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

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

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 $45.3m increase in budgeted costs. **[ALL NUMBERS TO BE CONFIRMED BY MANAGEMENT]**

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 (1 to 7) was given the task of bridging 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 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.
- The other items and reconciling differences 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.

RTI Release

DOH-DL 16/17-009
RTI Document No. 22

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.

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 $23.4m. The following new services in 2015/16 had a material full year impact in 2016/17:
  - Perioperative services ($4.1m) – Relates to the opening of 9th theatre and increase in surgical services
  - Non ABF facilities ($2.3m) - Increase in medical staff as a result of Coroner recommendations at Mossman and Tully.
  - Medical Imaging and PET Scanner ($5.0m) – Increase in costs to run the PET scanner and opening of 24/7 medical imaging.
  - SIFT ($1.3m) - Full year impact of SIFT 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 ($1.0m) – Increase due to additional 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 standards.
  - Anesthetics ($0.6m)

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 $7.9m. Key amounts include:
  - Tropical Public Health Unit ($2.1m) – includes items such as Zika
  - Commonwealth funding underspends ($1.2m) – several programs were underspent in 2015/16
  - Nursing ratios ($2.5m) – FTE increase relating to nursing BPF ratios
  - Oral Health ($0.6m)

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, reducing the cost base of CHHHS in 2016/17.
- Actual Digital Hospital costs incurred in 2015/16 totalled $31.8m which was fully funded by the Department of Health.

4 Digital Hospital (b)

- Recurrent costs in relation to digital hospital in 2016/17 separately identified by CHHHS totalled $6.8m and comprised of:
  - 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 a risk to the budget is if the levies end up being higher than budget.
  - Labour costs in relation to the medical records and scanning team ($1.9m).
  - A business as usual ("BAU") case for 18.0 FTEs in relation to the long term sustainability of the initiative ($3.0m).
  - 6.5 FTE's in relation to FirstNet (a part of Digital Hospital) ($0.9m).

5 Enterprise Bargaining escalation

- An EB increase of $16.4m increased the budgeted costs for 2016/17. This amount relates to agreed funding from the Department of Health.

RTI Release

DOH-DL 16/17-009
RTI Document No. 23

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.

6 Escalation

- Escalation factors contributing to operating expenses (non-labour) increased the 2016/17 cost base by $5.8m 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. DoH funding totalled [OPEN].

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 MBS. [OPEN: to disclose total cost of Hepatitis C drugs in 2015/16 and 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 $0.8m from 2015/16 to 2016/17.

RTI Release

DOH-DL 16/17-009

RTI Document No. 24

4

Organisational sustainability plan

In this section	Page
Initiatives	26
Project delivery	28
Long term plan for operational sustainability	31

RTI Release

DOH-DL 16/17-009

RTI Document No. 25

Organisational Sustainability Plan - Initiatives (1/2)

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 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

Initiative No.	Name	Objective	Full Year Savings Target ($'000)	2016/17 Risk Adjusted Savings[1] ($'000)	2016/17 Newly Identified Savings ($'000)
1	Own source revenue	Improve the practice of converting public to private patients and income from international patients	$4,550	$3,640	
2	Clinical coding and documentation	Improve classification of service activity and clinical coding across the CHHHS to maximise income	$3,000	$3,000	
3	Reduction in locums	Reduce dependence on locums by planning a more sustainable recruitment strategy to provide improved continuity of care to CHHHS patients	$2,295	$1,836	
4	Telehealth	Reduce the amount of patient transport through an increase in the number of patients seen via telehealth	$2,000	$1,200	
5	Nurse specials	Confirm there are adequate guidelines for the best practice use of nurse specials and that they are being followed and enforced	$1,870	$1,870	
6	PUMP/MUMP/RUMP	Increase transparency of orders through the development of pharmacy, radiology and pathology dashboards and monitoring for clinicians	$1,664	$821	
7	Medical establishment and rostering	Review CHHHS rostering policy to confirm rostering is in accordance with the relevant awards to deliver safe and sustainable services	$1,200	$960	
8	Nurse rostering	Review the CHHHS rostering policy to confirm rostering is in accordance with the relevant awards to deliver safe and sustainable services	$1,100	$880	
9	Hep C drug management	Additional support provided to the Hep C clinic to allow patients to fill prescriptions on the spot enabling appropriate recouping of PBS revenue [OPEN: to confirm nature of savings]	$1,000	$400	
10	Novell licence fee review	Expedite removal of unused Novell licenses (and associated fees)	$744	$744	
11	Reduce staff travel	Improve controls on staff travel in accordance with DOH policy	$490	$294	
12	Stationery controls	Improve controls around stationery orders and stationery range	$270	$270	
13	Sustainable (HP) Allied Health	Investigate current allied health expenditure and identity an improved cost effective service delivery model	$250	$250	$1,750
14	Nurse agency optimisation	Reduce dependence on agency nurses by planning a more sustainable recruitment strategy to provide improved continuity of care to CHHHS patients	$250	$250	$1,250
15	Outpatient imaging optimisation	Reduce the outsourcing of medical imaging and improve self-sufficiency	$250	$200	
16	SOA contracts	Review current contractual agreements and identify procurement savings	$235	$200	
17	Energy efficiency	Improve recycling and reduced general waste	$212	$170	
18	Reduce staff relocation expenses	Improve controls that facilitate compliance with awards	$150	$120	

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.

RTI Release
DOH-DL 16/17-009
RTI Document No. 26

Organisational Sustainability Plan - Initiatives (2/2)

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

Organisational Sustainability Plan: Summary of Initiatives (cont'd)

Initiative No.	Name	Objective	Full Year Savings ($'000)	2016/17 Risk Adjusted Savings[1] ($'000)	2016/17 Newly Identified Savings ($'000)
19	Support services and Admin establishment and rostering	Review the CHHHS rostering policy to confirm rostering is in accordance with the relevant awards to deliver safe and sustainable services	$131	$131	
20	Reduce ICT printing	Remove colour printing profiles for some printers, bulk ordering of paper and campaign to raise awareness on the use of electronic equipment for viewing material in lieu of printing	$120	$96	
21	Streamlined courier services	Consolidate courier services across CHHHS	$120	$72	
22	Reduce staff catering	Reduce staff catering, except in special circumstances	$101	$61	
23	Corporate establishment	Implement a process to establish sustainable staffing and future workforce planning	$100	$100	
24	Room fees (doctors)	Establish standardised charges for third party room rental	$100	$60	
25	SMO contracts	Reduce SMO contracts	$25	$20	
26	Minimise expensive equipment servicing	Identify and prioritise on-site servicing required to maximise downtime and increase possible revenue	$24	$19	
27	Clinical and non clinical supplies	Review current contractual agreements and identify procurement savings from current suppliers including consolidation of suppliers	$16	$16	
28	PBS reconciliation	Implement formal process of obtaining and verifying a complete and accurate list of patient's current medicines against medications should be prescribed	$12	$12	
29	SLA contracts	Review current contractual agreements and identify procurement savings	$10	$8	
30	Reduce cab charge usage	Tighten controls for cab charge use and improve reconciliation of vouchers	$4	$4	
31	Workforce - Overtime management	Identify split in overtime targets and introduce robust governance structures to implement the required interventions to reach targets			$1,700
32	Fleet cars	Reduce the number of vehicles in the current fleet to generate a net decrease in overall fleet operating costs			$300
33	Workforce - Short term contract analysis	Detailed review of all short term contracts to identify those without a funding source or contract end date across all divisions	TBD	TBD	
34	Service activity	Detailed review of bed management and service delivery to confirm services are delivered efficiency	TBD	TBD	
	Total original OSP initiatives savings ($'000)		**$22,293**	**$17,704**	
	Newly identified savings ($'000)				**$5,000**
	Adjusted total savings target identified FY17				**$22,704**

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.*

RTI Release

DOH-DL 16/17-009

RTI Document No. 27

Organisational Sustainability Plan - Project Delivery

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

The purpose of the OSP was to deliver a range of initiatives that supported CHHHS in achieving a balanced financial operating position for FY17. 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 estimated the expected savings to be realised and phased these across the financial year as follows.

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
Expected savings to be realised ($'000)	691	741	786	2,087	2,087	2,087	2,087	2,112	2,112	2,112	2,697	2,697
Cumulative total of expected savings to be realised ($'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 ($'000)	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]
Cumulative total of risk adjusted savings ($'000)	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]	[OPEN]

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

RTI Release

DOH-DL 16/17-009
RTI Document No. 28

Organisational Sustainability Plan - Project Delivery Risks

The OSP has maintained a focus on balancing the initiatives' imperative with its associated risks. The risk 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 an ability 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.

RTI Release

DOH-DL 16/17-009

RTI Document No. 29

Organisational Sustainability Plan - Project Delivery Next Steps

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

CHHHS should further assess each initiative relating to their 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.

RTI Release

DOH-DL 16/17-009

RTI Document No. 30

Organisational Sustainability Plan – A long term plan for Operational Stability

[OPEN: this section to include further focus on additional cost saving initiatives]

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 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.

RTI Release
DOH-DL 16/17-009
RTI Document No. 31

5

Additional deficit reduction initiatives

In this section	Page
Additional deficit reduction initiatives	33

RTI Release

DOH-DL 16/17-009

RTI Document No. 32

Additional deficit reduction initiatives

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

- 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 (Additional Savings Schemes) of initiatives that could impact on the 2016/17 financial position are summarised below. Any financial benefit from these initiatives are 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	$5.3m	$5.3m
Elective surgery scheduled to avoid peak Christmas and Easter periods	Service scheduling	0 – 3 months	$1.0m - $2.0m	$1.0m - $2.0m
Cap increase to Junior Medical Staff to [x] more than in 2015/16	FTE containment	3 - 6 months	$1.5m - $1.8m	$0.6m - $0.8m
Procurement savings	Improved purchasing	0 – 3 months	$8.7m - $11.8m	$2.5m
TOTAL			**$20.5m - $25.9m**	**$13.4m - $15.6m**

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:

- Where the initiative relates to an entire cost centre or account code line item, the estimated cost has been taken from the 2016/17 budget.
- Where the initiative relates to direct labour costs (i.e. clinical labour), the estimated cost has been based on indicative salary ranges, provided by management and where possible checked to Queensland Health published rates. Where the initiative reflects a level of support overheads (including cleaning, catering, security) these costs have been included if management has considered them to be material. In most cases this is not the case.
- 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.
- 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.

RTI Release

DOH-DL 16/17-009

RTI Document No. 33

6

Budget build process and recommendations

In this section	Page
CHHHS budget build process	35
Budget phasing	37
Recommended improvements to budget controls and systems	38

RTI Release

DOH-DL 16/17-009

RTI Document No. 34

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

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Stage 1 - Cost budget preparation									
Budget principles agreed									
Tool prepopulated									
Budget tool developed									
Stage 2 – Organisational Sustainability Plan									
Initiatives identified									
Delivery commenced									
Stage 3 - Cost budget analysis									
Analyse year on year variance									
Provisional budget sign off									
Stage 4 - Revenue budget formulation									
Revenue assumptions reached									
Stage 5 - Budget finalisation									
Amendments identified									
Stage 6 - Additional deficit reduction initiatives									
Initiatives identified									
Initiatives qualified									
Initiatives prioritised									

RTI Release

DOH-DL 16/17-009

RTI Document No. 35

CHHHS Budget Build Process

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

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 – Jul 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.
- Budget review meetings were led by a combination of the Chief Executive, CFO and COO, with some other Executive team members contributing.

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 05). Financial benefits budgeted from these initiatives were not factored into the $80.5m budget deficit.

Stage 3 – Cost Budget Analysis: Jul – Aug 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 $912.6m.

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 the same level of services would be delivered in 2016/17 as were delivered in 2015/16.

Stage 5 – Budget finalisation: Aug – Sep 2016

- The initial budget deficit calculated using the cost budget from Stage 1 and the revenue budget from Stage 4 was $97.2m, considerably more than would be covered by the Sustainability initiatives.
- Management conducted a detailed review of costs and revenues and identified amendments to reduce the deficit to $80.5m.

Stage 6 – 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 (Additional Savings Schemes) of initiatives is included in Section 06 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.

[OPEN: to review whether reference to earlier budget deficit of $97.2m should be removed]

RTI Release
DOH-DL 16/17-009
RTI Document No. 36

2016/17 Budget Phasing

Budget phasing

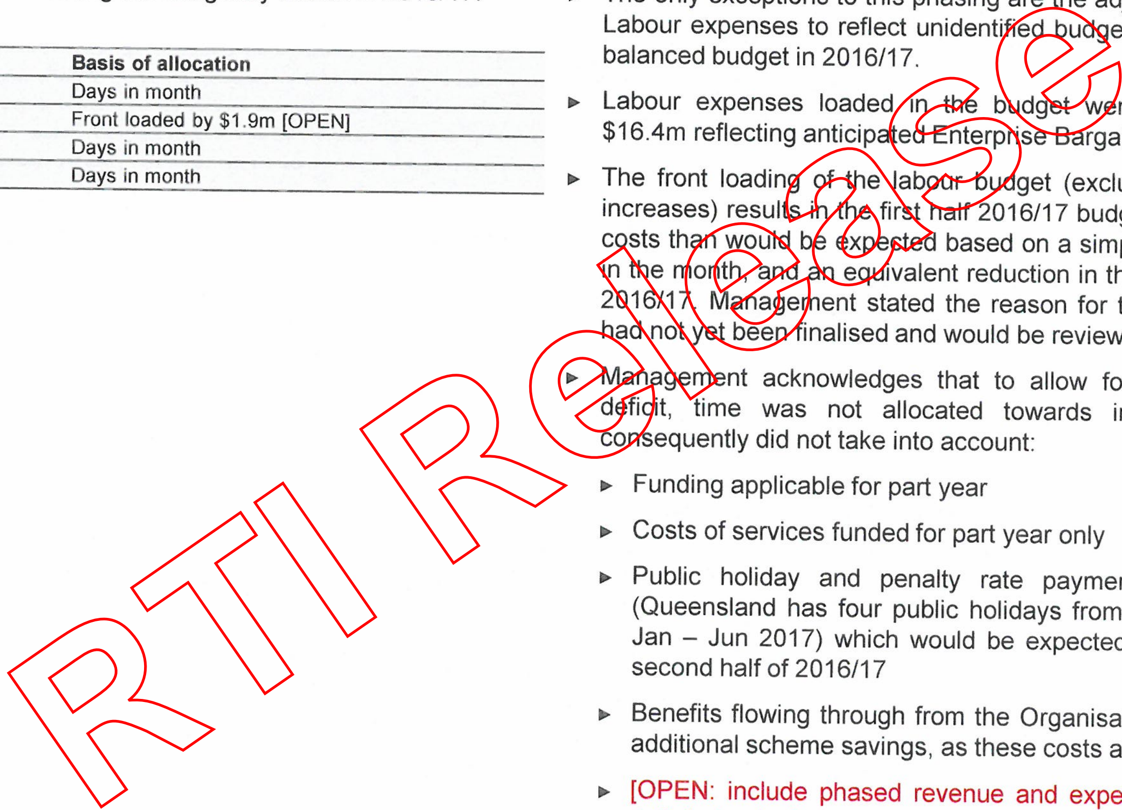
- The following basis was used for allocating the budget by month in 2016/17:

Budget phasing methodology

	Basis of allocation
Revenue	Days in month
Labour expenses	Front loaded by $1.9m [OPEN]
Operating expenses	Days in month
Depreciation and amortisation	Days in month

Budget phasing

- The only exceptions to this phasing are the adjusting entries to Labour and Non Labour expenses to reflect unidentified budget savings in order to deliver on a balanced budget in 2016/17.
- Labour expenses loaded in the budget were understated by an estimated $16.4m reflecting anticipated Enterprise Bargaining cost increases.
- The front loading of the labour budget (excluding Enterprise Bargaining cost increases) results in the first half 2016/17 budget including $1.9m higher labour costs than would be expected based on a simple apportionment based on days in the month, and an equivalent reduction in the labour costs in the second half 2016/17. Management stated the reason for this was that the budget phasing had not yet been finalised and would be reviewed.
- Management acknowledges that to allow focus to remain on reducing the deficit, 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
  - [OPEN: include phased revenue and expenditure chart to provide view of deficit phasing]



DOH-DL 16/17-009
RTI Document No. 37

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.
- 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 [OPEN: and have discussed with management] our suggestions for improvements to the budget setting process.

Systems

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

- 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: [OPEN: to confirm] 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.
- 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 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.

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DOH-DL 16/17-009
RTI Document No. 38

Recommended improvements to budget controls and systems

Dashboard
1 Executive summary
2 Budgeted revenue
3 Budgeted costs
4 Organisational sustainability plan
5 Additional deficit reduction initiatives
6 Budget build process and recommendations

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.
- 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.
- 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 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.

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DOH-DL 16/17-009

RTI Document No. 39

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 Financial 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.

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DOH-DL 16/17-009
RTI Document No. 40

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
Additional Savings Schemes	A subset of the additional options identified by management to deliver cost savings (refer page 5)
BAU	Business as usual
BPF	Business Planning Framework (nursing)
CET	Clinical Education and Training
CHHHS	Cairns and Hinterland Hospital and Health Services
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
FTE	Full time equivalent
Hep C	Hepatitis C
HP	Health practitioner
ICT	Information and Communications Technology
m	Millions
MBS	Medicare Benefits Scheme
MUMP	Medication Utilisation Medical Project
NWAU	National Weighted Average Activity Units
OSP	Organisational Sustainability Plan
OSR	Own source revenue
PosOcc	Positions Occupied Report
PUMP	Pathology Utilisation Medical Project
QWAU	Queensland Weighted Average Activity Units
RUMP	Radiology Utilisation Medical Project
Service Agreement	Cairns and Hinterland Hospital and Health Services Service Agreement 2016/17 – 2018/19
SMO	Senior Medical Officer
SOA	Standing Offer Arrangement
SRG	Service Related Group
WAU	Weighted Activity Units

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DOH-DL 16/17-009

RTI Document No. 41

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