The full year impact of services introduced in 2015/16 is the primary driver of the budgeted cost increase in 2016/17

The following section shows an increase in the 2016/17 cost base of CHHHS from 2015/16 highlighting the key areas which contributed to a $45.2m increase in budgeted costs.

2015/16 v 2016/17 cost base

Source: Management information & EY analysis

Cost base bridging process

- In order to understand the increase in the budgeted cost base from 2015/16 to 2016/17, each division performed analysis to bridge their 2015/16 actual results to their 2016/17 divisional budget as split by the cost categories presented in the chart above.
- There were a number of limitations that were uncovered from this process including:
  - Material year on year unexplained movements in labour and non-labour expense categories
  - Different methods for costing labour and non-labour expenses
  - Inconsistencies in the application of CPI
  - Inconsistencies in interdivisional movements from 2015/16 to 2016/17.
- Where possible, cost estimates have been recalculated using information from the budget tool (CHHHS' in-house tool for developing its budget) and general ledger but remain subject to uncertainty.

2016/17 costs

- Costs are budgeted to increase from $855.3m in 2015/16 to $900.5m in 2016/17.
- The increase of $45.2m from 2015/16 actuals to 2016/17 budget is due to full year impacts of 2015/16, new services in 2016/17, Hepatitis C increase and EB and escalation increases offset by non-recurring Digital Hospital costs. This analysis is based on 2015/16 actuals as provided to us for our analysis. We note minor variances between this and the costs published in CHHHS' 2015/16 annual report.
- The other category comprises of adjustments identified by divisions that do not align to any of the categories presented as well as unexplained and unreconciled differences arising from limitations of the budgeting controls and processes.
- Note that allocation of Enterprise Bargaining increases and other minor allocations were processed by CHHHS in October 2017 after providing us with information for our analysis, and the cost bridge does not reflect these changes.

The full year impact of services introduced in 2015/16 is the primary driver of the budgeted cost increase in 2016/17

1 Full year impact of 2015/16 new services

- New services introduced part way through 2015/16 costed at a full 12 months of 2016/17 increased the budgeted cost base by $26.7m. The following new services in 2015/16 had a material full year impact in 2016/17:
  - Perioperative services ($6.4m) – Relates to the opening of the Ninth Theatre and increase in surgical services.
  - Non ABF facilities ($2.3m) – Management advised there was an increase in medical staff at Mossman and Tully.
  - Medical Imaging and PET Scanner ($4.5m) – Increase in costs to run the PET (Positron emission tomography) scanner and increasing the operating hours of medical imaging services to 24 hours a day, seven days a week.
  - SIFT ($1.3m) - Full year impact of SIFT (Service Increment for Teaching) model in Emergency Department introduced in December 2015.
  - Pediatrics and adolescent wards ($2.6m) – Full year impact of new ward introduced in 2015/16.
  - Patient flow unit ($2.5m) – Increase due to extension of opening hours in the transit lounge (extended hours and weekends), Scheduled Care Unit and Health Pathways.
  - Catering, security and cleaning ($0.8m) - Increase in costs to support growth in services and to meet new catering guidelines.
  - Anesthetics ($0.6m) – Increase in anaesthetic expenses relating to the Ninth theatre.

2 2016/17 new services

- New services budgeted to be introduced in 2016/17 increased the budgeted costs from 2015/16 to 2016/17 by $5.5m. Key amounts include:
  - Tropical Public Health Unit ($2.1m) – including zika virus management
  - Commonwealth funding underspends ($1.2m) – several programs were underspent in 2015/16 and this is not budgeted for 2016/17.

2016/17 new services (continued)

- Oral Health ($0.6m) – an underspend in 2015/16 is not budgeted in 2016/17
- Nursing ratios ($0.6m offset) – we were advised of a slight FTE decrease determined through use of nursing Business Planning Framework ("BPF") ratios

3 Digital Hospital (a)

- The Digital Hospital initiative, to transition CHHHS towards a higher level of electronic record-keeping enabling online record access among other benefits, went live in 2015/16. The movements in this category reflect non-recurrent costs incurred in 2015/16, not included in the cost base of CHHHS in 2016/17.
- Actual Digital Hospital implementation costs incurred in 2015/16 totalled $31.8m which was fully funded by the Department of Health.

4 Digital Hospital (b)

- Costs in relation to Digital Hospital in 2016/17 separately identified by CHHHS totalled $6.8m and comprised of:
  - A business as usual ("BAU") case for 18.0 FTEs to deliver the core functionality of the initiative.
  - Additional labour costs in relation to the medical records and scanning team ($1.9m).
  - 6.5 FTE's in relation to FirstNet (a part of Digital Hospital) ($0.9m).
  - Digital Hospital levies budgeted to be charged to CHHHS by eHealth Queensland ($1.0m).
- Digital Hospital levies for 2016/17 had not been finalised as at 30 September 2016 and the above is an estimate.
- Management has advised that to the extent that Digital Hospital processes become more efficient in 2016/17, some temporary resources associated with the initiative may no longer be required.

The costs of Hepatitis C drugs increased the 2016/17 budgeted cost base by $17.5m however had no effect on the CHHHS deficit as it is a fully funded initiative.

5 Enterprise Bargaining escalation

- Enterprise Bargaining wage escalations are funded by the Department of Health. The estimated impact of Enterprise Bargaining increases currently factored into the budget is $16.4m.

6 Escalation

- Escalation factors contributing to operating expenses (non-labour) increased the 2016/17 cost base by $6.0m relating to CPI increases on non labour and an electricity escalation of 12% based on the expected agreement with CHHHS' energy provider for 2016/17.

7 Hepatitis C

- Hepatitis C drugs costs are budgeted to increase by $17.5m, which is offset by an equivalent budgeted revenue amount received through PBS.
- Hepatitis C costs were $7.2m in 2015/16 and budgeted at $24.7m in 2016/17.

8 Other items

- Other cost movements not categorised and unreconciled items have been combined into one category providing a net decrease in the cost base of $1.9m from 2015/16 to 2016/17.

4

Organisational sustainability plan

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The Organisational Sustainability Plan initiatives focus on both revenue optimisation and cost containment

CHHHS Management identified initiatives to partially address the budgeted deficit position through the establishment of an Organisational Sustainability Plan ("OSP") which commenced implementation in July 2016. The purpose of the OSP was to prioritise initiatives to enhance the sustainability of CHHHS's health service delivery and endeavour to meet the health needs of the community and patients, now and into the future. The initiatives to improve sustainability were:

Organisational Sustainability Plan: Summary of Initiatives

Stream	Stream Name	Objective	2016/17 Risk Adjusted Savings[1] ($'000)
1	Revenue Optimisation	This includes all initiatives aimed at increasing the revenue generated by CHHHS through own source revenue and improved clinical coding.	6,640
2	Workforce	This includes workforce establishment, rostering, overtime and contract management.	6,297
3	Service Delivery	This includes a variety of initiatives to improve efficiencies in services delivered by CHHHS. Different areas include telehealth, pharmacy and medical imaging.	2,633
4	Business expenditure	This includes a variety of different initiatives to reduce waste including improving stationary controls and raising awareness on the use of electronic equipment for viewing material in lieu of printing.	1,819
5	Procurement	This includes reviewing contractual agreements and identifying procurement savings across different services.	315
Total			**17,704**

1. CHHHS management have calculated the risk adjusted savings by applying a rating score to each initiative from 0-100% based on the level of confidence to achieve the full year savings target.

Management estimates the Organisational Sustainability Plan project has already delivered $2.6m savings and on a risk adjusted basis will deliver $17.7m by Jun 2016

The purpose of the OSP was to deliver a range of initiatives that supported CHHHS in achieving a balanced financial operating position for 2016/17. The OSP was determined to be the strategic priority for CHHHS with executive management sponsors appointed for each initiative.

Management performed an evaluation of each initiative and have developed full year savings targets and phased these across the financial year as follows. These have been risk adjusted to reflect the level of confidence in achieving the target.

Month	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017
Savings target ($'000)	691	741	786	2,087	2,087	2,087	2,087	2,112	2,112	2,112	2,697	2,697
Cumulative total of savings target ($'000)	691	1,432	2,218	4,305	6,391	8,478	10,565	12,676	14,788	16,899	19,596	**22,293**
Risk adjusted savings ($'000)	561	601	637	1,633	1,633	1,633	1,633	1,653	1,653	1,726	2,172	2,172
Cumulative total of risk adjusted savings ($'000)	561	1,162	1,800	3,432	5,065	6,697	8,330	9,982	11,635	13,361	15,532	**17,704**

As at the end of August 2016, CHHHS have calculated $2.6m of savings realised under the OSP, which is higher than the cumulative year to date savings target of $1.4m. Annualising the savings realised to date results in a total annual saving of $15.6m.

Management has identified risks to delivering the Organisational Sustainability Plan including lack of clarity and insufficient engagement

The OSP has maintained a focus on balancing the initiatives' imperative with its associated risks. The risks identified below represent a sample selection of the actual risk register, deemed essential recognising the interoperability of the initiatives and their varying degree of complexity.

Risk ID	Risk Title	Risk Description
1	Poorly defined savings opportunities	Inability to meet savings targets due to a lack of appropriate strategies, clearly identified improvement areas and an understanding of how benefits will be realised.
2	Delay in realising savings associated with targets	Due to the complexity and interdependencies between initiatives, consideration needs to be given to appropriately manage the potential clinical and organisational impact. These initiatives will necessarily take a longer period to implement and realise the savings target.
3	Insufficient engagement and adoption of required actions	Variable engagement and commitment from staff at all levels to implement, drive, deliver and sustain the actions necessary to realise savings targets.
4	Loss of project momentum	Lack of ownership over individual initiatives could result in inability to establish and sustain the efforts required to achieve targets.
5	Increased public interest and scrutiny	Due to the projected CHHHS budget deficit, there is an increased interest from the media, unions and wider community which could affect the speed of specific initiatives.
6	Constant changes in scope	Inability to clearly define the strategies and actions to implement a number of initiatives. This has resulted in a number of significant scope changes since the commencement of the project.

Organisational Sustainability Plan initiatives impact multiple dimensions for CHHHS and this impact should be monitored to confirm ongoing acceptability of the initiative progressing

CHHHS should further assess each initiative relating to its impact on the factors outlined below. Implementation of the scheme can then be considered in the context of the impact on these factors and an associated acceptability rating applied to inform potential risks and mitigations.

- Service delivery
- Accessibility
- Impact on activity and financial flows
- Need for capital redevelopment
- Availability of workforce
- Patient safety
- Implementation
- Industrial relations
- Reputational
- Community response

The outcome of this approach would be to present an overall acceptability rating score to proceed.

Organisational Sustainability Plan – A long term plan for Operational Stability

CHHHS has experienced significant change in the last three years with a major re development of physical infrastructure, implementation of the new Cairns Digital Hospital program, adjustment in resource models and models of care to meet the demands of a growing population across the health service.

CHHHS should commence a structured operational stability program that will support the organisation to achieve a medium-to-long term sustained position of improvement. This should be considered against an enterprise risk management framework that will help the CHHHS board and management make effective decisions for the long term sustainability of the organisation. As such the organisation needs to satisfy itself and its stakeholders that it has appropriate governance arrangements in place, supported through risk enabled strategic and operational processes with appropriate risk monitoring.

The OSP program needs to be complemented by a broader program of work to support the organisation to achieve a sustainable long-term position. EY recommends the following approach in establishing a long term plan for a system configuration which delivers operational sustainability:

- Revisit the CHHHS master plan for health services for its region with a view to optimising the system around demand, performance, quality, access and capacity.
- Agree the criteria for assessing the appropriate options for the provision of health services, ensuring the assessment is clinically lead, data driven and transparent.
- Establish an appropriate governance structure with clinical and technical working groups to drive local ownership, accountability and results.

The immediate steps that EY would typically recommend for an organisation under fiscal pressure would include:

Phase	Steps	Description
1	Establish system impact of existing initiatives	This includes activity, acuity, volume, utilisation, net cost to serve, bed occupancy and clinical risk. Consideration of system wide and/or local implications. In addition all aspects of patient safety and quality, value, patient experience, leadership and governance and access.
2	Seek appropriate levels of approval to progress 'workable' initiatives for adoption	Develop long list of delivery options relating to improvement initiatives and service configuration. Review each initiative against pre determined criteria to assess clinical and operational acceptance for future delivery. Criteria would include but would not be restricted to the following: quality of care, patient access, financial, future service sustainability, workforce sustainability including teaching and training, alignment with appropriate legislation and system leadership directives actively supported by staff, community and others. Feasibility in terms of difficulty to implement and levels of necessary disruption for patient, staff and community. Agree future initiatives and configuration options based on agreed criteria.
3	Develop and roll out implementations plans as approved – with consultation as required	Establish and communicate an engagement plan and a plan for building organisational capability for sustainable improvement.
4	Review KPIs on a quarterly basis	Consider and report on organisational impact of actual against planned performance against key measures. Make transparent opportunities with evidence to make appropriate decisions about the actions which may include stronger governance, more agile capability and innovation.
5	Maintain continuous improvement program, identifying additional initiatives using preliminary and updated service planning and implementation experience	Continually monitor the operational stability schemes identifying further investment and dis-investment opportunities.

5

Additional deficit reduction initiatives

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Management identified additional initiatives to deliver an estimated $11.4m - $13.6m to offset the deficit in 2016/17

- Noting that the efficiency savings from the Organisational Sustainability Plan were inadequate to address the budget deficit, CHHHS Management identified and considered other alternatives.
- Initiatives were categorised into priority categories for further assessment including the essential consideration of patient safety / clinical impact.
- The top priority category of initiatives that could impact on the 2016/17 financial position are summarised below. Any financial benefit from these initiatives is not incorporated into the 2016/17 budget at the date of this report.

Description	Nature of initiative	Timeframe to implement	Full year benefit	2016/17 benefit
2016/17 WIP accrual adjustment	Increase revenue	Immediately	$4.0m - $5.0m	$4.0m - $5.0m
2016/17 growth revenue adjustment	Increase revenue	Immediately	$3.8m	$3.8m
Elective surgery scheduled to avoid peak Christmas and Easter periods	Service scheduling	0 – 3 months	$1.6m - $2.8m	$1.6m - $2.8m
Procurement savings	Improved purchasing	0 – 3 months	$8.7m - $11.8m	$2.0m
TOTAL			**$19.6m - $24.9m**	**$11.4m - $13.6m**

Notes

1. Full year savings represent Management's estimate of full year benefits arising from incremental increased revenues and / or reduced costs.
2. 2016/17 in-year savings represent the portion of full year benefits that Management expects to be realised in 2016/17 after taking into account Management's estimated timeframe for realisation, but excluding implementation costs and assuming timely implementation.

Key assumptions adopted by Management in preparing these savings estimates include:

- Budgeted revenue is unaffected by the initiatives designed to reduce the cost base.
- Labour savings can be achieved through redeployment or alternative methods, with no redundancies.
- Costs to implement initiatives have not been factored into Management's analysis to date.
- Where the saving is presented as a number (instead of a range) this is not indicative of a higher level of certainty. All savings are estimates only, with a high degree of uncertainty, that require further in depth consideration before a decision is taken as to whether to proceed with the initiative.

6

Budget build process and recommendations

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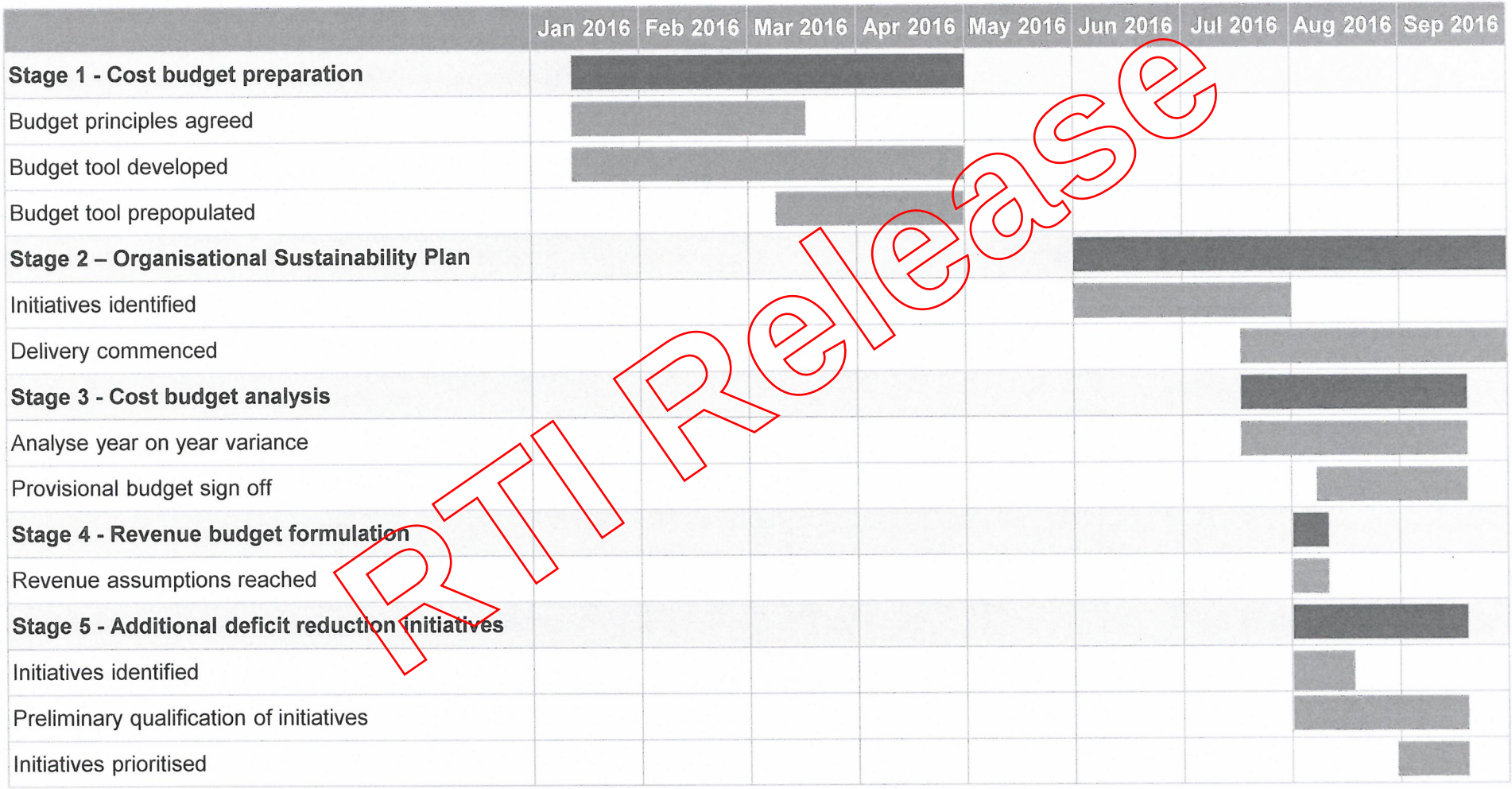
CHHHS commenced the budget build process in January with selection of measures to close the deficit gap extending into September 2016



CHHHS budget build process first developed the cost budget and then independently the revenue budget; the mismatch necessitated steps to address the resultant deficit

Context

- There was turnover in the CHHHS Management team in 2015/16 resulting in a loss of corporate knowledge.
- Previous budgeting processes had been developed in spreadsheets creating version control and accuracy issues.
- Lack of Management ownership of the 2015/16 budget was seen as a contributory factor to the budget deficit in 2015/16.

Budget stages of development

Stage 1 – Cost Budget Preparation: Jan – Apr 2016

- A database budget tool application to manage cost budgeting was created in-house to reduce dependency on spreadsheets.
- Budget principles were authorised by the CHHHS Board.
- CHHHS Finance prepopulated the budget tool with data reflecting annualised balances derived from Feb 2016 YTD actual costs.
- Consistent with the 'bottom up' methodology, responsibility for initial preparation of divisional budgets rested with divisional Management (supported by Business Analysts).
- CHHHS Finance provided staff involved in the budget build process with a briefing giving instructions and assumptions to be adopted in the budget build process; a key assumption was that budgets should be prepared on a 'bottom up' basis assuming no changes in services provided.

Stage 2 – Development of Organisational Sustainability Plan: Jun 2016

- Management identified budget costs were higher than funding and commenced planning the organisational sustainability initiatives (see Section 04). Financial benefits budgeted from these initiatives were not factored into the $80.5m budget deficit.

Stage 3 – Cost Budget Analysis: Jul – Sep 2016

- To understand the drivers of the growth in the cost base from 2015/16 actual costs to 2016/17 budget costs, Management analysed movements into categories including new services, 2016/17 full year impact of 2015/16 part year services and changes driven by Digital Hospital and Commonwealth Funding. Variances between 2015/16 actual costs and 2016/17 budget costs that were unexplained by this processed were further investigated.
- Through this high level iterative process, Management identified necessary budget changes that were entered into the budget tool.
- Provisional budgets received Divisional sign off at this point, with a cost base of $900.5m.
- Budget review meetings were led by a combination of the Chief Executive, CFO and COO, with some other Executive team members contributing.

Stage 4 – Revenue Budget Formulation: Aug 2016

- Management compiled the revenue budget drawing on Service Agreement revenues and other funding sources.
- The revenue budget assumed a lower level of services would be delivered in 2016/17 than were delivered in 2015/16.

Stage 5 – Additional deficit reduction initiatives: Aug - Sep 2016

- Noting that the efficiency savings from the Organisational Sustainability Plan were inadequate to address the budget deficit, Management identified and considered other alternatives.
- A number of initiatives were scoped for a preliminary qualification process to eliminate initiatives that would not contribute to reducing the budget deficit.
- Initiatives were categorised into priority categories for further assessment including the essential consideration of patient safety / clinical impact.
- The top priority category of initiatives is included in Section 05 of this report. At the date of this report, the full qualification process to assess whether the initiative satisfies patient safety / clinical impact and other priorities (e.g. redeployment of staff with no forced redundancies) has not yet been performed and none of the initiatives have been enacted as at the date of this report.

The budget phasing shows a steady accumulation of the deficit during the year

Budget phasing

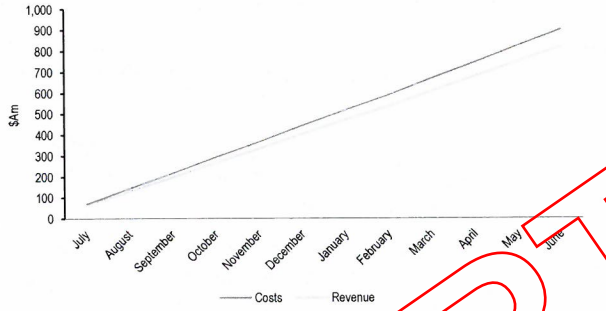
- The following basis was initially used for allocating the budget by month in 2016/17:

Budget phasing methodology

	Basis of allocation
Revenue	Days in month
Labour expenses	Front loaded by $1.9m by Dec 2016
Operating expenses	Days in month
Depreciation and amortisation	Days in month

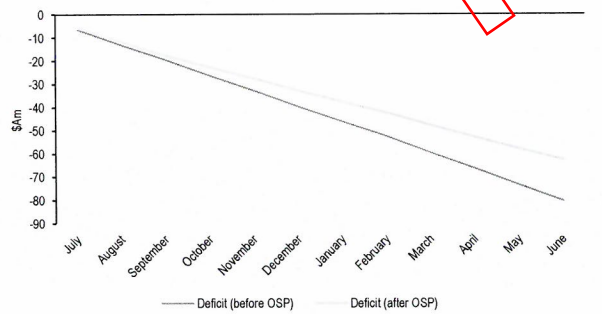
Revenue and costs phasing – 2016/17 budget

Source: Management information



Deficit phasing excluding and including OSP savings – 2016/17

Source: Management information



Budget phasing

- Management acknowledged that to allow focus to remain on reducing the deficit, initially time was not allocated towards in-depth budget phasing which consequently did not take into account:
  - Funding applicable for part year.
  - Costs of services funded for part year only.
  - Public holiday and penalty rate payment variations through the year (Queensland has four public holidays from Jul – Dec 2016 and eight from Jan – Jun 2017) which would be expected to increase labour costs in the second half of 2016/17.
  - Benefits flowing through from the Organisational Sustainability Plan nor the additional scheme savings, as these costs are not factored into the budget.
- The methodology for phasing revenue and labour was subsequently finalised in early October 2016 and our report does not consider a detailed analysis of this phasing. At a high level we note the labour phasing appears to incorporate a weighting to recognise more public holidays in the second half of the year.
- The chart mid left shows the phasing of budget revenues and costs in 2016/17. We note there is no noticeable impact due to seasonality based on this phasing approach.
- The chart at the bottom left reflects Management's phasing assumptions to show how the deficit accumulates in 2016/17. The lower line reflects the budgeted deficit and the higher line shows the reduced deficit that will eventuate if the risk adjusted savings of the OSP are achieved.

Recommended improvements to budget controls and systems

Set out below are our observations on financial controls and systems at CHHHS in the context of the budget setting process.

Commendation

We commend Management on the following:

- Budget preparation commenced in Jan 2016, which under normal circumstances would be in good time for completion pre Jun 2016.
- We observed a high level of engagement from Management and support staff in formulating a meaningful budget to act as a financial plan for 2016/17. This was facilitated through Management's decision to implement a bottom up budget build, compared to the top down process that was adopted in 2015/16 of rolling over the previous budget.
- Issues from the prior year were addressed: the budget tool was developed in-house in response to budgeting issues experienced in the prior year budget process.
- Access to the budget tool was controlled by CHHHS Finance who ran the 2016/17 budget process.
- Budget principles were documented and considered at Board level at the commencement of the budget setting process.
- CHHHS ran a consultative and transparent process to introduce a methodology for the allocation of revenue across divisions.

Improvement recommendations

We noted and have discussed with Management our suggestions for improvements to the budget setting process, and note that Management had already independently identified some of these findings.

Systems

Limitations in the budget tool evident in its first year of use include:

- No provision for sensitivity analysis: The budget tool is essentially a repository for storage of budget data, not a tool that is useful as part of the decision making process. We consider the ability to flex data and determine the sensitivity of outputs to various inputs to be an important part of the budget setting process.
- Time consuming data entry: Data is entered at a detailed level by cost centre and account code for non labour costs and by employee for labour costs. The 2016/17 budget contains over 23,000 separate lines of data which assuming each decision takes only 30 seconds will take over 26 man days of effort to populate unless completed through a spreadsheet upload. Flowing budget changes through the budget tool (e.g. changes to the nursing business planning framework ("BPF")) can also be time consuming as multiple data inputs need to be updated.
- Lack of reporting: Data cannot be reviewed in context or in aggregate within the budget tool as the tool does not have reporting functionality nor comparative (2015/16) data. Once the budget is close to final and is uploaded into DSS, reports are available; however, a principle of good budget setting is progressive review during the budget setting process.
- Inability to accommodate seasonality or phasing: the budget tool only captures annual costs for non labour expenses and while it captures employee start and finish dates it does not accommodate seasonality in costs driven by factors such as public holidays. We understand that Management is investigating a modification to the budget tool to accommodate this.
- No capacity to manage cash flow or balance sheet positions: the budget tool does not allow budgeting for cash flow or balance sheet positions.
- We understand Management is seeking to extend the functionality of the budget tool to make it the source of approved labour positions, replacing current labour reporting which is considered inaccurate. As such, we understand that the labour budget will be updated as approved positions in the organisation change. We envisage this could become confusing as the Board approved budget will potentially be over-ridden during the year as new approved positions are created, and as a minimum will require implementation of strong version controls.
- In the light of the above, we recommend the suitability of the budget tool for use in future budget cycles is assessed in consultation with users, with a view to incorporating modifications or identifying an alternative solution.

Recommended improvements to budget controls and systems

Process

We identified a number of limitations in the process adopted:

- Lack of a documented Operational Plan: A budget represents the financial outcome of operational planning. The lack of a documented Operational Plan hindered the organisation from co-ordinated and consistent budgeting, as decisions on service levels in one division were not apparent to another division that might be impacted. We recommend (and note that current Management are supportive of) the development of an annual Operational Plan prior to next year's budget setting process.
- A disconnect between budgeting for revenue and costs: Delays in allocating revenue across divisions resulted in detailed cost budgets being developed which were not supportable by the funding available. We recommend the revenue allocation is distributed early in future budget processes to provide divisions with visibility of their available funding. We understand Management is supportive of this recommendation.
- Minimal use of cost drivers to determine the cost base: Adoption of operational metrics to determine certain budgeted costs (for example, cost per FTE) provides insight into areas where the budget may be inaccurate. The budget tool does not accommodate such metrics nor was this approach built into the budget process. Management raised the desirability of a Queensland or national benchmark for clinicians required across services (i.e. a Business Planning Framework for doctors) which could assist with planning and budgeting.
- Lack of tested methodologies: Methodologies for uploading enterprise bargaining costs and phasing revenue and costs appeared to be developed late in the budget process and had not been resolved at the planning stage. We recommend this is planned at the outset for the next budget process to ensure necessary information is captured as part of the budget build.

Scope

- An important part of budget setting is allowing an organisation to plan the year ahead in the light of the year underway, including identifying opportunities to improve performance. We note that Management chose to plan and track labour operational efficiency savings (such as through improved rostering practices) separately to the budget, through the Organisational Sustainability Plan. We recommend these savings targets are incorporated into a budget revision to preserve the budget as the primary financial performance target.
- We consider the budget data captured by CHHHS to be to an extraordinary level of detail, using over 700 cost centres and over 1,000 accounts. Noting that the budget is primarily a financial planning and control tool, we recommend Management consider whether budgeting to a less detailed level will improve accuracy (by improving a 'big picture' overview) while still retaining the ability to hold Management accountable for performance against budget.

Phasing

- As previously noted, the budget was initially phased without taking into account:
  - Funding applicable for part year.
  - Costs of services funded for part year only.
  - Public holiday and penalty rate payment variations through the year (Queensland has four public holidays from Jul – Dec 2016 and eight from Jan – Jun 2017) which would be expected to increase labour costs in the second half of 2016/17.
  - Benefits flowing through from the Organisational Sustainability Plan nor the Additional Savings Schemes savings, as these costs are not factored into the budget.
  - We recommend that in future budgets, phasing information is captured at the time of initially preparing the budget to improve the efficiency and accuracy of the budget setting process.
  - For the final 2016/17 budget to provide an indication of planned performance, we recommend that it is phased to incorporate the factors noted above otherwise incorrect conclusions on year to date performance may be drawn.

Recommended improvements to budget controls and systems

Reporting

When Management has finalised phasing of the budget we would expect to see monthly reporting against budget which would ordinarily include:

- An analysis of variance of the actual month's result to the monthly budget for the purposes of reporting to the Chief Executive and Chief Finance Officer, to explain key drivers of variances and clearly differentiating between timing variances and cost or revenue amount variances.
- Preparation of a full year forecast in the light of year to date performance and known future changes that will impact on year to date performance (e.g. sustained movements in activity levels, latest FTE numbers and locum usage).
- We recommend development or adoption of a simple high level tool to capture and consolidate divisional forecast updates while preserving version control.
- Other practices which we have observed to work well include a monthly "driving results" meeting of the Executive, with each executive providing a verbal update focused not on the past performance but on what actions they plan in order to bring future performance back to budget. The constructive discussions that ensue amongst the Executive crystallise action plans and drive accountability and teamwork.

7

Appendices

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Appendix A – Management accounts to audited financial statements reconciliation

Management to audited financial statements reconciliation – 2015/16

Currency: A$m	2015/16 Management accounts	2015/16 Audited financial statements	Variance
Revenue	**835.3**	**839.2**	**3.9**
Labour expenses	(588.6)	(590.0)	(1.4)
Operating expenses	(229.4)	(231.9)	(2.5)
Depreciation and amortisation	(37.3)	(37.3)	0.0
Total costs	**(855.3)**	**(859.2)**	**(3.9)**
Operating surplus (deficit)	**(20.0)**	**(20.0)**	**0.0**

Source: Management information and 2015/16 Cairns and Hinterland Hospital and Health Service Annual Report

Management to audited financial statements reconciliation

The table on the left presents the 2015/16 management accounts, as presented in this report, to the audited financial statements as presented on page 58 of the 2015/16 Cairns and Hinterland Hospital and Health Service Annual Report.

- A $3.9m adjustment for capital works exists between the management accounts and the audited financial statements.
- The audited financial statements includes labour costs of $1.4m and operating expenses of $2.5m in relation to capital works costs that are not included in the management accounts.
- These expenses are fully funded and the audited financial statements reflects $3.9m of Department of Health funding not included in the management accounts, resulting in a nil operating deficit movement.

Appendix B - Definitions and abbreviations

Abbreviations

2015/16	Actual period 1 July 2015 to 30 June 2016
2016/17	Budgeted period 1 July 2016 to 30 June 2017
ABF	Activity Based Funding
ACEM	Australasian College for Emergency Medicine
BAU	Business as usual
BPF	Business Planning Framework (nursing)
Budget tool	The in-house database developed by CHHHS to manage its budget build process
CE	Chief Executive
CET	Clinical Education and Training
CFO	Chief Finance Officer
CHHHS	Cairns and Hinterland Hospital and Health Services
COO	Chief Operating Officer
DSS	CHHHS' Enterprise Reporting System
Digital Hospital	Transition to interconnected electronic storage of medical records
Division 1	Family Health and Wellbeing
Division 2	Integrated Medicine
Division 3	Critical Care and Perioperative
Division 4	Facilities Management
Division 5	Business Support Services
Division 6	Executive Office
Division 7	Corporate Accounting and Contingency
DoH	Department of Health (Queensland Health)
EB	Enterprise Bargaining
Efficient Growth Funding	Commonwealth funding of services delivered above contracted activity levels
FTE	Full time equivalent
Hep C	Hepatitis C
HHS	Hospital and Health Service
HIPO	Health Innovation and Projects Office
HP	Health practitioner
ICT	Information and Communications Technology
KPI	Key Performance Indicator
m	Millions
Management	CHHHS Management
MBS	Medicare Benefits Schedule
MOHRI	Minimum Obligatory Human Resources Information
MUMP	Medication Utilisation Medical Project
NWAU	National Weighted Activity Units
OSP	Organisational Sustainability Plan
OSR	Own source revenue
PBS	Pharmaceutical Benefits Scheme
PosOcc	Positions Occupied Report
PUMP	Pathology Utilisation Medical Project
QH FTE	Queensland Health full time equivalent
QWAU	Queensland Weighted Activity Units
RUMP	Radiology Utilisation Medical Project
SDS	Service Delivery Statement
Service Agreement	Cairns and Hinterland Hospital and Health Services Service Agreement 2016/17 – 2018/19
SIFT	Senior Intervention for Triage
SMO	Senior Medical Officer
SOA	Standing Offer Arrangement
SRG	Service Related Group
WAU	Weighted Activity Units
WIP	Work in progress – specifically relating to the recognition of revenue equivalent to WAU earned in treatment of long stay patients
YTD	Year to date

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