EXHIBIT 718

QCOS/01978/20 MAR 2013

Department RecFind No:	BR056379
Division/District:	SSS Division
File Ref No:	FPL04532

Briefing Note for Noting

Director-General

Requested by: Deputy Director-General, System Support Services **Date requested: 7 February 2013** **Action required by: 21 March 2013**

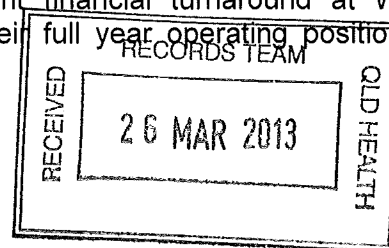
SUBJECT: Paxton Partners intervention at West Moreton Hospital and Health Services is finalised

Proposal

That the Director-General:

Note that Paxton Partners financial report for West Moreton Hospital and Health Service (HHS) has been completed. This concludes Paxton's engagement at West Moreton HHS.

Note that Paxton's engagement coincided with significant financial turnaround at West Moreton HHS. The HHS has the capacity to balance their full year operating position in 2012-2013.



Urgency

1. Routine

Headline Issues

2. The top issues are:
   - West Moreton demonstrated unsatisfactory financial performance throughout 2011-2012, which resulted in a financial review by an independent party – Paxton Partners.
   - Paxton Partners assessed West Moreton's financial turnaround plan, and believe that the HHS has the capacity to balance their full year 2012-2013 operating position subject to three major risks:
     1. That MOHRI FTE reductions are achieved within the assumed timeframe.
     2. That expenditure remains controlled through the remaining months of the year.
     3. That activity is monitored to prevent additional expenditure particularly in relation to activity in excess of waited activity unit (WAU) targets.
   - At the time of writing, the cost of Paxton Partners work at West Moreton was $188,969 (excluding GST).

Key issues

3. West Moreton finished 2011-2012 with a $17.3 million deficit. This was driven by a 4% increase in FTEs (or 102 FTE) and a 59% increase in external labour expenditure (or $4.3 million).

4. In 2012-2013, the financial turnaround has been a result of FTE numbers decreasing by 168 FTEs (excluding the impact of an additional 50 FTEs transferred to the HHS for Offender Health Services). External labour has also decreased by $2.7 million when compared with the same period last year. This has resulted in an affordable level of expenditure. Activity is currently trending higher than funded levels however savings made in FTEs and external labour are offsetting the financial impact of this.

5. The intervention of Paxton Partners at West Moreton HHS was effective for these reasons:
   - The presence of an independent party was accepted by West Moreton's senior management team as an opportunity to renew their focus on their financial performance. In addition, the commencement of a new Executive team at West Moreton has resulted in a significant cultural shift towards economy in health care delivery; and
   - Paxton Partners brought fresh technical context and expertise to West Moreton HHS.

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Background

6. In 2011-2012, the financial performance of West Moreton was highlighted in a number forums including Resource Executive Committee. In January 2012, Resource Executive Committee noted the following:
   - "West Moreton has a full year forecast deficit of $9.953 million, a deterioration from December. West Moreton's growth activity is far lower than its growth in expenditure, and this may be related to the split from the Darling Downs. The District faces extreme cost pressures in relation to labour expenditure, and further deterioration may result if effective FTE management practices are not employed."

7. Consistent with the intervention response outlined in the Queensland Health Performance Management Framework, the Director-General requested a financial review be performed by an independent party – Paxton Partners. This occurred late in the 2011-2012 financial year.

Attachments

8. Attachment 1: Paxton Partners Review of West Moreton Hospital and Health Service 2012-2013 - Financial Turnaround Plan December 2012.

   Attachment 2: Paxton Partners Review of West Moreton HHS Financial Management Capability November 2012

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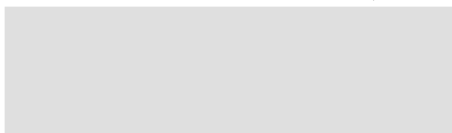
Recommendation
That the Director-General:

Note that Paxton Partners financial report for West Moreton Hospital and Health Service (HHS) has been completed. This concludes Paxton's engagement at West Moreton HHS.

Note that Paxton's engagement coincided with significant financial turnaround at West Moreton HHS. The HHS has the capacity to balance their full year operating position in 2012-2013.

APPROVED/NOT APPROVED **NOTED**



DR TONY O'CONNELL
Director-General

21/3/13

To Minister's Office For Noting ☐

Director-General's comments

Author:	Cleared by:	Cleared by:	Content verified by:
Leeanne Howcroft	Mark Davey	Tony Hendry	Susan Middleditch
Principal Finance Officer	Senior Director	Chief Finance Officer	Deputy Director-General
Finance Branch System Support Services Division	Budget and Analysis Finance Branch	Department of Health	System Support Services Division
13 March 2013	14 March 2013	14 March 2013	19 March 2013

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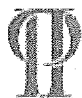

PAXTON PARTNERS

QUEENSLAND HEALTH

REVIEW OF WEST MORETON HHS

2012-13 FINANCIAL TURNAROUND PLAN

DECEMBER 2012

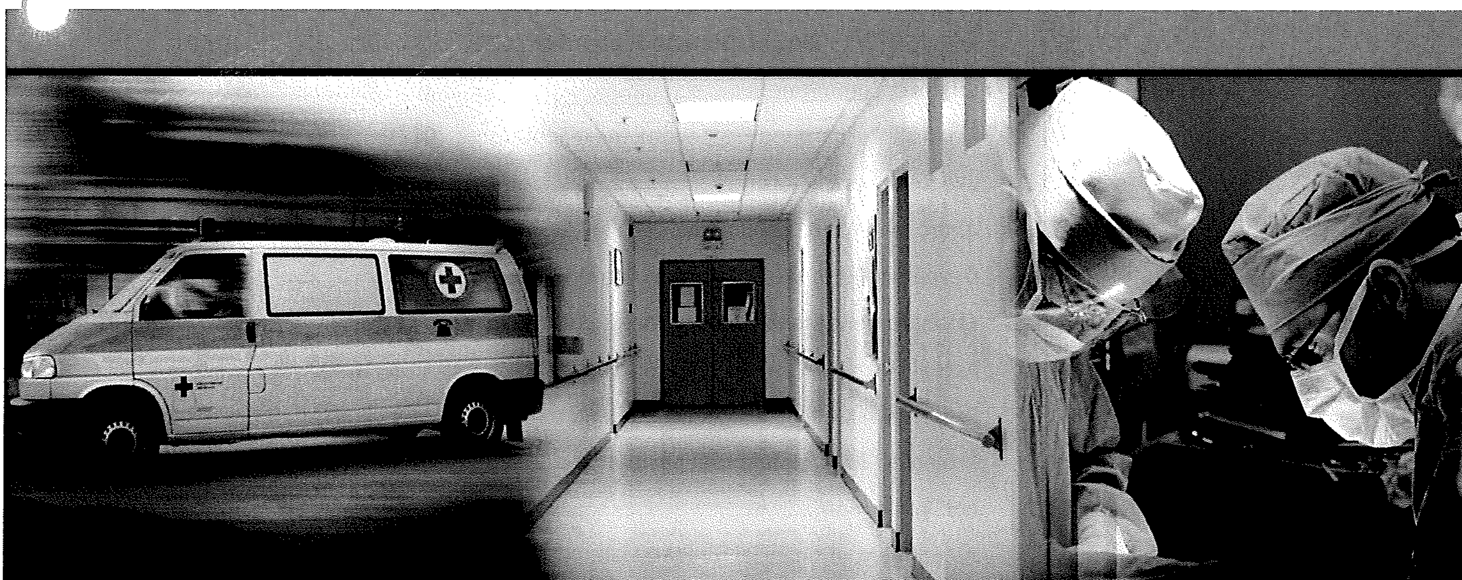

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EXHIBIT 718

Review of West Moreton HHS Financial Turnaround Plan
December 2012

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Disclaimer:

The information provided in this report is based on information supplied by West Moreton HHS and Queensland Health. Paxton Partners has relied on the information and data as sourced. The scope of work for this project did not include procedures considered necessary under generally accepted auditing standards for the purposes of expressing an opinion on the data provided. Accordingly, Paxton Partners does not express such an opinion. Furthermore, projections, assumptions and estimates that relate to the future may be affected by unforeseen events. As such, Paxton Partners expresses no opinion on the projections or how closely they will correspond with actual results.

EXHIBIT 718

Executive Summary

Background

In the 2011-12 financial year, West Moreton HHS ("WMHHS") reported continuing deterioration in financial performance with most financial indicators declining and the HHS being unable to articulate a strategy to achieve targeted budget outcomes. The reported operating deficit was $17.5m in 2011/12, representing over 5% of the HHS's total annual budget. The HHS also reported deteriorating performance against access targets (NEAT and NEST), together with increasing activity in excess of agreed WAU targets.

At the same time the HHS experienced substantial issues in compiling the 2012/13 budget with sudden unexplained changes to the budget build being reported, causing the newly formed HHS Board and Queensland Health to question the HHS's financial management capability.

Queensland Health placed the HHS on the highest intervention level of its performance management framework, requiring the HHS to meet with the Director General monthly to explain financial and operational performance.

Paxton Partners was engaged by Queensland Health to undertake a review of the financial position of WMHHS (WMHHS) with the objective of assisting the HHS to achieve a balanced operating position by 30 June 2013.

Paxton Partners also performed a review of the HHS's financial management capability, the findings of which are documented in a separate report dated November 2012.

Purpose of this report

The purpose of this report is to document the results of the work performed being

- the results of West Moreton HHS's financial management plan, including the current forecast financial result and key risks to the 2012/13 financial result; and
- outstanding issues.

Our findings and recommendations in relation to WMHHS's financial management capability are documented in a separate report dated November 2012.

Financial governance, budget and establishment management practices

Under the direction of the Board, the appointment of a new Chief Executive in August 2012 paved the way for a review of WMHSS's organisation structure and individual executive roles and for the implementation of a new financial governance framework. These initiatives were assisted by the appointment of an acting (now appointed) Chief Financial Officer in mid September and the creation of the ED Performance, Strategy and Planning position with a key role being to lead and oversight development of the financial turnaround and other performance plans.

Financial management practices were reviewed and tightened with stricter controls being established to approve ordering and purchasing of goods, backfill of staff and any increase in resources above approved rosters (including overtime). The tightened control, particularly in relation to control of backfill, appears to have favourably impacted MOHRI FTE with FTE reductions being reported in excess of agreed turnaround strategies in the month of October.

Financial turnaround plan

The HHS has developed a turnaround plan which includes 60 strategies across 9 workstreams, with estimated 2012-13 part year impact of $11.53m[1] and MOHRI FTE reductions of 190.0.

Workstream	No. turnaround strategies	2012-13 Financial Impact	MOHRI FTE Reduction
Allied & Community	12	1,125,822	23.5
Chief Exec	3	203,679	4.8
Finance & Corporate	6	1,214,552	26.4
Infrastructure & Ipswich Expansion	7	615,360	14.3
Medical & Ipswich Hospital	7	1,659,248	26.2
Mental Health & Specialised Services	16	5,185,751	64.2
Nursing, Midwifery & Rurals	4	1,046,517	20.6
Perf, Strategy & Planning	2	305,159	5.5
Workforce	3	180,000	4.5
Grand Total	**60**	**11,536,089**	**190.0**

All savings in the turnaround plan are a result of MOHRI FTE reductions, i.e, there are no non-labour savings included in the turnaround plan.

The turnaround plan is accompanied by a robust reporting and monitoring process managed by the performance, strategy and planning unit with financial and FTE reductions being monitored against target (with MOHRI FTE reductions being monitored by payroll fortnight) and the risks relating to individual turnaround strategies being continuously reassessed. As a result of this risk assessment, the HHS has discounted the expected 2012-13 impact by $1.5m relating to expected difficulties with implementing reform strategies at the Park mental health facility.

Monthly "3 on 3" meetings have been established within all divisions and also at an Executive level, with the monthly Executive meetings involving the Chief Executive, Chief Financial Officer and ED Performance, Strategy & Planning, together with the divisional Executive Director, key reports and divisional business managers.

MOHRI FTE reductions

WMHHS 2012-13 year-end MOHRI FTE target is 2,570 which is a reduction of 113 FTE against actual FTE of 2,684 at 11 July 2012. The target, however includes the transfer of 59 FTE from offender health, hence the actual FTE reduction required to reach the target is 174.

Actual MOHRI FTE at 24 November 2012 was 2,627, which is a net reduction of 57 FTE. The actual FTE reduction achieved is 108 FTE, which is offset by 51 FTE transferred from offender health. 37 of the 108 FTE reduction was achieved through the turnaround plan with the other 71 FTE reduction being achieved through the improved establishment management process, with tightened control over backfill of positions yielding immediate MOHRI FTE reductions.

Financial forecast (at 5 December 2012)

Forecast

The reported YTD financial position of WMHHS as at 31 October 2012 was a deficit of $5.54m, however the result contained a number of one-off items for timing differences between receipt of funding and expenditure.

[1] WMHHS turnaround plan Version 5. October 31 2012.

The underlying financial result, after excluding these items, was an operating deficit of approximately $1.8m. The HHS's full year extrapolation of this result was a full year 2012-13 deficit of $5.7m, which would be offset by the benefits of turnaround strategies to result in a break-even financial position.

Subsequent to this analysis, the HHS was notified of a further funding reduction of $4.3m, to pass on the impact of Commonwealth funding adjustments. Further savings strategies are being sought to address this budget gap.

HHS ability to achieve the forecast

The HHSs breakeven forecast is dependent on the assumption that $4.3m of the turnaround plan benefits were already realised by the end of October 2012. We note that 35.5 of the planned 196 FTE reductions were achieved by this date (i.e. 18% of total FTE), whereas the estimated financial impact of $4.3m represents 37% of the total 2012-13 financial benefit. This could indicate that the HHS's forecast of the year end result is conservative.

The forecast is also potentially conservative due to:

- Approx 70 MOHRI FTE reductions achieved, in addition to the turnaround plan, through the tightened EMP process and not being included in the forecast;
- The favourable impact of potential non-labour savings not being included;
- The turnaround strategy being risk adjusted by $1.5m to allow for the possible non-achievement of FTE reductions at the Park.

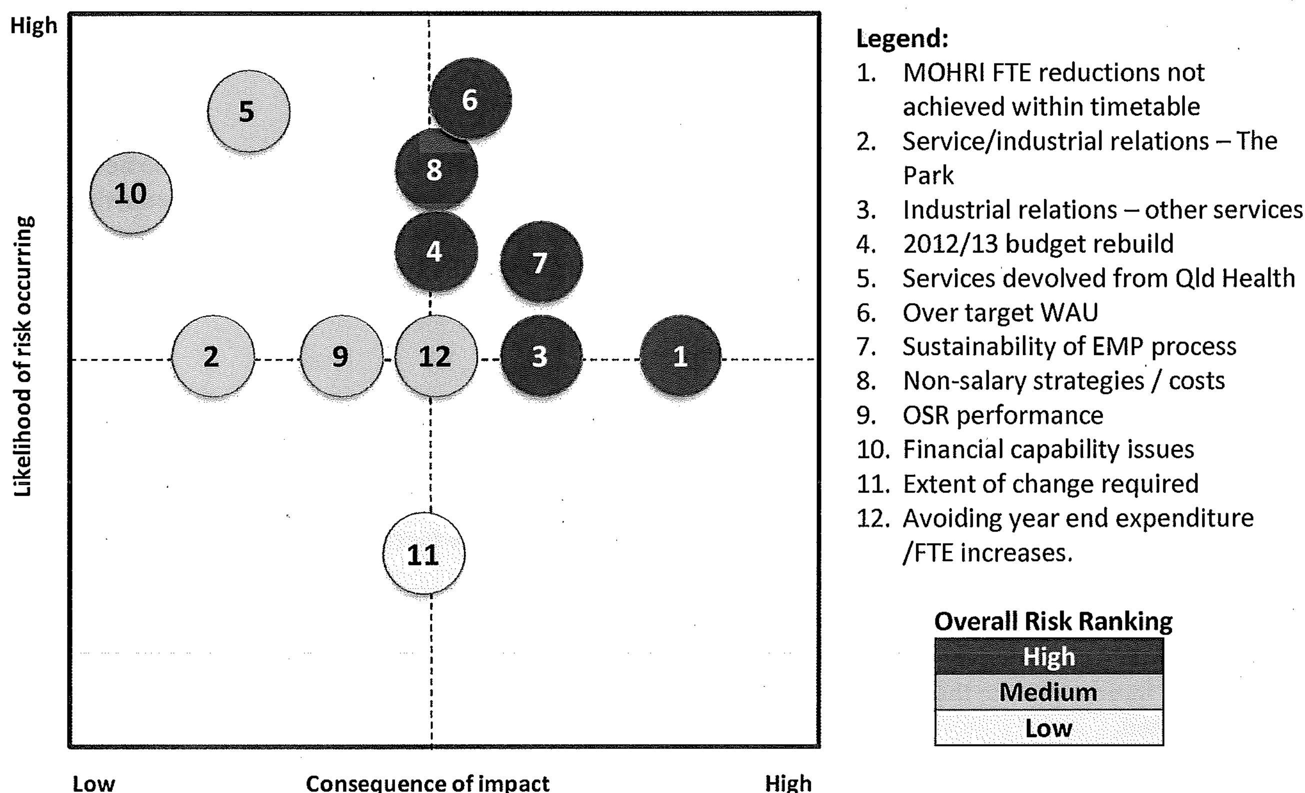
The positive impact of these factors would be used to address the $4.3m Commonwealth funding adjustment. At the time of preparing this report, the HHS was in the process of reconciling the turnaround plan to the financial forecast, hence the extent to which the above factors addressed the remaining gap could not be determined.

Risks

The above factors could be offset by risks to the financial position with the key risks relating to:

- MOHRI FTE reductions not being achieved within timetable (thus reducing the 2012-13 financial impact);
- The 70 MOHRI FTE reductions achieved through the EMP process not being sustainable throughout the financial year
- Over target WAU increasing non-salary and wage expenditure above budget; and
- Non-salary and wage cost reduction strategies not being implemented within a timetable to achieve current year cost reductions.

Our assessment of the specific risks associated with the likelihood of WMHHS achieving a break even budget result for 2012-13, based on the HHS's financial forecast prepared as at 5 December 2012, is shown in the following risk map:



January 2013 Update

Subsequent to the drafting of this report, the HHS's financial position has further improved due to:

- Queensland Health confirming reimbursement of voluntary redundancy costs ($1.35m); and
- Financial results for each of the months of November and December being reported as surpluses, with a key contributor to the favourable variance being a further increase in the MOHRI FTE reduction achieved through improved budgetary controls (total MOHRI FTE reduction achieved through the EMP process was 95 MOHRI FTE as at 6 January 2013).

The HHS has also continued to refine its turnaround plan, with the 2012-13 financial impact of turnaround strategies now quantified at $12.04m (an increase from $11.5m), with actual salary savings relating to the planned FTE reduction being higher than originally assumed. The risk rating of the financial turnaround plan has also been reviewed, with the $1.5m risk discount relating to expected difficulties with the implementation of turnaround strategies at the Park now being reduced to $0.59m.

The above improvements to the reported financial result do not change our risk assessment with the key risks remaining as:

- MOHRI FTE reductions assumed in the turnaround plan not being achieved within the assumed timetable;
- expenditure not being controlled through the remaining months of the year;
- cost increases associated with WAU performance in excess of target; and
- key financial reports not being prepared using consistent assumptions (budgets, actual results, the turnaround plan, other financial improvement strategies and financial forecasts).

EXHIBIT 718

1. Background

In the 2011-12 financial year, West Moreton HHS ("WMHHS") reported continuing deterioration in financial performance with most financial indicators declining and the HHS being unable to articulate a strategy to achieve targeted budget outcomes. The reported operating deficit was $17.5m in 2011/12, representing over 5% of the HHS's total annual budget. The HHS also reported deteriorating performance against access targets (NEAT and NEST), together with increasing activity in excess of agreed WAU targets.

At the same time the HHS experienced substantial issues in compiling the 2012/13 budget with sudden unexplained changes to the budget build being reported, causing the newly formed HHS Board and Queensland Health to question the HHS's financial management capability.

Queensland Health placed the HHS on the highest intervention level of its performance management framework, requiring the HHS to meet with the Director General monthly to explain financial and operational performance.

Paxton Partners was engaged by Queensland Health to undertake a review of the financial position of WMHHS (WMHHS) with the objective of assisting the HHS to achieve a balanced operating position by 30 June 2013.

Paxton Partners also performed a review of the HHS's financial management capability, the findings of which are documented in a separate report dated November 2012.

2. Terms of Reference

The objectives of this review were determined by Queensland Health as follows:

1. Financial Governance
    a. Review the financial management capability (including consideration of the financial governance/accountability framework, budget development process, management reporting, responsiveness to budget to actual variations and financial systems, resources and processes). Whilst this financial management capability review should not be limited to finance staff, it should include recommendations for an appropriate finance team structure.
    b. Perform a high level review of the reasons for the 2011/12 financial deficit.
    c. Review the 2012/13 budget and comment on achievability of current savings/revenue strategies, including an assessment of the % cost reduction required in 2012/13 (when compared to their current running rate).
    d. Work with the HHS to develop/refine a coherent set of financial management strategies for 2012/13 which targets a balanced position and which is underpinned by an appropriate accountability/responsibility matrix. Report back to Queensland Health on this review.
    e. Work with HHS management to develop the 2012-13 budget management framework in the context of:
        i. Implementing the agreed financial management strategies (refer 1d. above);
        ii. Balancing the 2012-13 budget;
        iii. Addressing the findings from the financial capability review (refer 1a. above);
        iv. being consistent with HHS purchasing agreement with Queensland Health (refer 2. below);
    f. Work with the HHS Management to develop a resourcing (FTE) plan consistent with the

2012-13 budget.

2. Demand Management
    - Work with HHS management to review their current demand management strategies which achieve the Departmental objectives around demand management and are consistent with the purchasing agreement and budget strategy.
3. Mental Health Considerations
    - Where appropriate, liaise with Queensland Health - Mental Health Branch in relation to the review they are currently conducting that includes services provided by the West Morton (e.g. The Park Mental Health facility).

3. Purpose of this report

3.1. Purpose

The purpose of this report is to provide a report on the results of the work performed including:

- the results of West Moreton HHS's financial management plan, including the current forecast financial result and key risks to the 2012/13 financial result; and
- outstanding issues.

Our findings and recommendations in relation to WMHHS's financial management capability are documented in a separate report dated November 2012.

3.2. Scope limitations

WMHHS is in process of implementing its financial turnaround plan. The information contained in this report is current as at early December 2012, ie. YTD October financial results and MOHRI FTE as at end November 2012. The HHS's financial circumstances may have changed since this date due to the impact of these strategies or due to external events.

The information contained in this report is based on discussions with Qld Health and the HHS and a review of the information provided by them. Paxton Partners has relied on the information as sourced and has not verified the underlying data. The scope of this review did not include procedures considered necessary under generally accepted auditing standards for the purposes of expressing an opinion on the information provided. Accordingly, Paxton Partners does not express such an opinion.

4. Paxton Partners assistance

Paxton Partners has worked with WMHHS from late June 2012 to November 2012. During this time, our work has comprised:

- High level quality assurance and analysis of initial budget build and forecasts;
- Various analyses of financial, activity and FTE data;
- Interrogation of divisional budgets and turnaround strategies;
- Assessment of financial management capability;
- Attendance at various executive and finance meetings and workshops;
- Facilitation of workshops with Executive and key clinical and operational managers to identify and develop financial turnaround strategies; and

- Ongoing advice to various Executives in relation to budget build, turnaround strategies, financial reporting, accounting issues and financial governance matters.

5. 2011/12 Financial Position

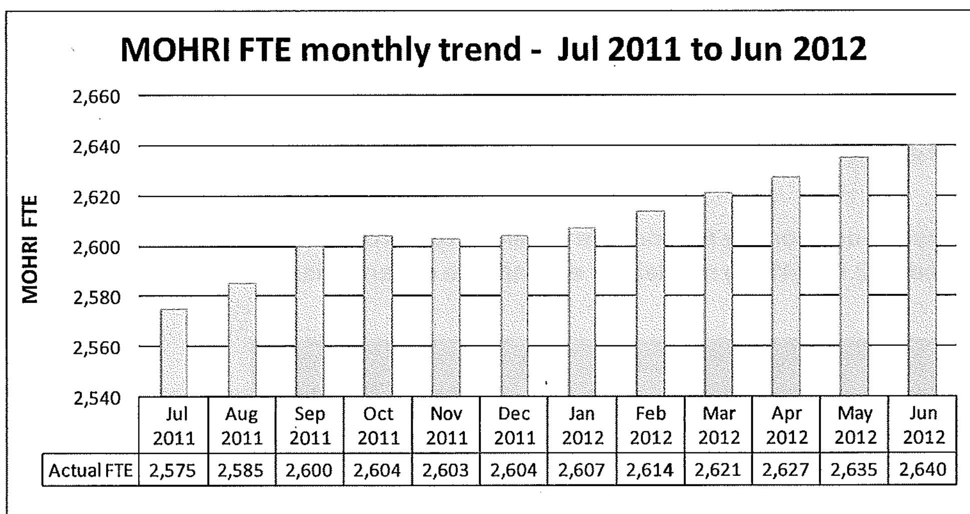
5.1. Overall financial position

WMHHS reported an operating deficit of $17.5m in 2011/12 representing over 5% of the HHS's total annual budget.

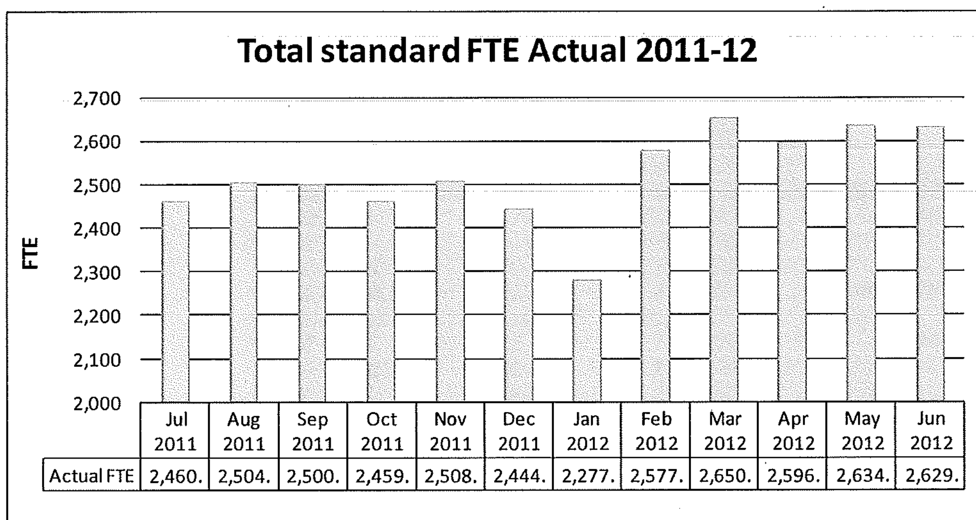
The variance was largely related to unfavorable expenditure variances comprising a $14.5m (5%) unfavorable labour related expenditure and a $2.6m (4%) in non-labour expenditure driven by increases in FTE and over activity WAU.

West Moreton expenses by account category		2011-12 actual expenditure	2011-12 expenditure budget	2011-12 Budget variance	2011-12 Actual variance % of budget
		$ 000's	$ 000's	$ 000's	%
Labour	Health Practitioners	36,427	39,844	(3,417)	-9%
	General	134	28	106	380%
	Managerial & Clerical	29,992	29,133	859	3%
	Medical	58,960	50,157	8,803	18%
	Nursing	120,128	113,869	6,258	5%
	Operations	26,941	26,209	732	3%
	Professional	2,938	3,115	(176)	-6%
	Technical	104	97	7	7%
	Trade And Artisans	2,581	1,935	646	33%
	Visiting Medical Officers	8,661	7,869	792	10%
	Other Employee Related Expenses	2,587	2,857	(271)	-9%
	Related Taxes	1,113	1,474	(361)	-24%
	Workcover Premiums	3,875	3,317	557	17%
Total Labour related expenditure		294,439	279,905	14,534	5%
Non-labour	Employment Agency Fees	705	106	598	562%
	Blood And Clotting	434	393	41	10%
	Building Services	503	789	(286)	-36%
	Catering And Domestic Expenses	5,957	7,955	(1,998)	-25%
	Clinical Supplies	12,846	11,819	1,028	9%
	Communications Expense	1,342	1,036	306	30%
	Computers Expense	3,731	3,898	(167)	-4%
	Drugs	8,807	8,568	239	3%
	Electricity And Other Energy Expense	1,855	1,883	(28)	-2%
	Other Motor Vehicle Expenses	670	615	54	9%
	Non Capitalised Asset Related Expenses	124	238	(114)	-48%
	Operating Leases	2,918	2,888	29	1%
	Other Supplies And Services	1,628	1,460	168	12%
	Pathology Charges	8,894	7,473	1,421	19%
	Prosthetics	3,818	3,515	303	9%
	Repairs And Maintenance	4,715	4,701	14	0%
	Shared Service Provider Charges	274	149	126	84%
	Travel Expenses	1,495	670	825	123%
	Water Supply Expenses	455	437	17	4%
	Supplies & Services Expense	61,168	58,592	2,576	4%
	Grants & Subsidies Expense	3,637	3,426	211	6%
	Other Expenses	2,320	2,466	(146)	-6%
Total non - Labour related expenditure		67,125	64,484	2,641	4%
	Depreciation & Amortisation Expense	9,812	9,586	226	2%
Total Expenditure		371,376	353,975	17,401	5%

The negative budget variation in labour expenditure was driven by a sustained increase in average MOHRI FTE during the year from 2,575 in July 2011 to 2,640 in June 2012, an increase of 2.5%.



The FTE increase, measured as standard FTE was more marked, with standard FTE increasing from 2,460 to 2,629, an increase of 6.8%.



No funding source was identifiable for the increase in FTE. The negative trend in FTE between January and June 2012 was particularly concerning as it indicated that the HHS would commence the 2012-13 financial year in a worse financial position with the full year impact of the increased FTE being reported.

The increase in FTE was a result of both increases in personnel and material increases in overtime, particularly in overtime worked at the Park.

5.2. Cost per WAU

The HHS overall cost per actual WAU appeared to be low compared to its peer group with actual cost per WAU at Ipswich Hospital of $4,466 being below the budgeted cost of $4,505 WAU. This comparison does not reflect the significant activity performed by the HHS in excess of target of 7.8%, hence the low unit cost was mostly due to the hospital performing unfunded activity.

EXHIBIT 718

6. Initial 2012/13 Budget (June to September 2012)

6.1. Contract Commitment

WMHHS's initial contract commitment (as at 29 June 2012) was $373.3m, which compared to an actual contract commitment of $353.9m in 2011/12.

WMHHS Service Agreement	2011-12 (Actual)	2012-13	Difference
Total funding ($'000) - 29 June 2012	**353,975**	**373,291**	19,316
Depreciation ($'000)	8,252	8,532	280
Funding before depreciation ($'000)	**346,766**	**364,758**	17,992
MOHRI Average FTE Target	*n/a*	2,561	*n/a*
WAU Activity Target	50,490	53,868	3,378
Actual WAU Activity	53,743	53,868	125

The HHS developed an initial budget build totalling to $386.5m, a gap of $13.2m to the initial contract commitment. The gap was intended to be addressed through the impact of $6.6m of identified financial turnaround strategies, resulting in a remaining budget gap of $6.7m to be addressed within the 2012/13 financial year.

Budget gap at 30 Aug 2012	$million
Contract Offer (29 June 2012)	373.29
Budget Build (30 Aug 2012)	386.52
Variance	(13.22)
Initial turnaround strategies identified	6.57
Budget gap at 30 Aug 2012	**(6.66)**

The budget build of $386.5m was based on a bottom-up budget build by operating division based on principles agreed in the budget principles document. Material issues were identified with the budget build, due to the ambiguity of the budget build principles, lack of quality assurance of the budget build and confusion between Executives and Business Managers as to what was included / excluded from the budget build. There was little documentation of specific strategies assumed into the budget build (to reduce the underlying deficit of $17.5m from 2011/12 to the modelled budget deficit of $13.2m).

The detailed issues arising from the initial WMHHS budget build are documented in our separate report: (Review of WMHHS's Financial Management Capability report – November 2012).

7. Financial Turnaround Framework (post September 2012)

7.1. Executive restructure

Under the direction of the Board, the appointment of a new Chief Executive in August 2012 paved the way for a review of WMHSS's organisation structure and individual ED roles and for the implementation of a new financial governance framework. These initiatives were assisted by the appointment of an acting (now appointed) Chief Financial Officer in mid September.

Key changes included:

- Creation of a new interim Executive Structure with an organisational restructure to focus accountability and realign the organisation structure;

- Creation of the ED Performance, Strategy and Planning position with a key role being to lead and oversight development of the financial turnaround and other performance plans.

7.2. Improvements to governance of financial information

Lack of governance of reported financial information had previously been a key weakness for WMHHS with the HHS Board and Queensland Health losing confidence in the credibility of financial information presented. Key reports including month end financial reports, budget build and turnaround strategies had been continuously changed resulting in:

- Version control issues;
- Confusion between WMHHS Executive Directors and between individual Business Managers as to which and how assumptions were applied;
- Executive Directors directing changes to budget builds without approval; and
- Lack of process to ensure agreed actions were implemented (e.g. agreed FTE reductions not being factored into budget builds).

An immediate improvement in financial management and governance processes was the implementation of processes to secure tighter financial and budgetary reporting, including management of version control, authorisation of change processes and clarity as to who holds custody of master files (e.g. budget build and turnaround strategies).

7.3. Development of the financial turnaround plan

7.3.1. Role of the Performance, Strategy and Planning Unit

The newly appointed ED Performance, Strategy and Planning was made responsible for oversight of the financial turnaround plan, using previous financial savings strategies as a starting point which were then revised and expanded.

The objectives of the turnaround plan articulated by WMHHS were to:

- Design and implement an effective initiative management framework that will enable effective delivery of objectives within the required timeframes;
- Clearly outline the process and authorisation for scoping of strategies, diagnostics and solutions design to ensure a coordinated and focused program management approach;
- Articulate key performance indicators and measures to monitor progress and escalate early triggers and adjustment to strategy as/when required;
- Provide clear lines of reporting, accountability and responsibility for Programs of Work and Work Streams;
- Minimise disruption to service delivery and minimise distress to individuals and teams involved in the process through effective change management, consultation and communication;
- Effectively communicate operational objectives, performance requirements and targets for each Division, Business Unit and individual;
- Promote a culture of service and operational excellence and provide a common sense of purpose and direction for the HHS; and
- Develop robust internal governance, performance and business processes within a sustainable infrastructure of performance monitoring and reporting.

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The turnaround plan was expanded to includes 60 strategies across 9 workstreams, with estimated financial benefits of $11.53m[2] (2012-13 part year impact) and MOHRI FTE reductions of 190.0[3]

Workstream	No. turnaround strategies	2012-13 Financial Impact	MOHRI FTE Reduction
Allied & Community	12	1,125,822	23.5
Chief Exec	3	203,679	4.8
Finance & Corporate	6	1,214,552	26.4
Infrastructure & Ipswich Expansion	7	615,360	14.3
Medical & Ipswich Hospital	7	1,659,248	26.2
Mental Health & Specialised Services	16	5,185,751	64.2
Nursing, Midwifery & Rurals	4	1,046,517	20.6
Perf, Strategy & Planning	2	305,159	5.5
Workforce	3	180,000	4.5
Grand Total	**60**	**11,536,089**	**190.0**

Refer Appendix 1 for detail of turnaround strategies.

Development of the turnaround strategy was supported by a review of each division's FTE on a position by position basis. The HHS then commenced a redundancy process with the aim of removing these positions within a timetable that would meet the HHS's targeted MOHRI FTE reduction. (Note that the difference between the 190 FTE identified in the turnaround plan and the MOHRI reduction target of 174 represents temporary FTE decreases through deferring the opening of the FTRU unit at the Park (with these FTE reductions not counting towards the targeted permanent reduction of 174 FTE).

It should be noted that the focus of the turnaround plan is on strategies that specifically achieve MOHRI FTE reductions. The plan does not include any strategies that produce non MOHRI FTE savings. In this context, we note that the HHS is developing non-MOHRI reduction strategies including:

- Review of RN / EN staffing mix at Ipswich Hospital and the Park;
- Non-salary and wage cost reductions arising from the turnaround strategies (e.g. through cessation or deferral of services); and
- Reductions in drug and pathology utilisation.

7.3.2. Reporting and monitoring processes

The turnaround process is accompanied by a robust reporting and monitoring process managed by the performance, strategy and planning unit with financial and FTE reductions being monitored against target (with MOHRI FTE reductions being monitored by payroll fortnight) and the risks relating to individual turnaround strategies being continuously reassessed.

Monthly "3 on 3" meetings have been established within all divisions and also at an Executive level, with the monthly Executive meetings involving the Chief Executive, Chief Financial Officer and ED Performance, Strategy & Planning, together with the divisional Executive Director, key reports and divisional business managers.

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[2] WMHHS turnaround plan Version 5. October 31 2012.
[3] Actual MOHRI FTE reduction identified equals 195.9 with individual workstream FTE reductions to be updated to reflect this total in Version 6.

7.4. Establishment Management Process (EMP) and other budgetary controls

Financial management practices were reviewed and tightened in conjunction with the turnaround strategy, with the new procedures being implemented effective 23 October 2012 as follows:

- ED approvals required for purchase of minor equipment and new works (value in excess of $1,000);
- ED approvals for ordering and purchasing of goods and services > $1,000 (regardless of method of procurement);
- Chief Executive approval required for backfill of staff;
- Stringent controls to fill vacant positions or establish new positions in accordance with the statewide Establishment Management Process;
- Director of Nursing, Medical Services / Medical Superintendent, Facility Manager or Operational Services Manager approval required for any increase of resources above approved rosters; and
- Director of Nursing, Medical Services / Medical Superintendent, Facility Manager or After Hours Coordinator approval required for all new rostered overtime.

The tightened control, particularly in relation to control of backfill, appears to have favourably impacted MOHRI FTE with FTE reductions being reported in excess of agreed turnaround strategies in the months of October and November. WMHHS is in the process of estimating the impact of these improvements on the 2012/13 forecast financial result taking into account the sustainability of the reductions (refer section 8.2).

8. Actual Financial Position (YTD October 2012)

The reported YTD financial position of WMHHS as at 31 October 2012 was a deficit of $5.5m, however the result contains a number of timing differences that need to be excluded to determine the underlying financial result:

	$mill
Reported financial deficit	5.54
Adjusted for:	
- Timing differences: Offender Health	2.70
- Timing differences: QGIF	1.60
- Timing differences – program funding	1.51
- Revenue phasing adjustment	(2.50)
- Budget load misalignment	0.35
Adjusted underlying deficit position	$1.88

WMHHS estimates that this underlying deficit would equate to a year-end deficit of approx $5.7m without the remaining benefits of the turnaround plan being achieved. The forecast result is break-even after taking into account the turnaround strategies (refer section 10.2).

The deficit was largely incurred in July and August 2012, with monthly underlying results reported as break-even in September and October and a surplus being reported in November.

9. Projected MOHRI FTE

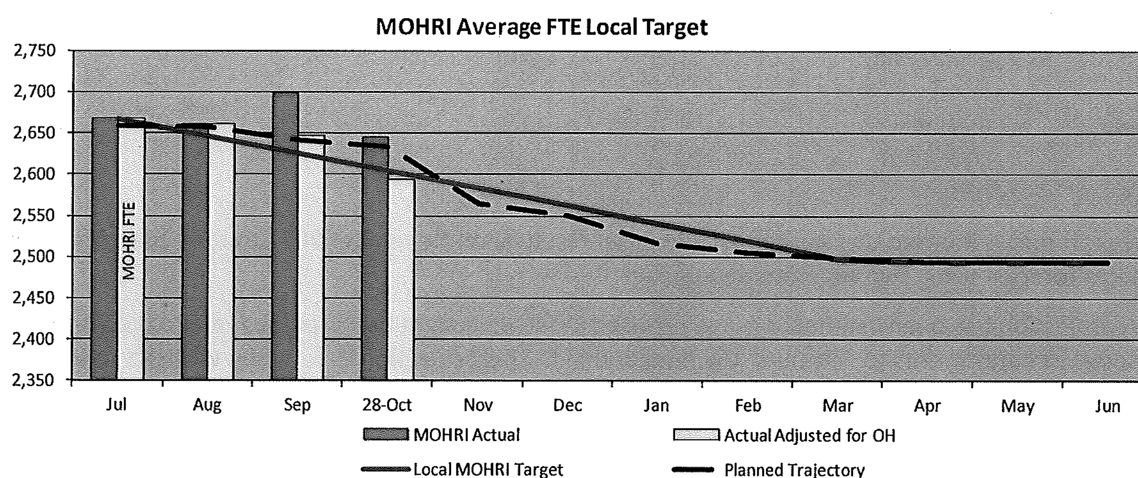
WMHHS has a target MOHRI FTE of 2,570, which is a reduction of 114 FTE based on actual FTE of 2,684 at 11 July 2012. The target, however includes the transfer of 59 FTE from offender health, hence the actual FTE reduction required to reach the target is 174.

Actual MOHRI FTE at 24 November 2012 was 2,627, which is a net reduction of 57 FTE. The actual FTE reduction achieved is 106 FTE, which is offset by 51[4] FTE transferred from offender health. 37 of the 106 FTE reduction was achieved through the turnaround plan and the balance of the FTE reduction (69 FTE) was achieved through the establishment management process, with tightened control over backfill of positions yielding immediate MOHRI FTE reductions.

A further 161 MOHRI FTE is identified to be realised from within the Turnaround Plan[5]. Key milestones for MOHRI FTE reductions are:

- 79 by 31 Dec 2012;
- 59 by 31 Mar 2013; and
- 23 by 30 Jun 2013.

The HHS believes that it will achieve the MOHRI FTE reduction target within the scheduled timetable as shown in the HHS's forecast below:



While there is a risk that there may be slippage in the timing of the reductions factored into the turnaround plan, the HHS notes that:

- Many of the identified positions are temporary contracts with the position able to be removed in an expedited manner; and
- The additional MOHRI FTE reductions through the tightened EMP process have, to date, offset the risk of slippage in the turnaround plan.

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[4] Actual FTE employed (51 FTE) is less than the targeted transfer of 59.

[5] Further turnaround plan FTE reduction 160.8 = Total planned reduction of 195.9 less 35.1 FTE removed to end of October 2012.

10. Projected 2012/13 financial position

10.1. HHS projection

WMHHS has performed a detailed forecast of the 2012-13 financial position as at 5 December 2012, which projects that the HHS would break-even, taking into account the 2012-13 part year benefits of the turnaround plan ($11.5m) and benefits of MOHRI FTE reductions achieved through the EMP process. Further strategies are required to address the recent $4.3m funding adjustment.

WMHHS Summary Financial Forecast	$ million
Projected Expenditure	399.6
Contract offer	393.9
Projected funding shortfall	(5.7)
Benefit of turnaround strategies (post Oct 2012)	5.7
Projected year end financial result	**(0.0)**
Anticipated funding adjustment	(4.3)
Funding gap to be addressed	**4.3**

The full-year forecast is based on October YTD financial results with November 2012 to June 2013 financial results being forecast using two separate approaches:

1. A projection has been estimated using a revised WMHHS budget build (as loaded into DSS) with a series of adjustments to "cleanse" the budget build. This projection is noted by WMHHS to include the savings impacts of the turnaround strategies only to the extent that they are loaded into the budget build. This method does not consider the benefits of:
   - turnaround strategies not loaded into the budget build;
   - other financial strategies including MOHRI reductions achieved through the EMP process or non-salary and wage cost reductions.
2. The HHS separately utilised Qld Health's HHS financial forecasting tool to forecast the year end result. WMHHS have informed us that this resulted in a forecast result within $400k of the result modelled in step 1. We note, however, that the two models are prepared on different basis as the first approach *includes* the impact of financial turnaround and other strategies (to the extent they are included into the budget build), whereas approach 2 is a straight line extrapolation (with some adjustments) as at the end of October, which *excludes* the impacts of strategies implemented beyond September 2012 of the turnaround plan, but assumes that EMP MOHRI reductions will continue.

While the two approaches used by the HHS forecast a similar projection, there are limitations in using either approach. A full reconciliation of the financial forecast is required to the turnaround plan and the budget build to ensure consistency of assumptions.

10.2. Assessment of financial forecast

The HHS has estimated that the forecast deficit of $5.7m will be offset by the positive impact of turnaround strategies yet to impact the financial result, reconciled as follows:

	$million
Full 2012/13 impact of turnaround plan	11.5
less: Estimated impact of strategies included in October YTD result	(4.3)
Risk rated mental health strategies	(1.5)
Estimated impact of turnaround plan available post October 2012	5.7

The HHS has risk rated the financial turnaround plan and notes that (as at 5 December 2012), the plan contains two high risk strategies at the Park (5.1 and 6.1 refer Appendix 1) relating to restructuring security at the Park and also reducing (non-security) FTE through a service review. The HHS expects that there may be substantial industrial relations issues relating to these strategies. Accordingly, in compiling a financial forecast, the HHS has risk adjusted the turnaround strategies to exclude the benefit of these strategies to the extent of $1.5m.

The HHSs breakeven forecast is dependent on the assumption that $4.3m of the turnaround plan benefits were already realised by the end of October 2012. We note that 35.1 of the planned 196 FTE reductions were achieved by this date (i.e. 18% of total FTE), whereas the estimated financial impact of $4.3m represents 37% of the total 2012-13 financial benefit. This could indicate that the HHS's forecast of the year end result is conservative.

The forecast is also potentially conservative due to:

- Approx 70 MOHRI FTE reductions achieved, in addition to the turnaround plan, through the tightened EMP process;
- The favourable impact of non-labour savings not being included;
- The turnaround strategy being risk adjusted by $1.5m to allow for the possible non-achievement of FTE reductions at the Park.

The positive impact of these factors would be used to address the $4.3m Commonwealth funding adjustment. At the time of preparing this report, the HHS was in the process of reconciling the turnaround plan to the financial forecast, hence the extent to which the above factors addressed the remaining gap could not be determined.

10.3. Other Comments

10.3.1. WAU performance

The HHS's financial performance has been affected in prior years by over performance against WAU targets. The HHS is estimating a small variance of approximately 1% to the WAU YTD November target with over-performance in inpatients (1%), outpatients (2.5%) and ED (2.5%)and Mental Health (2.5%) being offset by underperformance in sub and non-acute (2.5%). The financial impact of any material variance from WAU targets, or any material change in WAU performance between the July to October period, compared to the rest of the year, requires careful monitoring as the financial forecast assumes that monthly non-salary and wage expenditure in November 2012 to June 2013 is consistent with expenditure levels during the initial months.

10.4. January 2013 Update

Subsequent to the drafting of this report, the HHS's financial position has further improved due to:

- Queensland Health confirming reimbursement of voluntary redundancy costs ($1.35m); and

- Financial results for each of the months of November and December being reported as surpluses, with a key contributor to the favourable variance being a further increase in the MOHRI FTE reduction achieved through improved budgetary controls (total MOHRI FTE reduction achieved through the EMP process was 95 MOHRI FTE as at 6 January 2013).

The HHS has also continued to refine its turnaround plan, with the 2012-13 financial impact of turnaround strategies now quantified at $12.04m (an increase from $11.5m), with actual salary savings relating to the planned FTE reduction being higher than originally anticipated. The risk rating of the financial turnaround plan has also been reviewed, with the $1.5m risk discount relating to expected difficulties with the implementation of turnaround strategies at the Park now being reduced to $0.59m.

The above improvements to the reported financial result do not change our risk assessment with the key risks remaining as MOHRI FTE reductions assumed in the turnaround plan not being achieved with the assumed timetable, expenditure not being controlled through the remaining months of the year, cost increases associated with WAU performance in excess of target and key financial reports not being prepared on a consistent basis (budgets, actual results, the turnaround plan, other financial improvement strategies and financial forecasts).

11. Turnaround strategies to bridge funding adjustment

WMHHS has been notified of a funding adjustment of $4.3m as part of the statewide funding adjustment to reflect a reduction in Commonwealth funding. The gap must be addressed from within the 2012-13 operating budget. The funding adjustment is not accompanied by changes in service targets.

The HHS is currently working on strategies to address this tap with key areas of review including:

- Non-salary strategies grouped into four workstreams:
  - reducing pathology expenditure (utilisation strategies);
  - reducing drug expenditure (various strategies including procurement, authorisation of use and improved management);
  - reducing clinical supplies expenditure through managing the range of supplies purchased and utilisation (including inventory management) throughout the HHS; and
  - reducing linen utilisation to take advantage of new contract arrangements from 1 July 2012;
- Contestability reviews of non-core services (recognising that these strategies are unlikely to be in place in time to provide material financial benefit within the current financial year);
- Benefits of turnaround strategies that have not been incorporated into either the turnaround plan or the financial forecast including:
  - Review of RN / EN staffing mix at Ipswich Hospital and the Park;
  - Non-salary and wage cost reductions arising from the turnaround strategies (e.g. through cessation or deferral of services)
- Additional services reviews of facilities at the Park.

It should also be noted that if the HHS is able to successfully manage the risks relating to the high-risk mental health strategies (estimated 2012-13 financial impact $1.5m, 15 MOHRI FTE) so that these strategies can be implemented, then the financial benefit of these strategies would offset the $4.3m gap.

12. Risks to 2012/13 Budget

12.1. Overview

We have undertaken a high level assessment of the key issues and potential risks associated with the likelihood of WMHHS achieving a break even budget result for 2012-13.

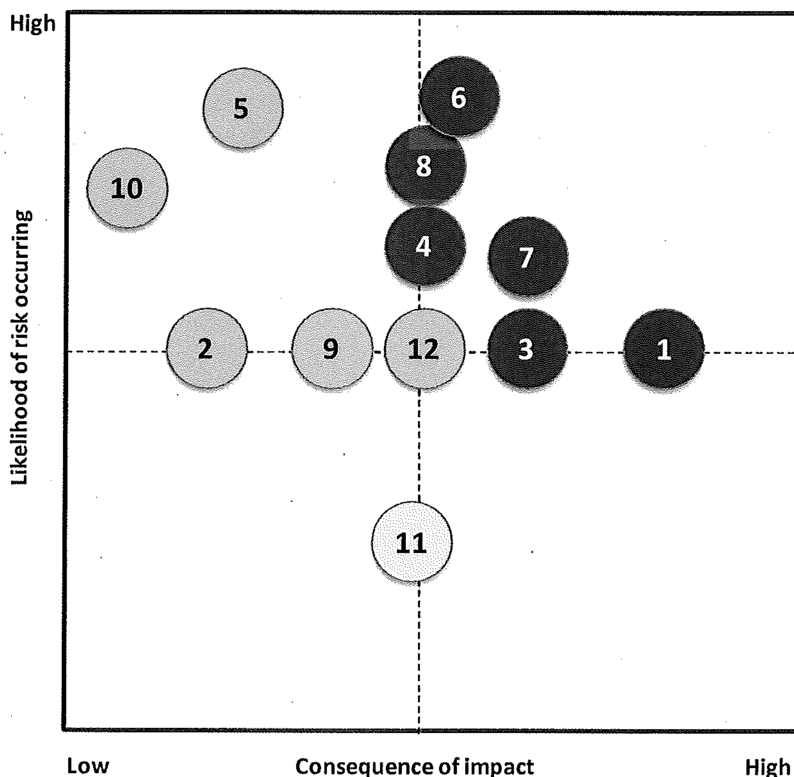
The risk assessment is based on the HHS's financial forecast prepared as at 5 December 2012 (refer section 10.2).

We have assessed the risks in terms of the 'Likelihood' and 'Consequence' of each risk and suggested actions being undertaken by WMHHS to ensure that these risks can be mitigated.

We have rated the likelihood and consequence risk based on a 'High', 'Medium' or 'Low' classification, based on a subjective assessment of each of the risks.

Consequence is rated based on potential dollar impact (taking into account any risk adjustments that the HHS may have included into existing forecasts). It should be noted that the scale of consequence for a number of risks could vary materially (e.g. impact of any budget adjustments as noted in the description of risks in 12.3. In these instances, consequence has been shown as "medium" in the risk map.

12.2. Risk Map



Legend:

1. MOHRI FTE reductions not achieved within timetable
2. Service/industrial relations – The Park
3. Industrial relations – other services
4. 2012/13 budget rebuild
5. Services devolved from Qld Health
6. Over target WAU
7. Sustainability of EMP process
8. Non-salary strategies /costs
9. OSR performance
10. Financial capability issues
11. Extent of change required
12. Avoiding year end expenditure /FTE increases

Overall Risk Ranking

High
Medium
Low

12.3. Detailed description of risks

Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy

Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy
1. **MOHRI FTE reductions not being achieved within timetable** The turnaround plan is built on achieving 190 MOHRI FTE reduction, with the impact on the current year financial result dependent on the timing of the reductions. Material delays to the reductions will result in financial savings not being achieved and alternative strategies being required to achieve a balanced budget. This risk is partially mitigated by: - the conservative nature of the MOHRI costings - the interest shown by staff in the VR process; and - the MOHRI FTE reductions achieved through the EMP process	Medium	High	High	• Ongoing reporting and monitoring of impact of FTE reduction strategies against targets by payroll fortnight. (Reporting and monitoring process already in place)
2. **Service / industrial relations issues at The Park negatively impact related turnaround strategies** Turnaround strategies include 11 strategies related to clinical and support service redesign, deferral of services and other initiatives at the Park. The Park is undergoing substantial change including service reviews (over and above what has been factored into the turnaround plan). The extent of change at the site and related industrial relations issues may prevent savings forecast in turnaround plan from being realised.	Medium	Low WMHHS has considered the financial impact of this risk in forecasting the year-end result and has discounted the impact of the financial turnaround plan by $1.5 to take account of these risks	Med	• Ongoing monitoring of status of risk and impact on financial forecast (including positive impact of any reduction in FTE / cost that is able to be achieved in 2012-13)
3. **Industrial relations issues at other locations defer implementation of turnaround strategies** Industrial relations issues at all sites may impact on ability to realise savings. The risk is also influenced by external factors including the extent of FTE reductions being achieved across the public health sector possibly increasing union resistance to changes. Risk is partially mitigated through the comprehensive change processes implemented by the HHS which are in accordance with agreed statewide protocols.	Medium	Med – High	Med - High	• Ongoing monitoring of implementation and risks.

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Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy
4. **Finalisation of rebuild of 2012/13 budget** WMHHS has not reported variances between monthly actual and budget results due to quality issues discovered in budget build. Lack of reporting against budget creates difficulty in monitoring the underlying financial performance of the HHS. Financial forecasting has been based on the budget build and may be misstated to the extent that the budget build is misstated. Risk partially mitigated by adoption of Qld Health's forecasting tool, which takes into account actual financial results at the end of October.	High	Unknown (Depends on the extent of any error detected in the budget build)	Med - High	• Budget rebuild to be finalised (including phasing of budget) and impact to be monitored on forecast financial results with a specific focus on ensuring expenditure does not increase during the final months of this financial year.
5. **Impact of services devolved from Queensland Health** Qld Health plans to devolve a further 50 FTE to the HHS (60 FTE for corrective services already devolved) for a range of services. • Risk that WMHHS will not be able to support the transfer of services and associated staffing within the existing budget; • Risk that FTE transfers confuse WMHHS's reporting of MOHRI FTE • Risk of costs exceeding the preliminary estimates	Unknown	Low – Med Consequence will depend on the balance of staffing resource transferred compared to function objectives	Med	• Develop transition and change management program to monitor the FTE and financial impact of changes. • Ongoing assessment of FTE to be transferred, funding transfers, cost of delivering services and impact on actual MOHRI numbers.
6. **WAU in excess of target** WMHH have historically delivered over target WAU and as at 30 November 2012 are ahead of current year WAU targets (with exact overrun in the process of being confirmed to take into account some data count issues). Overrun of inpatient WAU is likely to incur non-salary and wage costs in excess of budget.	High	Low – High (Depending on type of WAU) Cost of excess inpatient WAU more likely to create cost overruns	Med - High	• WAU measurement issues to be resolved • Ongoing monitoring of non-salary and wage costs and relationship to activity • Budget principles for 2013-14 to be developed to link budgets to activity assumptions.

Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy
7. Sustainability of EMP MOHRI reductions The extent to which the MOHRI FTE reduction achieved through the EMP process is sustained throughout the rest of the financial year. The risk is partially mitigated through: - the 3x3 monthly performance meetings including a focus on FTE and overtime movements; -EMP processes designed to prevent FTE and both rostered and unrostered overtime increasing.	Med Likelihood mitigated through existing risk manageme nt practices	Med - High Extent of consequence depends on the area of overrun, with increases in medical FTE having the greatest financial impact	Med - High	• Continued monitoring of trends in FTE and overtime, particularly higher cost medical FTE. • Clarity regarding extent to which reductions achieved through the EMP process are included into financial forecasts.
8. Non-salary strategies do not bridge budget gap WMHHS has commenced the process of identifying specific initiatives to reduce / constrain non-salary and wage costs (pathology, diagnostic imaging, drugs, clinical supplies, linen), however implementation of strategies will only have part year impact on 2012-13 (or lesser impact if not implemented prior to end of December) and may not be sufficient to bridge financial gap	Low – Med (Depends on size of budget gap)	Med - High (Depends on size of budget gap)	Med to High (Depends on size of budget gap)	• Strategies should focus on areas of "quick win" based on ability to decrease/constrain costs in current financial year.
9. Achievement of own source revenue target The financial forecast is built on the forecasting of expenditure and assumes that OSR targets will be achieved. Non-achievement of the target may place achievement of a breakeven financial position at risk. We note that as at the end of October that the HHS is tracking behind on OSR strategies, however the financial impact is offset by above-expected inter HHS charging, with the net variance between the two being minimal. The financial impact of any deviation in these two revenue streams should be monitored carefully.	Med	Med	Med	• Existing reporting and monitoring processes (from Board level down) are designed to monitor progress against OSR strategies. • Underachievement of strategies should be factored into year end forecasts to determine extent to which alternative turnaround strategies are required to bridge budget gap.

Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy
10. Financial management capability issues – in finance and throughout the HHS WMHHS has been challenged by substantial gaps in financial management capability, particularly within the Finance Department (refer Review of Financial Management Capability Report – November 2012). These gaps have created difficulty in obtaining reliable financial information, particularly in relation to the current year budget build, impacting the HHS's ability to forecast likely year-end financial result. The key risk to the financial forecast relates to consistency of the assumptions made in the financial forecast with those made in the financial turnaround plan, particularly in relation to timing of benefits to be realised.	High	Unknown	Med	• Ongoing reconciliation between financial turnaround plan, financial forecasts and budget build to ensure consistency of assumptions. • Strategy has been developed to restructure finance to address issues raised. • Ongoing monitoring of reasonableness of forecast financial results required.
11. Extent of change management required / burnout / program management of turnaround strategies in conjunction with other key strategies The HHS commenced the financial year with an operating deficit of > 5% of total budget. The extent of change required to achieve this level of budget reduction is substantial. The risk is partially mitigated by the nature of the deficit that is being addressed by the HHS (i.e. a large part of the deficit relates to a blowout in recruiting and expenditure processes within the current calendar year) which has enabled the HHS to identify a number of strategies without creating substantial operating risk. The risk is also partially mitigated through the HHS's change program and consultation processes. The HHS has also not met substantial resistance to date.	Low	Med	Med	• Reporting and monitoring processes are designed for early detection of slippage in turnaround plans

Risk	Likelihood of risk occurring	Consequence / Impact	Overall Risk Ranking	Suggested Mitigation strategy
12. Avoiding increase in expenditure at end of financial year. Public hospitals historically increase expenditure and FTE in the last few months of the financial year (April to June). There is no allowance in the forecast for any increase in expenditure in these months with salary costs being based on October costs and non-salary costs being based on an average of the first three months of the financial year. The risk is partially mitigated through the EMP and performance monitoring processes (e.g. the 3x3 processes) which are designed to prevent expenditure and provide an early warning of any blowout in expenditure.	Med	High	Med - High	• Continued monitoring of FTE and non-salary costs in all operating divisions.

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Appendix 1 West Moreton HHS Financial Turnaround Plan (as at 31 October 2012)[6]

Workstream Reference	Labour (FTE) Strategy	Due to Commence	2012-2013 Value	MOHRI FTE Reduction
1.1	Legal Advice Model	6-Jan-13	$61,937	1.00 FTE
1.2	Communications & Engagement Team Structure & Model	25-Nov-12	$116,896	3.00 FTE
1.3	IH Foundation Position	23-Dec-12	$24,847	0.84 FTE
2.1	Executive and Senior Management Restructure	9-Dec-12	$99,766	1.00 FTE
2.2	Finance Branch structural review	9-Dec-12	$193,846	4.20 FTE
2.3	Medical records review	6-Jan-13	$131,107	4.00 FTE
2.4	Front Office	11-Nov-12	$104,615	2.00 FTE
2.5 / 2.6	Administration Vacancy Management & Growth (15)	6-Jan-13	$640,438	14.18 FTE
2.7	The Park Switchboard	6-Jan-13	$44,780	1.00 FTE
3.1	Executive Support Officer Structure	9-Dec-12	$223,481	4.50 FTE
3.2	Service Planning	9-Dec-12	$81,678	1.00 FTE
4.1	Rural Social Worker HP5	6-Jan-13	$69,682	1.00 FTE
4.2	Women's Health	05-Sep-2012	$113,522	2.80 FTE
4.3	Re-evaluate HACC services to match funding allocation	6-Jan-13	$254,789	6.60 FTE
4.4	Remove Backfill for Sick Leave & Annual Leave	11-Jul-2012	$108,508	1.24 FTE
4.5	Delay Recruitment for Principal Dentist	11-Jul-2012	$0	-1.00 FTE
4.6	Delay Recruitment for 2 FTE senior dentist	11-Jul-2012	$107,242	-2.00 FTE
4.7	Reduction of AO support in Community Health & Goodna Community Health	22-Aug-2012	$99,547	1.03 FTE
4.8	Removal of 003 Allied Health Assistant	11-Jul-2012	$59,772	1.00 FTE
4.9	Coordinator Ethnic Health DCS	11-Jul-2012	$111,496	0.00 FTE
4.10	Service Agreement Notification - Reduced Funding Oct Performance Resource Committee	6-Jan-13	$181,318	8.52 FTE
4.11	Ipswich Hospital Social Work Review	11-Nov-12	$38,667	1.08 FTE
4.12	Healthy Communities (Projects and Research Services) Review	6-Jan-13	$195,763	3.20 FTE
5.1	Non-Clinical Model of Service Redesign and Realignment: Security at The Park+	6-Jan-13	$181,737	4.20 FTE
5.2	Non-Clinical Model of Service Redesign and Realignment: Ipswich Hospital Courtesy Bus	12-May-13	$14,728	1.50 FTE
5.3	Explore opportunities for savings by rationalising BEMS management structure	6-Jan-13	$47,961	1.00 FTE
5.4	Security at the Plaza	25-Nov-12	$62,609	1.63 FTE
5.5	Operational Services Restructure	25-Nov-12	$59,511	1.40 FTE
5.6	Review Hotel Services - inefficiency, utilisation of less demanding hours YTD Actual QH FTE over Budgeted FTE	11-Nov-12	$182,612	3.60 FTE
5.7	Corporate and Corporate Support Functions (including District Wide), including service manager at The Park	6-Jan-13	$66,201	1.00 FTE
6.1	Review Service Model at The Park	11-Jul-2012	$2,397,895	20.20 FTE
6.2	Relocation of Patients within the Park to reduce staffing costs	28-Oct-12	$1,010,506	12.79 FTE

[6] Version 5

Workstream Reference	Labour (FTE) Strategy	Due to Commence	2012-2013 Value	MOHRI FTE Reduction
6.3	Non-Clinical Model of Service Redesign and Realignment: Mailroom at The Park	14-Oct-12	$47,578	1.00 FTE
6.4	Model of Care Redesign - Mental Health Rehab at The Park	25-Nov-12	$319,748	6.00 FTE
6.5	Mental Health (Corporate 3.1FTE /IMHS)	28-Oct-12	$166,154	3.00 FTE
6.6	Mental Health Nursing Structure	19-Sep-2012	$246,154	4.00 FTE
6.7	CYMSH HPs	28-Oct-12	$110,769	2.00 FTE
6.8	Mental Health IMHS Clinical Support	28-Oct-12	$55,385	1.00 FTE
6.9	Mental Health Nursing Support; Mental Health Clinical Support; Mental Health Unit	28-Oct-12	$221,538	4.00 FTE
6.10	Administration (and data management) Review Mental Health & The Park	28-Oct-12	$276,923	5.00 FTE
6.11	Pharmacy Review Mental Health & Offender Health	28-Oct-12	$55,385	1.00 FTE
6.12	QCMHR	6-Jan-13	$145,500	2.00 FTE
6.13	DSO Position - Remove from budget build from 31.12.12;	6-Jan-13	$80,191	1.00 FTE
6.14	ESO - 1FTE transferred to Offender Health from 24.09.2012	28-Oct-12	$51,076	1.00 FTE
6.15	QCMHL	6-Jan-13	$950	0.20 FTE
6.16	Drug Court - Service to cease from 30 June 2013	1-Jul-13	$0	0.00 FTE
7.1	Demand Management (10 FTE to be found)	19-Sep-2012	$911,379	11.48 FTE
7.2	Allied Health Efficiencies	08-Aug-2012	$191,240	1.90 FTE
7.3	Medical Workforce Realignment with current purchasing agreement	08-Aug-2012	$195,908	0.80 FTE
7.4	Radiology - resource model	6-Jan-13	$102,113	2.00 FTE
7.5	ED Medical Model and VMO		$1,331	5.00 FTE
7.6	Medical Imaging Administration Efficiencies	9-Dec-12	$122,171	3.00 FTE
7.7	Rational use of Pharmacy & Radiology	05-Sep-2012	$135,105	2.00 FTE
8.1	Nursing & Midwifery Review Work in Progress - Service Review Feedback 5 November; Numbers Locked Down	25-Nov-12	$283,181	9.60 FTE
8.2	Safety & Quality	9-Dec-12	$129,886	2.00 FTE
8.3	Rural FTE efficiencies / CSO Rationalisation and Redesign Service Review Feedback 5 November	6-Jan-13	$388,895	5.10 FTE
8.4	Education, Training & Development (inc Medical Admin Growth 2.9) Note: Could be 4.47FTE	28-Oct-12	$244,554	3.93 FTE
9.1	Occupational Health & Safety/Safety & Quality	6-Jan-13	$80,000	2.00 FTE
9.2	Workforce	6-Jan-13	$100,000	2.50 FTE
9.3	Recruitment devolution back to HHS (efficiencies)		$0	0.00 FTE
			$11,536,089	**190.02 FTE**

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EXHIBIT 718

PAXTON PARTNERS

QUEENSLAND HEALTH

REVIEW OF WEST MORETON HHS FINANCIAL MANAGEMENT CAPABILITY

NOVEMBER 2012

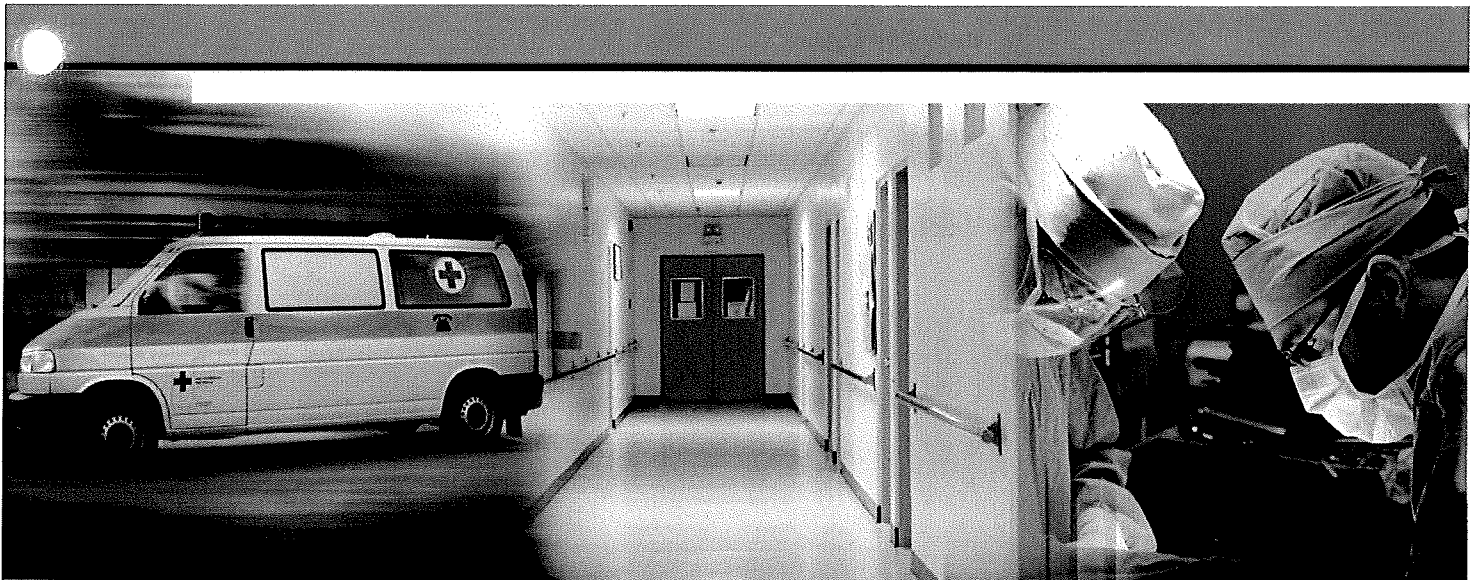

EXHIBIT 718

Queensland Health
Review of West Moreton HHS Financial Management Capability
November 2012

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1. Background

1.1. Background

West Moreton HHS ("the HHS") reported a substantial operating deficit of approximately $17.5 million for the 2011-12 financial year, which represented approximately 5% of the HHS's total operating budget. Queensland Health appointed Paxton Partners to work with the HHS to develop / refine a coherent set of financial management strategies for 2012-13 which target a balanced position, while being consistent with the HHS's purchasing agreement with Queensland Health.

1.2. Purpose of this report

The terms of reference included a review of the HHS's financial management capability. This report sets out the results of this review .

2. Scope

The scope of our review of financial management capability was determined by QH in conjunction with the HHS. Specifically the scope is to review the HHS's financial management capability (including consideration of the financial governance/accountability framework, budget development process, management reporting, responsiveness to budget to actual variations and financial systems, resources and processes supporting financial governance). This financial management capability review should not be limited to finance staff but should also include recommendations for an appropriate finance team structure.

Paxton Partners approach to addressing the scope is set out in Appendix 1.

3. Review Procedures

Our interim findings are based on interaction with management and the finance function since early July 2012. Work performed to date has included:

- Review of the 2012-13 budget build principles and processes;
- Reasonableness review of the 2012-13 budget build in comparison to 2011-12 actual results (in relation to both expenditure and FTE);
- Various interactions with Executive management and the finance function in relation to development of financial management strategies and identification and descriptions of risks to the 2012-13 budget result;
- Meetings with key Executive directors and business managers (Ipswich Hospital, Mental Health, Community Health and rural hospitals)) to gain an understanding of the revenue and cost drivers for divisional budgets;
- Review of finance function structure and position descriptions; and
- Observation of finance month-end and reporting processes.

There have been substantial changes in West Moreton HHS management during the time period of this review, including a new Chief Executive and acting Chief Financial Officer together with a restructure of Executive responsibilities. The HHS has also been actively improving financial accountability and budget frameworks throughout this time period. This report reflects both our initial observations and subsequent improvements.

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4. Findings

4.1. Organisation wide financial management capability

The context for the review of the HHSs organisation-wide financial governance framework is the deterioration in reported financial performance during 2011-12 as indicated by:

- FTE increases in excess of budget (particularly in 2011-12);
- The HHS reporting an operating deficit for 2011-12 of $17.28 million, which is equivalent to 4.9% of the HHS's total operating cost base. This deficit is understood to be one of the largest negative budget variances reported across the state, both in terms of dollar value and as a percentage of the operating cost base, for that financial year;
- The HHS not achieving performance targets (access) or volume targets (over achievement of WAU) in prior years; and
- Inability of Executives to formulate financial management strategies to bring the budget back to a break-even position in 2012-13.

The HHS has implemented a number of initiatives to enhance financial accountability including:

- Development of a coordinated Financial Management Plan (refer section 4.2.2 below);
- Changes in organisation structure and financial governance processes to centralise accountability for the achievement of performance, demand management and financial targets for Ipswich hospital.

At the commencement of this review, budget review and monitoring processes were not well developed (refer section 4.2 below) and financial management plans and budget strategies were not directly linked to strategic, service and performance plans. The HHS does not have a long term strategic or service plan that can be used to drive operational and financial performance.

There was no effective consistently applied organisational wide financial accountability framework or monitoring processes. Formal monthly review processes varied throughout the organisation, e.g. "3x3" performance meetings were held at the Divisional level within Ipswich Hospital, however there were no formal "3x3" performance meetings held between the Chief Executive and Executive Directors. "3x3" performance meetings have subsequently been implemented throughout the organisation.

Organisational reporting processes are also fragmented without standard operational and financial datasets being readily available throughout the organisation. Executive, facility, divisional and unit managers have access to a basic suite of operational and financial data, but the data is not linked to performance measures that are aligned to organisational objectives including performance measures agreed with QH (access, activity, financial outcomes etc). This creates difficulty in providing "drill-down" capability to analyse the extent to which individual facilities, departments or operational units are contributing / detracting from overall organisational performance.

The HHS is currently reviewing the availability of data to Executives and managers at all levels of the organisation and the ability of existing toolsets (eg DSS) to provide information from a single source, consistently and on a timely basis.

The size of the task of reducing the HHS's operating deficit requires a change of culture requiring all levels of management to "live within their means" in a new environment of QH as contract manager capping the volume of service that will be purchased. This will challenge many managers who have been able to procure additional resources and who have not been held accountable in the past for the deteriorating financial performance.

4.2. 2012-13 Budget

4.2.1. Budget build

The 2012-13 budget build is based on a budget process and model that was previous used by the combined Darling Downs / West Moreton HHSs. The budget model is based on a detailed bottom-up build for each cost

centre based on the cost centre's staffing establishment. Nursing staffing establishments are linked to the agreed BPF.

The budget model is supported by a 13 page document detailing the budget build principles.

Whilst the budget model is a useful tool for developing the budget, the following areas for improvement were noted:

- Whilst detailed budget principles exist, some principles are unclear and do not provide guidance in relation to:
    - Linkages of non-salary and wage expenditure areas (e.g. drugs, clinical supplies, prosthetics, pathology, medical imaging) to targeted activity (e.g. WAU, Mental Health bed days)
    - Treatment of vacant positions, with the guidelines appearing to suggest that budgeted FTE should be build to agreed establishment, which may not reflect current needs (particularly in areas where there have been long standing vacant positions). This principle would appear to build-in staffing inefficiencies;
    - Escalation assumptions are unclear (e.g. application of EBA increases).
- The specific strategies adopted to achieve any cost savings built into the budget build are not documented. This lead to some confusion as to whether some cost reductions built into the budget build were a result of deliberate strategies or were in fact "plugged" to achieve the reduction (e.g. initial treatment of pathology costs);
- Some Executive Directors and Business Managers appeared unclear about the application of specific items in the budget with Executives and sometimes Business Managers providing contradictory explanations about what is included in / excluded from the budget build. This was a particular issue in ensuring consistency between the assumptions made as to which costs were to be included in the budget build and what funding is included in the contract commitment.

We understand that West Moreton HHS will be adopting a new budget tool, BPT, which is being developed by Financial Solutions. The HHS will be a pilot HHS for the use of this tool in Queensland. The HHS expects that BPT will provide it with substantially enhanced budgeting and modeling capability.

Quality assurance processes to ensure budget integrity were not documented, nor were the results of review processes. Documentation would normally include:

- Explanations of material variances in FTE (either absolute numbers or in grading of staff positions) or expenditure from 2011-12 actual FTE to the 2012-13 budget build in the context of:
    - agreed changes of service;
    - agreed budget saving strategies; and / or
    - other Queensland Health directives (e.g. reduction of MOHRI FTE)
- Explanations of material variances in non-salary expenditure (e.g. drugs, clinical supplies, pathology, domestic and catering expenditure);
- Justification of vacant positions (both clinical and non-clinical) being included in the budget build;
- Responsibilities for resolving specific issues.

There have been multiple iterations of the budget, with the audit trail of changes made between versions not always being clear.

The result of these issues has been multiple, sometimes material, changes to the budget build, undermining Executive's confidence in the integrity of the budget build.

4.2.2. Financial turnaround strategy

The budget was initially supported by a documented Financial Management Plan which set out:

- Detail of each of the individual strategies;
- Expected financial impact in 2012-13 (based on a part year effect of strategies implemented midyear);
- Impact on FTE reduction in 2012-13;
- Accountable officer (Executive Director) and secondary accountable officer
- Traffic-light assessment of performance against target.

This is a useful document to coordinate the development and reporting of Financial Management Strategies.

The initial Financial Management Plan could be enhanced through:

- Development of supporting action plans for individual strategies that set out milestones and lead operational performance indicators that can be used to monitor and hold individual executives accountable for performance;
- Establishing a reporting process for tracking performance on individual strategies (with an initial focus on strategies targeted to deliver cost savings in July, August and September 2012);
- Linkage / integration of the Financial Management Plan to West Moreton strategic, service delivery, performance and demand management plans;
- Agreement of the formal reporting and monitoring process to be utilised to track progress.

The HHS has subsequently expanded the financial management plan into a financial turnaround plan which includes both the initially identified financial management strategies and additional strategies. The turnaround plan is focussed both on addressing the current year deficit, meeting MOHRI FTE target reductions and achieving a sustainable financial performance over a two year period.

The turnaround plan is coordinated by the acting Chief Financial Officer, working closely with a newly appointed ED Performance Strategy and Planning. This ensures that the turnaround plan is coordinated with performance management and other plans.

4.2.3. Identification of budget risks

Risks to the achievement of the budget financial result have been identified in the 2012-13 Budget Projection summary worksheet.

Version 20 of the budget worksheet identified 13 risks totaling to $13.3 million.

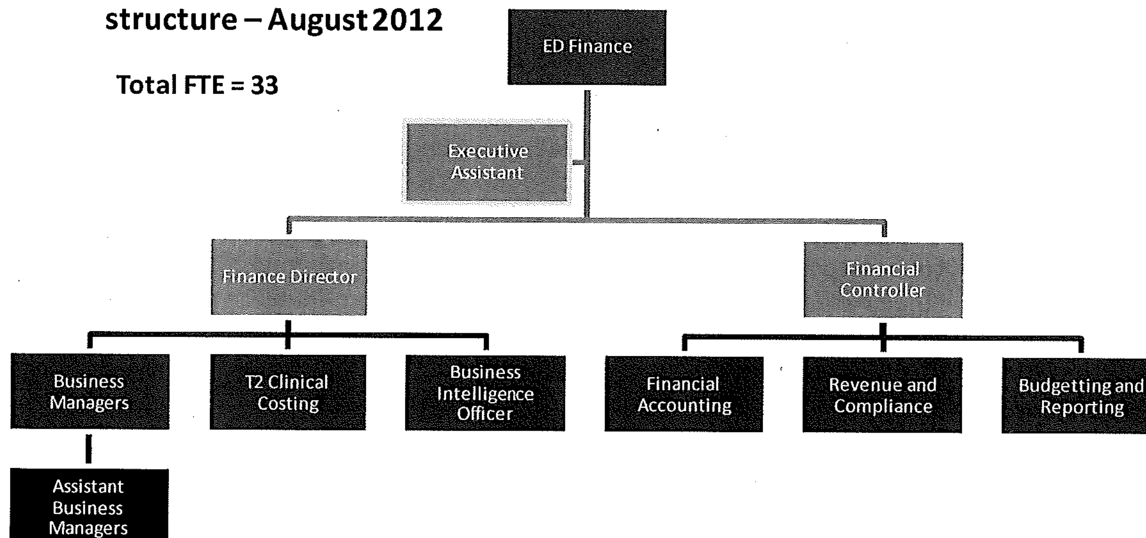
The risk identification process could be further enhanced through:

- Developing a financial risk assessment process including risk rating;
- Documenting and reviewing risk management strategies, together with the assessment of residual risk;
- Developing a risk reporting process to the HHS Board, relevant Board committees and Executive;
- Ongoing reporting / updating of identified risks / risk assessment in the context of actual month end financial results.

4.3. Finance Function

4.3.1. Structure

The current finance function structure is overviewed in the following diagram:



The overall structure is consistent with a QH recommended structure that splits the finance function between financial accounting / compliance and business management (management accounting). The structure also includes appropriate segregation of duties with clear delineation between operational responsibilities (eg. Cashier functions) and monitoring and reconciliation processes).

It is difficult to identify the budget resource associated with the Finance function as the budget for individual positions is devolved to organisational units (e.g. Ipswich Hospital, Mental Health). The Finance cost centre includes only the Chief Financial Officer, Financial Controller and Executive Assistant.

The scope of this engagement does not include detailed benchmarking of the finance function against other organisations or detailed review of individual job responsibilities / process review. We do however make the following observations about the Finance function structure based on our experience with other Health Services:

- The Finance function is "top heavy" with three senior positions (the CFO, Financial Controller and Finance Director) which represents a significant allocation of resources for an organisation the size of West Moreton HHS. This structure is possibly a carry-over from the combined West Moreton / Darling Downs HHSs and may no longer be appropriate for the smaller West Moreton HHS;
- The roles and responsibilities of a number of positions, particularly in relation to Financial Accounting and Budgeting and Reporting have been in flux, are unclear and require review;
- Financial accounting and reporting roles and responsibilities, particularly in relation to new cash flow and balance sheet management and reporting are under development. The scope of these roles are also likely to change as finance roles are devolved from QH to the HHS;
- There are 10 FTE Business Managers included in the finance budget. The allocation of Business Manager and Assistant Business Managers to divisions is a result of historical decisions arising from the split of Darling Downs and West Morton HHS and temporary reallocations of responsibilities to deal with urgent issues (e.g. developing the Financial Management Plan). Specific issues noted are:
    - There are variances in the allocation of business manager resource to divisions when compared to the size and complexity of the division with Mental Health ($95m budget with complex costing and funding issues) not having the support of a Business Manager whereas Community Services ($30m budget) having a dedicated senior Business Manager;
    - Responsibility for individual Business Managers being split over multiple personnel (Ipswich Hospital and Rural Hospitals) resulting in there being no single point of accountability / contact

for these divisions, with individual Business Managers sometimes taking different approaches to similar issues;

- o The roles of the Business Managers in budget processes and month end processes varies between Business Manager;
- o In our experience, the overall level of resource applied to Business Managers (10FTE) appears high comparative to other similar organisations. A review of Business Manager and Assistant Business Manager roles and responsibilities is required to determine whether the roles are appropriately assigned to Finance, or whether roles should be reassigned to operational management, or whether the overall Business Manager resource should be reduced;

A structured review of roles, responsibilities and alignment of Business Manager positions across West Morton would improve the development of the financial capability and accountability across the organisation. This will be important in clarifying the budget ownership and financial accountabilities of divisional and cost centre managers compared to the facilitation role that the business manager role plays in supporting the organisation.

The allocation of Business Mangers will also require review in the context of a forthcoming Executive restructure. This restructure should consider the substantial corporate knowledge held by the Business Managers and how this would best be utilised.

- Governance of the Business Managers is unclear with Business Managers sometimes making decisions that impact budget (eg phasing of budget) at the instigation of Executive Directors without agreeing changes with the Finance Director and/or the ED Finance. This is possibly the result of recent instability at the ED Finance Director with there being multiple changes).

  The delegations of the Business Managers to apply these types of changes and the quality assurance / review / supervisory role of the Finance Director and the ED Finance should be enhanced to ensure that changes are agreed and reviewed prior to financial information being released to the Executive and other stakeholders;
- The role of the Finance Director requires review. It should be possible to combine this role with the senior Business Manager roles through restructure of the Business Manager positions. This should be considered in the context of restructuring required to support the HHSs new Executive organisation structure;
- The minimum position grading in Finance is "AO3" which we understand to have agreed on an organisation wide basis with relevant unions in 2010-11. In our experience we would not expect to see all positions (particularly cashiers and trust accounting personnel) graded at this minimum level.

We have not specifically reviewed the operational roles of the Clinical Costing team or Revenue and Compliance teams as these do not have a direct impact on the 2011-12 reported financial result or the 2012-13 budget.

4.3.2. Role descriptions

Role descriptions have not been updated since the split of the Darling Down and West Moreton HHSs with the result that role descriptions do not reflect current organisational needs. Specifically:

- Some position titles and descriptions continue to be based on the combined workload requirements of the two HHSs (eg Finance Director). These position descriptions may no longer be appropriate for the smaller West Moreton HHS;
- There have been substantial changes in the allocation of responsibilities to individual personnel and these are generally not reflected in current role descriptions.

4.3.3. Short term planning

Recent changes at the ED Finance level and within the Finance department have resulted in some instability within the Finance Department. The Finance Department requires a short term plan that clearly identifies the tasks to be completed together with clearly assigned roles and responsibilities. The plan should consider:

- The steps required within Finance to finalise the 2012-13 budget, including:
  - the resolution of specific budget issues (e.g. Mental Health funding and cost overruns);
  - assurance as to the integrity of the budget build;
  - identification and reporting of risks;
  - finalisation of the Financial Management Plan including the work up required for newly identified financial management strategies;
  - phasing of the budget build and financial management strategies;
  - clarity as to which Financial Management Strategies are loaded into the budget build (and consequently to DSS and the General Ledger); and
  - Finance's specific role in relation to the identification of strategies to address the remaining budget gap including both specific issues and systemic analysis required to support organisation wide strategies (e.g. analysis of vacant positions; review of corporate and clinical support models);
- Month end general ledger close and reporting processes (to Executive, the Board and Queensland Health), particularly in relation to responsibilities for quality assurance of preliminary results within the timeframe available to identify and correct errors prior to system wide (i.e. Queensland Health) finalisation of the month end results. This should specifically consider the roles of:
  - The Business Managers in identifying issues to be resolved at a Divisional level and reported back to Finance as part of month-end processes;
  - The role of the Finance Director;
  - The role of the Financial Controller in quality assuring general ledger accounts, including balance sheet accounts and reconciliations;
  - The role of the ED Finance in strategic analysis and interpretation of the results.

  Month end processes should also include steps which provide adequate time to evaluate preliminary financial results. Processes are also required to monitor fortnightly FTE trends, and to evaluate month end financial results in the context of the fortnightly FTE review.

  This acknowledges that month end processes can sometimes be complicated by Queensland health unexpectedly processing journals (particularly funding variations related to EBAs, but also payroll accruals) without clear communication to the HHSs. Continued vigilance will be required at month end to ensure that sufficient review procedures are performed to determine whether initial variations are due to operational changes, or are the result of accounting adjustments made by either Queensland Health or the HHS (either correctly or incorrectly).

  We understand that the Finance department has taken steps towards addressing the above issues and has developed roles and responsibilities for the month-end process that were successfully implemented for the August month-end;
- Ongoing management of operational functions including general ledger reconciliations, clinical costing and revenue and compliance functions; and
- Supporting the ongoing needs of the Board, Executive, Division and Unit Managers for financial information and input.

4.3.4. Strategic Analysis and Reporting of Financial Information

Finance's role in the strategic analysis and reporting of financial information requires enhancement.

Key areas for enhancement would include:

1. Identification, interpretation and communication of both one-off and underlying financial performance issues;
2. Interpretation and communication of the relationships between various financial drivers and strategies, for example, the Mental Health program is experiencing multiple changes to cost driven by factors sometimes impacting on the same patient cohort (transfer of patients to other HHSs; redevelopment; changes in acuity of patients; funding model issues). Finance needs to be capable of analysing and clearly explaining all key drivers and the relationships between them, in order for HHS Executives to determine informed financial management strategies and understand the financial implications of operational strategies and decisions;
3. Linking financial indicators to operational performance indicators and the identification of lead indicators, particularly in relation to FTE and activity;
4. Better utilising existing datasets to provide managers throughout the organisation with timely data.

The Chief Financial Officer must be capable of leading these enhancements, but these skills must be embedded throughout the Finance Function, particularly at the Financial Controller level.

Executive stakeholders consulted a number of areas for improvement including:

- Reconciliation of financial and operational dataset with information sometimes being reported from two different dataset with differing results;
- Better management of financial data integrity, with there being a history of there being multiple unexpected changes in reported financial results and other financial information (e.g. budget build). Stakeholders noted that Finance sometimes struggled to explain the reason for changes in information between versions of financial documents, thus undermining their confidence in the information being presented and detracting from management of core underlying financial issues.

The Finance function must focus on rebuilding credibility with key stakeholders including Queensland Health, the Board, the Chief Executive, Executive Directors and management throughout the HHS.

5. Recommendations

Key recommendations are as follows:

5.1. Planning

1. Develop a short tem plan for Finance (refer 4.3.2 above) to document:
   a. Resolution of remaining 2012-13 budget processes (refer 4.2 above);
   b. Remaining improvements required to end of month financial close and reporting processes;
   c. Implementation of changes to Finance Structure;
   d. Improvements required to management reporting processes.

5.2. Strategic Financial Analysis

2. Establish structured and periodic financial review practices across the Finance and Business Manager teams for identifying, interpreting and communicating key issues and variances affecting the HHSs financial results particularly with regards to extraordinary, one-off and underlying financial impacts;

3. Increase capacity for evaluating the financial impacts and cost / benefit analysis of proposed budget improvement strategies to better inform the Executive and Divisional management teams of the anticipated financial benefits, flow on effects, actions and likelihood of achievement of the strategies
4. Develop a common approach for providing awareness and education to divisional and budget managers of the use of financial information for performance reporting. The program should include an understanding of the relationships between health service operations and their related cost drivers and financial impacts. This will become particularly important with the introduction of the QH Activity Based Funding and purchasing framework.
5. Link financial performance indicators to other activity and operational performance measures including the development of dashboard and lead performance indicators, particularly in relation to FTE and activity;
6. Improve the use of financial and non-financial activity datasets to provide managers throughout the organisation with enhanced and timely performance data.

5.3. Structure, roles and responsibilities

We have suggested two options to structure the Finance Department (Appendix 2):

- Option 1 – Budget controller reporting to a Financial Controller, with the Financial Controller having responsibility for all Finance functions.
- Option 2 – Finance Department responsibilities split between a Financial Controller and a Budget Controller, with both positions reporting to the Chief Financial Officer

The choice between the two options will be influenced by the skill sets available to the HHS. Option 1 would provide the greatest level of cohesion within the Finance function but would require a higher skill set of the Financial Controller. The Financial Controller would require skill sets to deputise for the Chief Financial Officer, specifically:

- strong strategic analytic capability iuncluding the ability to analyse and interrogate financial results in order to explain and identify financial drivers and the ability to explain results and trends in a meaningful format in Board, Executive and other reports;
- communication skills that would generate credibility with key stakeholders including Queensland Health, the Board, the Chief Executive and Executive Directors. The Financial Controller would be required to be able to present on all financial issues including financial accounting, reporting, budget process and budget performance. The Financial Controller would also be required to lead relationship building between Finance and the rest of the organisation;
- staff and project management skills, with the Contoller being responsible for the performance of all personnel within the Finance function;
- project management and business planning skills to oversight and guide the finance function and the budget process; and
- leadership skills to develop the customer focus of the Finance function.

Option 2 provides an alternative in the event that these skills are not available to the HHS in a single individual, with a Financial Controller focussing on financial accounting, reporting and management of the finance function and the Budget Controller separately focussing on budget development and business intelligence.,

Specific recommendations regarding structure, roles and responsibilities are listed below:

7. Review the role of the "Finance Director". The role could be restructured to focus on single point accountability for managing the budget process as a "Budget Controller". The position should also include Business Manager responsibility for at least one division.
8. Reallocate Business Manager roles to new Organisation Structure

   a. Ensure single point of accountability for each major organisational unit;
   b. Ensure equitable distribution of work between Business Managers taking into account the size and complexity of each organisational unit;
   c. Appoint a senior Business Manager to support the Mental Health division;

9. Review allocation of responsibilities for Financial Accountants to ensure appropriately skilled resources are in place to manage all monthly and year-end financial accounting, forecasting and cash management processes. This should take into account functions and resources being transferred from QH corporate to the HHS.

10. Review and update the role descriptions of all finance personnel in the context of current West Moreton finance requirements. This should involve a review of the current roles and responsibilities of all personnel. All positions should be justified in the context of the HHS's ongoing review of non-front line positions.

11. Consolidate all Finance resources into a single cost centre to establish single point accountability for resource use.

5.4. Processes

5.4.1. Budget processes

11. Review budget build processes to ensure:
   a. Budget build principles are simplified and clearly documented
   b. Underlying organisation assumptions are identified (e.g. activity targets) and that budget assumptions are made on a consistent basis;
   c. Appropriate quality assurance processes are documented including:
      i. Specific responsibilities of individuals for quality assurance;
      ii. The result of quality assurance reviews
   d. Risks are identified and evaluated and risk management plans are documented;
   e. Financial Management strategies to achieve cost reductions included in the budget build are documented.

5.4.2. Financial Management Strategies

12. Develop supporting action plans for individual financial management strategies that detail specific milestones and accountability for their achievement

13. Establish reporting processes for tracking the achievement of individual strategies

14. Integrate the Financial Management Plan with strategic , service delivery, performance and demand management plans

5.4.3. Month end close and reporting

15. Review Month end processes to ensure appropriate timetable for variance analysis and correction of any identified errors prior to general ledger close. This should also include consideration of the specific responsibility of Business Mangers in month end processes.

16. Formalise the role of Business Managers and Executive Management in providing explanation of month end results for incorporation into monthly financial reporting to the Board, Executive and organisational management.

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5.5. Governance of Financial Information

17. Strengthen governance processes over changes to key datasets including the budget build (the budget build, the phasing of the budget and the loading of the budget into DSS) to require Chief Financial Officer approval of changes to agreed budgets including changes identified by Executive Directors. The role of the Financial Controller and Budget Controller in approving changes to reported financial information should also be agreed.

18. Establish processes to maintain audit trails and version control of key documents including the budget build and other key reports (e.g. monthly Board reports).

Appendix 1

Specific scope of review procedures to be applied.

Scope

The scope of financial management capability assessment includes identification of issues in regards to:

Organisational Capability

1. Overall financial governance processes
2. Accountability of executive, divisional and cost centre management
3. Linkage of financial plans with organisational plans (strategy, service, performance plans)
4. Implementation of financial management strategies
    a. Robustness of plans
    b. Reporting and monitoring
5. Spread of skills through organisation (identification of weak spots with specific Divisions)
6. Management reporting processes
    a. Quality / timeliness / integrity of financial information
    b. Linkages between financial and operational indicators

2012/13 budget build

1. Assumptions/ guidelines
2. Process
3. Quality assurance / reasonableness
4. Consistency with demand management and other organisational strategies
5. Consistency with Queensland Health purchase agreement
6. Risk management processes

Finance Function

1. Structure
    a. Overall structure to support the organisation and the CFO
    b. Business managers
        i. Allocation between facilities
        ii. Linkage with Executive structures
    c. Financial accounting
    d. Operational functions
        i. Revenue
        ii. Trust Accounting
        iii. Clinical Costing

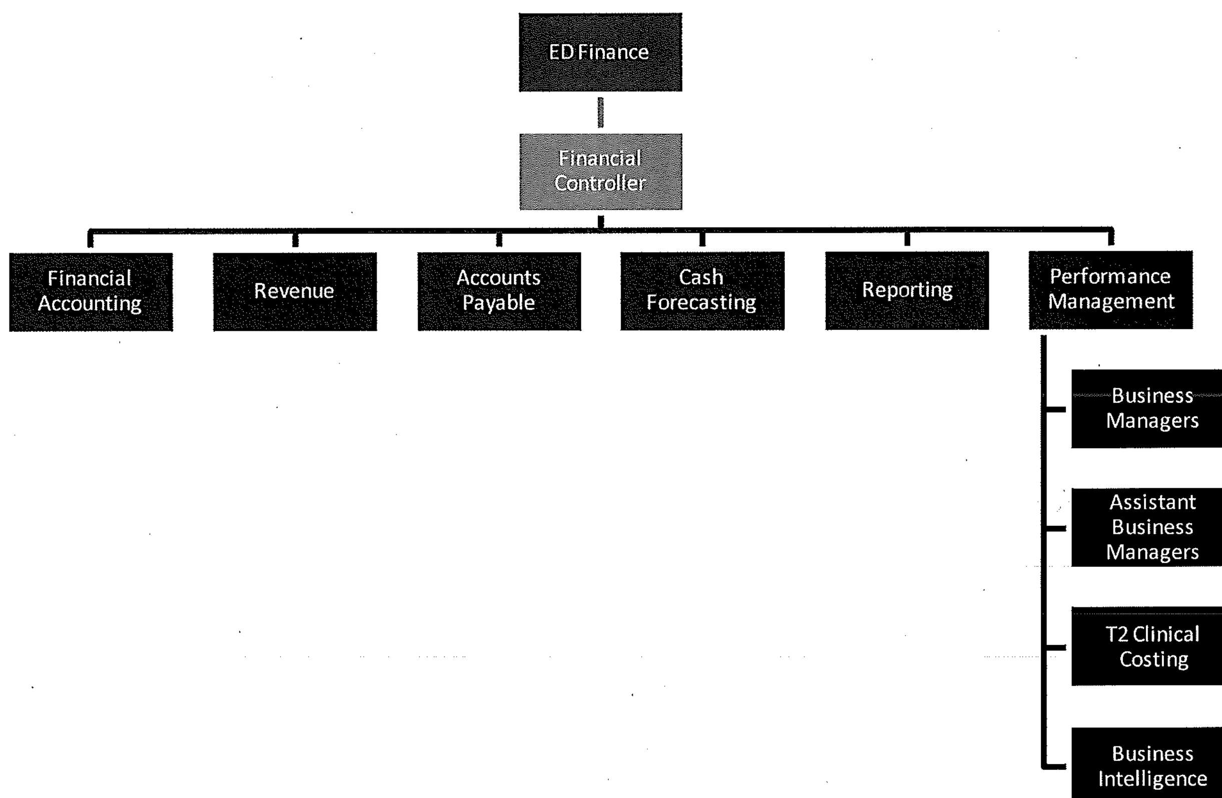
2. Skill Sets
    a. Mix of senior / junior staff
    b. Mix of strategic analysis vs operational analysis skills
3. Financial and management reporting processes
4. High level comments on overall resourcing of finance function
   (Note this does not include detailed benchmarking of finance function or detailed process review)

The assessment of the Finance function would include recommendations for an appropriate finance team structure.

Appendix 2

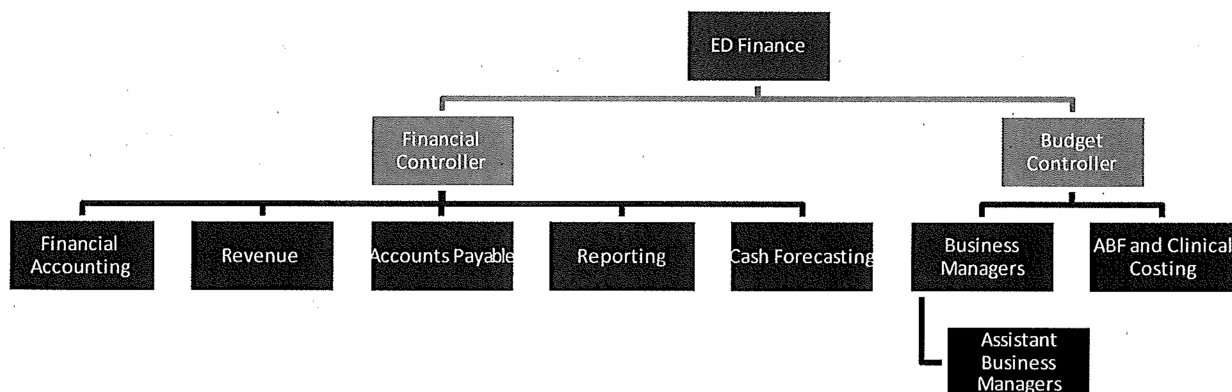
Suggested Finance team structures

Option 1 – Single point of accountability at the Financial Controller level



Pros	Cons
Structure promotes cohesion of the Finance Function with Financial, Budget and other functions coordinated by the Financial Controller	Requires a higher skill level of the Financial Controller (when compared to Option 1)
Clear accountability at Financial Controller level for all functions and provides backup in absence of Chief Financial Officer	Higher workload for the Financial Controller and possibility of "bottleneck" of workflow
Clear authority provided for Financial Controller for staff performance of all Finance team members	Creates an additional hierarchy below the Financial Controller

Option 2 – Responsibilities split between a Financial Controller and Budget Controller



Pros	Cons
Structure would require a lesser skill set from the Financial Controller	Possibility of silo mentality / fragmentation of processes between financial accounting and business managers, particularly in relation to month-end analysis and reporting processes
Flatter management structure	
Allows both the Financial Controller and the Budget Controller to focus on own areas of responsibility with the Budget Controller reporting directly to the ED Finance in relation to the budget process	

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