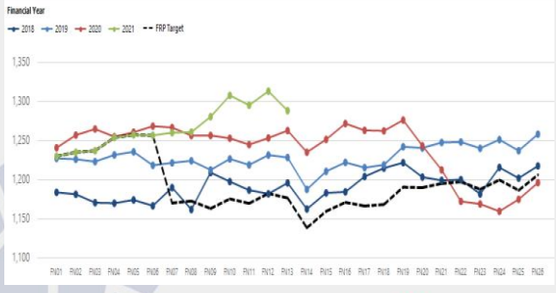
Wyong



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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

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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

NSW GOVERNMENT Health

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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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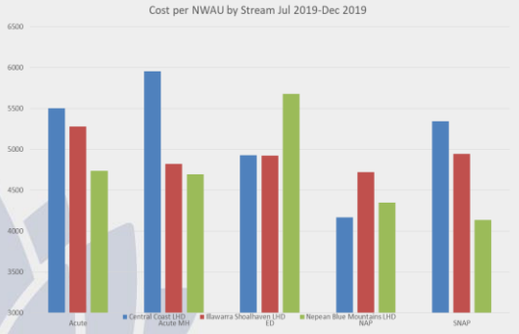
Major Findings and Opportunities: ABF



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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 – Project on a Page template for Concept/Idea capture

OSP - A3 Project Plan on a Page

NSW GOVERNMENT Health

Project Name			
Project Lead		**Contact**	
Lead		**Contact**	
Executive Sponsor		**Contact**	

Rational and Background

Rational/ Background	
Aim	
Objectives	•
Benefits	•

Scope

Inclusions	
Exclusions	
Constraints	

Key Stakeholders

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

Key Dates & Milestones / Deliverables / Outputs

Project Start Date	Project End Date		
Milestones / Deliverables / Outputs	**Who**	**Start Dates**	**Completion Dates**

Overall Initiative Implementation Costs & Savings Target

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

Governance and Reporting

Structure / Meetings / Committees / Reports	Who / Chair	How often / When

Risk Identified as at *

Major Risks	Likelihood	Consequence	Rating ⓘ	Management Strategy
	Likely	Moderate	High	•
	Possible	Major	High	•
	Possible	Major	High	•

Monitoring & Evaluation

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

Approval

Name	Position	Signature	Date
Jude Constable	Executive Director Acute		

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Appendix 3 - CCLHD CNC Review Framework

CCLHD Clinical Nurse Consultant review

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

Key issues

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

Benchmarking with like organisations in 2020-21 demonstrated: -

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

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

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

The following was highlighted: -

- The mapping of the CNCs across the district demonstrated there were efficiencies to be made by realigning some CNC roles to the north or south end. For example, there are four CNCs in aged care and all four travel to all four facilities in the CCLHD. Reporting lines could also be realigned with the example that in Gosford Medicine, three CNCs report to the Operational Nurse Manager (ONM) compared with Wyong's Medicine ONM that has 6 CNCs reporting to that position. These discussions and decisions should be referred to local site management. Professional nursing advice from the NMD can be provided.
- The CNC1's (19) employed across the CCLHD are not meeting the Research domain or the Clinical Services Planning and Management domain.
- The CNC2's (53) over 90% are not meeting the Research Domain and 79% did not meet the Clinical Services Planning and Management domain.
- The CNCs (6) only 1 person (16%) met the research domain.

Recommendations

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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.