States of Jersey
States Assembly

États de Jersey
Assemblée des États

Public Accounts Committee

Public Hearing

States Annual Report and Accounts 2023 Review

Witness: Chief Officer, Health and Community Services

Wednesday, 3rd July 2024

Panel:

Deputy R.S. Kovacs of St. Saviour (Chair)

Deputy D. Warr of St. Helier South

Mr. G. Phipps

Mr. G. Kehoe

Mr. V. Khakhria

Mr. P. Taylor

Witnesses:

Mr. C. Bown, Chief Officer, Health and Community Services

Dr. S. Chapman, Chief of Service, Surgery

Mr. O. Hasan, Financial Recovery Director

[13:58]

Deputy R.S. Kovacs of St. Saviour (Chair):

Hearing with the Chief Officer for Health and Community Services in relation to the States of Jersey Annual Report and Accounts 2023. I would like to draw everyone's attention to the following: this hearing will be filmed and streamed live. The recording and transcript will be published afterwards on the States Assembly website. All electronic devices, including mobile phones, should be

switched to silent. For the purpose of the recording and the transcript, I would be grateful if everyone who speaks could ensure that you state your name and role. If we can begin with introductions, I suggest that the Committee Members introduce ourselves, followed by the Chief Officer and their team. I am Deputy Raluca Kovacs and I am the lead member for this review. I should note that the Members of the Committee who hold ministerial positions relating to this subject area are not participating in the hearing or review. If we can introduce ourselves.

Mr. G. Phipps:
On Graeme Phipps, lay member of P.A.C. (Public Accounts Committee).

Mr. G. Kehoe:
Glen Kehoe, lay member, P.A.C.

Mr. P. Taylor:
Philip Taylor, lay member.

Mr. V. Khakhria:
Vijay Khakhria, lay member.

Deputy D. Warr of St. Helier South:
Deputy David Warr, committee member.

Comptroller and Auditor General:
Lynn Pamment, Comptroller and Auditor General in attendance.

Chief Officer, Health and Community Services:
I am Chris Bown, not Brown, Chief Officer, Health and Community Services.

Financial Recovery Director:
I am Obi Hasan I am the finance lead in the change team and the Financial Recovery Director.

Chief of Service, Surgery:
I am Dr. Simon Chapman. I am an A.&E. (accident and emergency) consultant, but I act as the Chief of Service for the Surgical Care Group, so I have oversight of all the surgical facilities, including intensive care, radiology, and dermatology.

[14:00]

Deputy R.S. Kovacs:

Thank you. I would just like to draw your attention to the fact that we have one hour scheduled for this hearing and a few areas of questioning. Therefore, I would please ask to keep the answers concise and to the subject and I will start the questioning area with subjects around the health funding. Therefore, please can you provide further details on the funding pressures and key areas of increased costs that the Health and Community Services Department faced in 2023? What measures were taken to address these pressures throughout the year and what ongoing plans are now in place to meet the increasing health costs?

Chief Officer, Health and Community Services:

Obi, do you want to talk about the drivers of the deficit?

Financial Recovery Director:

Yes. So back in the beginning of the year, in February last year, when we first came, we realised that there was a very rapidly deteriorating financial position that had not been realised at that point in time. When we started looking into it, we realised that there was a lot of moving parts and we had to do a piece of work that we called “the drivers of the deficit”, which is understanding the underlying cause of what is driving it, rather than just fixing the problem quickly and then going away and then it come back again. What we understood was there was 5 or 6 things that were major issues that had been there systemically for quite a while. One of those was the recruitment and retention problems that Health and Community Services faces, and the Island faces in general, which causes it then to rely on very high-cost premium agency that costs about, premium-wise, anywhere between 75 per cent to 100 per cent premium on a nurse or a doctor if you cannot employ them substantively and you bring in agency staff. That was a major driver to the deficit, we found. That was one. The second one was also on the lack of capacity to deal with large procurement contracts, to deal with them in a commercial way and really extract best value for money and also buy better. That requires resource. That requires proper procurement systems to do so. We found they were quite weak and that needed addressing. That meant that very significant contracts were tendered without real scrutiny and being able to buy at best there. That was another big opportunity we identified and we put that as part of our plan there for recovery, so informing how the plan was built. The third area in particular was just about having financial grip and control and about just having systems where we reduce wastage in areas where there is not enough scrutiny around some of the expenditures, especially around what we would call discretionary expenditure. Sometimes it is too easy to spend that sort of money. So we had to put in some very quick control measures where things were authorised properly as we went through it. The fourth area was on income generation. We found that there was a productivity issue as well in the way we worked, both clinically and administratively,

which is within, for example, theatre time or within that we can treat a lot more patients for the same amount of capacity that we have and for the same amount of money, than we are, and therefore paying more overtime to people to do so. So there was a productivity delta, if you like, we found there was a productivity opportunity, we could improve productivity significantly. We came up with that number or how we could do that and how we would go about doing it. That is another driver, which means that we could treat more patients, bring waiting lists down, for the same amount of money used more efficiently than having to spend more money to do it because we were slightly inefficient. That is the fourth area. The final area was income. Income generation, where we have a great opportunity on this Island to do both public service but also to treat private patients. Offering a good private patients service alongside the public patient is another opportunity we identified and the Island has got a lot of opportunity to do so and to be organised. Those were the 5 key financial areas. Then there were the structural issues we found, which was historically where things have been funded non-recurrently, in other words money is given to do a service for a period of time as a pilot. That money then stops, but the service still requires the funding to continue and is not sustainable. There was a number of services over the last 3 years, since 2019, that were developed. We calculated the impact of those was between £17 million and £20 million of costs that had entered services that were established. We call those the structural deficit. Then the funding had stopped and the costs were still there without any budget being available to run them.

Chief Officer, Health and Community Services:

So that gives an illustration, of course, that the underlying problem and the underlying run rate around deficit was there way before last year. It had been masked through the non-recurrent funding that was made available to the department for particular things, and so COVID is a good example, and the Jersey Care Model funding. But those projects finished but, for example, a service that was funded through that money was the stroke service. We need a stroke service in Jersey and therefore there was a decision at that time to continue to provide that service, which was a sensible clinical and managerial decision. But the funding that was used to start it up had then disappeared as well. So we saw a number of those when we arrived last year that had meant that the underlying run rate of deficit was there, we think going back to 2019.

Mr. P. Taylor:

So that suggests to me, some of those reasons, a complete lack of financial control in the budgeting process because you are telling me that it was discretionary spending, spent without scrutiny, and the budgeting system was inadequate. Is that what you are telling me?

Chief Officer, Health and Community Services:

Yes, there was a lack of control in the way that I would expect it to be. The other thing is about how the Government planning process works. So it is about providing money for a non-recurrent basis and then things stopping. So I think there is a real issue, not just about financial control, just about how the system itself works and the funding mechanism for, I can only talk about Health, but for Health is something that is not sustainable. We know through the work that has happened since and the plans that we have this year that our Financial Recovery Plan, which is a £25 million plan, is not going to be sufficient to deal with the financial gap that is going to emerge in Jersey over the next few decades. To be honest, within the next few years that the work undertaken by the economists here shows the same pattern as you would expect to see globally about rising costs of healthcare and national income not keeping up. But we know at some point that we Health would consume the whole of the Government's income in not that short a period of time. So there is a bigger issue, which is a political issue, of course, not an issue for us, around how Health is funded going forward in Jersey. Because it is inevitable those costs are going to rise for a whole range of reasons. So our plan for 2025, which we were implementing last year and made £3.2 million savings on last year, and we have plans for £5 million this year, is going to help contain the growth of cost and expenditure, but it is not going to be sufficient. So, this year, we are forecasting a £24 million deficit, which the Minister for Health and Social Services has obviously been discussing as part of the Government Plan, but it is only in some ways a sticking plaster to a much bigger problem for Jersey. As I say, we are not alone globally, same in the N.H.S. (National Health Service), around health spending. So it is important I guess to put our £25 million in that context.

Deputy R.S. Kovacs:

Then we noted a bit of a pattern in expenditure year on year. So if you look at figures for 2019 was £207 million expenditure, 2020, £240 million, 2021 was a bit less, £228 million, but then we come again to 2022, £247 million, and 2023 is the highest we have seen so far, is £330 million. Then you say that this year as well, we are looking at having £24 million deficit. What was the reason of having such a high figure and do we expect this pattern to continue year on year to have increased expenditure?

Financial Recovery Director:

Yes, that is partly what I have explained, what the drivers of the deficit does is to answer exactly that question. When you look at those numbers, what you also have to realise is that when the Government Plan is done, it is done before any pay awards are done or any service transfers are done. So when we look at figures, I would urge some caution, which is 249 is the number you will remember from the 2023 budget. The budget was 270, it was not 249. The reason is simple, because at the time that the Government Plan is done, we do not know what the pay awards are going to be. What you then have to do is there are allocations made, the budget is 270. That is the

baseline number we should all be talking about. The 270 then turned into 302.5, which is where the 32.5 deficit came from. That deficit, the 32.5 deficit, that is what I have described as the 6 things that have been driving it. But what has happened in 2023, to answer your question very directly, what is different to 2019 is Jersey's healthcare system has reached a tipping point. There is only so much you can mask the underlying problem by providing one-off funding, which is what we have done since 2019. That is begins to run out and services are established, which have globally an activity increase, inflation rises, which are far more than the funding that you get. Drugs inflation is running at 12 percent, 15 per cent R.P.I. (retail price index), we have not been funded anywhere near that. The only response that the health system has without solving its funding issue is to look for efficiencies within the system. When you have the structural issues that we have or recruitment and retention problems, it is not just budgetary control, I would say, Philip, it is not just about cost control. You are absolutely right, budgetary control grip was definitely one of the issues that we have had to address. But there are fundamental structural problems here about attracting people to this Island, making it easy for people to come, getting the agency out that is not giving us the productivity we need, costing us twice the amount that people that are living here could be doing. Getting proper procurement systems in place so we can buy better. Those are all the things that we should be able to do to mitigate it. But, as Chris has then said, what that will do is help solve a £25 million to £30 million problem, but 3 studies, 3 pieces of evidence that I will point to that we have had before even we arrive at that, Health Economic Unit has done a study that showed the expenditure rising so that over the next 24 years it would consume the entire Jersey budget. When the J.C.M. (Jersey Care Model) was done, there was a piece of work done at that point in time that also said that the costs are going to rise much faster than income.

Mr. G. Phipps:

But some of these would be trends you would expect year over year over year. The reality when I look at the budget, 2020 was 240, 228, 247 to 2022, so it is fairly flat. Then we had a big increase in 2023. So we are trying to understand, not the budgeting stuff, but on an absolute basis why the big increase in 2023 and is this going to be something that is going to be ongoing or is it unique to 2023, just absolute numbers, forget about budget process.

Financial Recovery Director:

Yes. It is not the process. So the first thing I described was the unfunded services. Between £17 million and £20 million of unfunded services. In other words, those were services that had budget before 2023 and then the budget began to drop off.

Mr. G. Phipps:

I am talking about absolute numbers. I am not trying to talk about budgetary. I am just trying to be clear. The absolute expenditures from 2020, 2021, and 2022 were fairly flat. And then we saw a significant absolute expenditure level going up in 2023. I am just trying to understand, not the process of budgeting, but the absolute increase of about 35 per cent increase in one year. So just total numbers, what happened in 2023 that the numbers went up so much?

Chief Officer, Health and Community Services:
From 2022.

Financial Recovery Director:
I am trying to understand the question, I beg your pardon.

Mr. G. Phipps:
I am sorry, 2022, to be clear, 2022 is 247. 2023 was 330. That is a big increase. The previous 2 years were fairly flat. So we had seen fairly flat expenditures for 3 years in a row and then a big jump in 2023. So I am just trying to understand what happened.

Chief Officer, Health and Community Services:
So was that expenditure or budget?

Mr. G. Phipps:
So I am not talking about budgeting because we can always do that. I am talking about what really happened that drove it up and is this something that is going to keep going is there an issue, what is happening?

Financial Recovery Director:
So the biggest issue here was the agency staffing went up very significantly between 2022 to 2023 and we went through, I think from using very little, I was not here in 2022 so I do not remember what the numbers were, but in 2023 we went up to anywhere between 160 to 180 agency staff. That cost us. Our agency spend increased in that year from almost nothing to £27 million. That was our agency spend in 2023. On top of that, we had additional hours where a lot of substantive staff, because even that was not enough, we did £4 million more in overtime additional hours that we had not done before.

[14:15]

So that was £30 million. The pay awards were I think around £10 million to £15 million, I will have to refer to the number, but there was pay awards as well included in that number which is obviously an absolute ...

Mr. G. Phipps:
But every year you get payables, you know, I am just trying to understand what is anomalous.

Chief Officer, Health and Community Services:
Yes. But I do not think there is big pay awards before. The pay awards significantly went up in 2022. I do not think there were big ones before that.

Financial Recovery Director:
Yes, they did go up, yes, there was a significant pay award in 2023 as well, as there is in 2024.

Deputy R.S. Kovacs:
To what extent were the essential services maintained while structural overspending and budgeting forecasting concerns were addressed?

Chief Officer, Health and Community Services:
All essential services have been maintained. So what we have said about the Financial Recovery Plan, this is not about cutting services. This is about addressing waste and improving financial grip. So this is not about cutting services. Clearly, if we are unable to secure the £24 million that we are looking for this year, then we would need to make £24 million worth of cuts. Now that would impact directly on patient services and it is clearly a politically unacceptable position to the politicians because it would just hit patients directly. I would say money is easy, saving money is easy if you do not care about the outcome. But we obviously do. So there is no service that is been hit through this. The issue though of course is that, even with the £24 million, that is about standing still, that is not about any new services. That is not about an additional diabetes nurse or additional orthopaedic surgeon. That is just doing what we are doing now. We know what we are doing now is not what we need to be doing. We know that through the Hugo Mascie-Taylor report back in the autumn of 2022, there are things that need to happen to strengthen our services. There are new things happening every day. We know that this year we have just agreed a drug for cystic fibrosis that is going to cost £200,000 per patient. There is one patient; there could be 3, there could be 4 of those. It does not take many before you are seeing a significant rise in cost. So the £24 million just leaves us, if we were to get it as part of the Government Plan, leaves us at a sort of standstill. It is not about developing services for the people of Jersey. It is just staying as is.

Chief of Service, Surgery:

If I just add something I think to your question as well, so through my desk, some of the consumables. So if we are using equipment or kit, the costs for that have gone up. So there is worldwide inflation that has definitely hit us as well. So we are a small fish in terms of the equipment that we use and, although we use some of the negotiating factors that the N.H.S. have for us, we still fluctuate in regards to what is happening with the cost pressures.

Mr. G. Phipps:

We can come back, if you can do a bit more thorough evaluation, because every year there is inflation. Every year there is things.

Chief of Service, Surgery:

But there has definitely been a jump.

Mr. G. Phipps:

This was a unique, you know, we had 3 years running, it was fairly flat. There is inflation. There is all this stuff is happening. Then we saw a 35 per cent increase in one year. So I am just trying to understand, I get part of it was you had to do a whole bunch of consultants, extra consultants and that drove your cost up £27 million, but that does not account for the total increase. That is all. You can come back to us and give us later.

Financial Recovery Director:

There are a couple of other factors here as well that will come into play.

Mr. G. Phipps:

We can do that later, but if you can maybe do that in a written response, just a factor analysis of what was the big drivers and then so we can just understand whether this is a recurring, and hopefully not, hopefully you will be able to recruit people for example.

Chief Officer, Health and Community Services:

That is the plan, yes.

Deputy R.S. Kovacs:

Talking about the key findings of the Financial Recovery Plan, which you find the most important ones and how it aims to stabilise the financial situation of the Health Department to a more sustainable level.

Financial Recovery Director:

Yes. The Financial Recovery Plan we then developed on the back of this was looking at all of these drivers and we have identified £25 million of savings over 3 years, we are said in 2023 we would deliver £3 million, we delivered £3.2 million last year. In this year, we are expecting to deliver £5 million, the year after we expect to deliver £8 million, and in 2026 we are looking to deliver £9 million.

Deputy R.S. Kovacs:

Which are the main areas of savings in effect?

Financial Recovery Director:

So there are 7 workstreams in the Financial Recovery Plan and they relate to these drivers that I have talked about. So, on workforce, agency reduction in particular is £6.5 million of that this year. Overall it will be £12 million in total, which is the premium spend that we have in agency over the 3 years. The second area is the non-pay procurement, buying better and contracts, that is worth another £3 million to £5 million over the 3 years. Then we have income generation, which I have talked about as well earlier. We have £3 million of that this year, another £2 million of that next year, and more, so there is £5 million to £6 million of that on top of that there. Then finally we have, on drugs, and that was one of the big drivers, drugs, mental health, social care. Those were the big inflation drivers. It is trying to buy by tertiary care contracts with the N.H.S. Those were very significant inflation factors that hit us in 2023. That is where a lot of the pressure came from as well. It is looking to procure those and buy those better through competitive tendering. That is the total programme. Then the final element of this is establishing the budgetary controls and the infrastructure control, which is procurement controls, recruitment, retention, better time to hire, being able to reduce that, it is taking quite a long time for us to do so, and generally having proper financial controls and budgetary accountability at care group level.

Chief Officer, Health and Community Services:

The latter point is important. We sort of established when we first arrived last year the clear governance rules and arrangements about holding people to account for budgets and providing support when they needed support through some special measures types of activities. So gripping control is important. I think the other thing, your question about is it going to continue. We know from various providers in the U.K. (United Kingdom), healthcare providers, hospitals, that use for tertiary work, one for example is looking to increase their prices by another £1 million next year, and so we are seeing those pressures arise. The N.H.S. is clearly under pressure, so they are often looking to increase their income as well. So it does not need many providers in the U.K. to say we are going to add another £1 million to your bill before ...

Mr. G. Kehoe:

Can I just ask why we use providers in the U.K.? Why are not we our own independent source of that?

Chief Officer, Health and Community Services:

We are just too small, so we do not have the critical mass of the expertise. There is just not enough patients in Jersey.

Mr. G. Kehoe:

Would it be better as a Channel Island rather than just ...?

Chief Officer, Health and Community Services:

No. The reality is that all Island jurisdictions, I have worked in the Caribbean as well, have the same challenges as we do. So critical mass is an issue that we just do not have the volumes that would ensure a particular doctor could keep up their skills in a particular area. So we are always dependent on the larger jurisdictions. But, as I say, those prices are going up, mental health packages of care is a significant issue and the top up on social care as well is a big issue for us by many millions of pounds.

Deputy R.S. Kovacs:

Just in this area, because you said we do not have the in-house skills used to be in health, done a very good programme of paid training and in paid work on social care and nurses, which proved the efficient. Are you looking to expand on this kind of training in house?

Chief of Service, Surgery:

Can I just answer that? So if you look at what is happening in the U.K., they are centralising significant numbers of services, they have tertiary centres that do all the cardiac, tertiary centres that do renal. We cannot provide all those services, although we provide the sort of primary and secondary to a level care, say for cardiology, any invasive cardiology will go off-Island, we just do not have the numbers and the support around that. So even if we had the training, the number of cases that we would do per person to maintain that service is just not there, not only from an economic argument, but also from a governance and safety argument.

Mr. G. Kehoe:

So would that lead into then your structural way, these sort of services you would just outsource effectively to the U.K..

Chief of Service, Surgery:

Yes, but then, if I look at cardiology, so we would send a lot of people off-Island for invasive investigations. But now technology has changed that we can do some of that through radiology. So now we can keep those patients on-Island that do not need the invasive, but it means the pressure goes on to our radiology services, which are not funded for that additional capacity. So it is always a constant balance. So we can solve some of the problems by boxing clever with how we deliver the service, but ultimately we always will need a link both from quality assurance and from a service provision from the U.K.. and then we are at their beck and call in terms of the pricing for that unfortunately.

Deputy R.S. Kovacs:

I will pass on to the further ...

Mr. G. Phipps:

One last real quick question on this, so I am assuming that, given you said these things are changing et cetera, you are going to be able to have trend analysis over years to see which trends are unique and which ones are consistent.

Chief Officer, Health and Community Services:

Yes.

Mr. G. Phipps:

Because this is what I was looking for.

Deputy D. Warr:

Now, I have the next serious questions. Just one burning question in my mind here is about recruitment and retention. What is the differential between keeping somebody, paying for someone to get their housing sorted out and being here, as opposed to the cost of the agency staff member coming over? What is it, a 50 per cent, I do not know, if one cost you £100,000, would the other cost you £200,000? Just the scale.

Chief Officer, Health and Community Services:

If we were to pay for their ...

Deputy D. Warr:

So if they come over to Jersey and we have better recruitment retention, you talked about some big numbers in terms of the savings that can be made, but the fact that this is ongoing, on a weekly

basis, are we talking about £1 million a week this is costing because we cannot retain and we have not got the packages in place to keep people?

Chief Officer, Health and Community Services:
Yes, it is close to £1 million.

Financial Recovery Director:
Yes, it is about £1 million a month, yes.

Deputy D. Warr:
A month, wow.

Financial Recovery Director:
About £1 million to £1.5 million a month. So our premium that we pay currently is about £14 million, £15 million a year, but it is rising.

Deputy D. Warr:
Yes, right.

Chief Officer, Health and Community Services:
The challenges, I guess, are not just in the health sector. I think they are well known. But one of the things that we hear, whether it be doctors or nurses or anyone else, allied health professions, is the cost of living here, and particularly housing and rent. Childcare is prohibitive. Although we pay staff more than they would in the National Health Service, that often it is just not enough.

Deputy D. Warr:
That is not enough, yes. Okay, I will carry on with some of my questions. So please could you advise the Committee on what lessons have been learned from the financial challenges faced by the Health and Community Services Department in 2023 and how will these lessons inform future financial management strategies and forecasts within the Department? So I feel you have kind of answered a bit of that. I do not know if you want to develop on that a bit more.

Chief Officer, Health and Community Services:
I think the drivers of the deficit work gave us an insight into some of the bigger deficit drivers, but there are other things that we noticed around financial systems. So things where we are still receiving invoices to pay that come out of the blue from sort of 2 years ago and where we have not taken account of those in the forecasts because we were not necessarily expecting that to happen.

We have become wiser now and realise that in Jersey that might happen. We take account of that. So I think we have learned that with some of the systems, they still need strengthening. So we are reliant on our Treasury colleagues for finance and obviously our workforce people services for hiring processes. We are working very closely with those 2 Government departments because we are very dependent, as we mentioned, on those working effectively, to be able to reduce the time to recruit, for example, the length of time between going out to advert and somebody starting is far too long and we lose people because it takes too long. So close working relationship with the Government People Services and the Treasury is really important and that is ongoing. Particularly around procurement, again, the procurement team in Treasury are depleted as they struggle with resource themselves. So we are having to look to augment that because it is so critical to one of our drivers is to reduce the costs of some of these big contracts. But bringing in our working with the Government procurement people, bringing in some procurement specialists to help us do that, because it does not exist within Government because it has been shrunk to the point where there is not anyone there to do it.

Mr. P. Taylor:

I am fascinated, because I would have thought where you are procuring is a very specialist area and I am surprised the people in the Treasury would have the specialist knowledge they need to make procurement that you having to undertake.

Chief Officer, Health and Community Services:

I think that it is specialist. The thing is, if they work with people like Simon and others that I think having the sort of commercial procurement experience is important because there is plenty of experts in health that can talk about the specification and what is required. So I think that that is where we are focusing on is the procurement expertise so they can work with people in Health, the doctors, the nurses, and others to get the specification right. But we need some commercial edge really to negotiating some of these big contracts. Some of these contracts are £10 million worth of contracts. These are not small contracts. We believe there is particular value to drive out of some of those contracts.

[14:30]

Deputy D. Warr:

I have a series of questions, but I think I am going to just drop them down to one more on my list. But just one observation really is paying agency staff double what the people on the ground are being paid, that must cause some serious resentment.

Chief Officer, Health and Community Services:

Now, remember, they do not themselves get double because the agency takes the whack. But, yes, absolutely it does. It does anywhere, it does in the U.K.. Some people choose to work on an agency basis because they enjoy the flexibility . Of course, if you are working agency, you do not get annual leave, you do not get sick pay, you do not get all the benefits you would as an employee. But because of the rewards, then people will tend to do it. But some people choose it because it is flexible.

Deputy D. Warr:

All right, so my ...

Chief of Service, Surgery:

I would add to that. In a system that is reliant on a degree of agency, those people are very good technically. But they are not invested in the service design and resilience of the service that we provide. So we lose out doubly because the future planning is not there. They can come and go pretty much as they please. The technical role is great, but using their experience for this is the 2-year plan, 3-year plan, 5-year plan, so that we can improve our health delivery, we do not get that from them because that is not the role they are employed for.

Deputy D. Warr:

It comes back to the sticking plaster thing, does it not? So should this structural deficit in the Health Department have been addressed earlier by the Treasury, do you feel?

Chief Officer, Health and Community Services:

I guess that is a political question for the politicians to answer. I think it would be handy if it had been, but it has not.

Deputy D. Warr:

Yes, it is water under the bridge.

Chief Officer, Health and Community Services:

But we know about it now, so we cannot pretend it is not there.

Deputy D. Warr:

Okay. I will hand over to Philip.

Deputy R.S. Kovacs:

It is Philip, yes.

Mr. G. Kehoe:

Thank you. I see you have a project management delivery team. What does it do?

Financial Recovery Director:

Does the the doing. So, the idea behind the project management delivery team is, when we come up with a programme, such as an improvement programme, our normal managers and clinicians on the frontline are firefighting day-to-day just to keep things going. There is no time to sit there and do improvement, no matter how good that plan looks on paper. So we have to bring in some capacity to work alongside them to do the doing, rather than sitting there reporting on it. That is the reason behind having those people. That has been a real recruitment challenge as you would expect.

Mr. G. Kehoe:

That was going to be my next question. How is it resourced? Where do they come from?

Financial Recovery Director:

Well, it is very hard to get those people who will come in and turn around an environment like this and do the doing. You will get lots of project managers, that is easy to find. That is not what we are looking for. It is not project managers. We are looking for doers, project delivery. That is why I call it the P.M.D.T. (project management delivery team). The clue is in the word "delivery". So they get out there, work alongside the general managers on the operating teams and alongside their clinicians and say: "What do you need doing and how can I help you make it happen? Because I know you are firefighting every day." Those are very difficult roles to get. I can usually get them in the U.K. because the pool is much bigger. I have really struggled to get them here, but we have secured 3 good people who are really making a difference, but we need some more.

Chief Officer, Health and Community Services:

The other thing is, for context, there is always a question that comes up, or certainly it has been a feature of my daily life, we just have to remember that the numbers of managers in H.C.S. (Health and Community Services), everyone says there are loads of managers in H.C.S., is 1.5 per cent of the total workforce. That, if you benchmark that with the N.H.S. or anywhere else, France, and particularly any insurance-driven, like the United States, where it is about 20 per cent, I do not know, the management cost. So we have got enough to sort of manage the day-to-day operations of the business. But anything around turnaround or any additional capacity that you need is not there. Also, of course, people need to have the skills, even operational staff need to be developed and have the skills to do turnaround. If that has not been necessary in the past in Jersey, this is also

new to them. Some will have experience, some will not. So we needed to develop people as well to sort of have the culture of turnaround. Remember, we are not just doing a financial turnaround here in Jersey, we are doing a clinical turnaround and the governance turnaround. Back to the Hugo Mascie-Taylor report. So there is a multi-organisational turnaround that is happening. So that is why additional capacity has been needed.

Mr. G. Kehoe:
So an obvious question, of course from an accountant, is how much do they cost? But a better question is what do they cost and are they paying for themselves?

Financial Recovery Director:
Yes, that is a much better question, I would say. I think I would turn that to say, what is the value they add. So let me answer it that way. What is the value they add; it is not what they cost. So the plan is to deliver £25 million over 3 years. These are people that will be here long after we have gone. The budgeted cost of a delivery team, which is not yet fully established, is 546 I think, it is 546 I think is the right number.

Mr. G. Kehoe:
546,000?

Financial Recovery Director:
That was budgeted cost for the year. The delivery is £25 million over 3 years. Last year delivered £3.2 million, the programme started, went into delivery mode. It was planning it for 3 months, went into delivery mode in October. Over the 3 months it delivered £3.2 million last year. There was hardly any cost of this team at that point in time.

Mr. G. Kehoe:
So that £3.2 million, where did they find the savings or the improvements should we say?

Financial Recovery Director:
Yes, good question. I will give you an exact number. So the savings were again, as you would not be surprised to learn, would be of the drivers of the deficit I talked about, which is where you would go. So in workforce, we had nursing staff and medical staff, that was £600,000 between those 2. That was where we were converting agency to become substantive and recruiting people. So we got a little bit of conversion, a bit of movement last year early on. Of course we want to do a lot more of that this year. It was more than that. It was £900,000 in total. Then we had non-pay cost reductions. So where we were looking at discretionary spend, clamping down on that, looking at

contracts where we could buy better, specifically on drugs, very expensive, high-quality drugs, expensive branded drugs, switching them to generic drugs, which costs a lot less. That was £1.2 million in total. Then we had some income generation where we were looking at again one of those 7 work streams that I talked about, where we were driving more work through surgery, through surgical income, and earning more money through the private patient work while still doing the public, bringing down the public waiting lists.

Mr. G. Kehoe:

Sorry, from a non-inflationary basis, that £3.2 million is an annual saving going forward?

Financial Recovery Director:

It is, yes, that is right. That was delivered last year. This year, the plan is then to deliver £5 million. Again with the same themes. The reduction in agency, the increase in income, the reduction in non-pay expenditure. It is the same thing.

Chief Officer, Health and Community Services:

We are seeing a net gain as regards to recruitment and wasted, so we are recruiting more people than we are we are losing. So I think last year we managed to recruit to 200 new posts. This year we are aiming for more than that. But we have now reached the point where we are losing less than we are we are gaining, so it is a good sign. Our turnover rates, our voluntary turnover rates, is remarkably low. A lot of people say to me everyone is leaving because it is so terrible. It is absolutely, if you look at the numbers, it is about 4.5 per cent voluntary turnover. If I was working, which I did in London before this, I would be expecting a voluntary turnover of some 25 per cent. It is really low. I have never seen a place with such a low turnover. It does not feel like it but it is incredibly low. But, nevertheless, we still have become so dependent on agency, and locum doctors can be incredibly expensive, as you know, Simon. We can spend, there was one nearly £500,000 a year of cost to us. That person is no longer with us but you can see it does not take many of those types of employees to start to get a financial problem. But, also, let us not forget that we are not recruiting or using agency and locums for the sake of it, we need these people to keep services safe for the people of Jersey because, without these people, we would not be safe. So it is not a waste in that respect.

Mr. G. Phipps:

Do you have a plan to drop it though? I note in 2023 the budget turned out to be about £330 million. What is your outlook for 2024? Are we going to see an absolute number that is going to go down or flat or up? What do you think? What is your best guess of how much we are going to need to spend in 2024 year end?

Chief Officer, Health and Community Services:
Year-end position forecast is what in total now for the 2024?

Financial Recovery Director:
We are looking at the £24 million, so we are looking at 330.

Mr. G. Phipps:
So flat 2023-2024. At least you have been able to control. It is important to understand that. Okay, thank you. Sorry, one other quick question, Chris.

Financial Recovery Director:
That is before pay awards, of course, those things just get added on.

Mr. G. Phipps:
Well, I am just looking at like for like. I think you said that you had 1.5 per cent of your total staff were management. Could you send us some org charts and data just to ...?

Chief Officer, Health and Community Services:
Yes. Well the reason I can remember it is I have just answered a Freedom of Information request on that, so I have written it all out, so I will send that.

Mr. G. Phipps:
If you could, just so we can understand that, because that is a low number.

Chief Officer, Health and Community Services:
Yes, it is low, yes.

Mr. G. Phipps:
Yes, thank you. Sorry.

Mr. G. Kehoe:
I think you told us the overspend this year will be around £24 million and the reasons are the same as they have been in the past. Having done this work, would you anticipate where you will be making savings and you have identified that to us in your introduction. Are there any other areas where you think savings could be made?

Financial Recovery Director:

Are there other areas, yes, yes. So the programme is constantly looking for new ideas. It is a constant pipeline of work. Because no plan, however well it is planned, goes exactly to plan. So we are always replenishing with other schemes all the time. Income generation is one of the big opportunities that we have not really tapped into fully and the angle we have come from is just taking the ones we know are just missing income that is sitting there for us to take. But really growing a private practice alongside the public benefit. An example of that would be, it is in the public domain, we did that with M.R.I. (magnetic resonance imaging) scanners. We invested in the second scanner. That was a risk we had to take. But we took a judgement call on it, did a commercial investment despite the deficit, but the clinicians really worked with us on that and they are guaranteed that they would, not only bring down the public waiting list from what it was at 26 weeks, it was running at, right down to 6 weeks, very quickly. They did that really quickly. It has gone up slightly again, but it will come down again. But they said they will pay for that through generating also increased demand from private income. That really worked well and it exceeded the income. Those are the sort of ideas that come from the frontline that people like us need to be listening to. We invest, we take the risk, we invest in those ideas and grow it, and I think that is a big untapped opportunity on this Island.

Chief Officer, Health and Community Services:

That is a good example of how private and public can work together, because, without the private income, we would not have been able to reduce the public waiting list, because it was the private income that allowed us to pay for the staff to do the public work. I do not know if the Committee is aware, the Government have published a Private Patient Strategy, which I think is on the Government website if anyone would like to read it.

Financial Recovery Director:

I think the other area also is in the much better procurement and buying. I think there is again a really big opportunity for us to consolidate a lot of how we procure all these different contracts off-Island, on-Island, I think there is a big opportunity there as well.

Mr. G. Phipps:

I mean, that is an obvious economy of ...

Mr. P. Taylor:

Coming to my colleague now, so we are moving into this area.

Mr. G. Kehoe:

That that leads me on to that £17 million spent on 16 on-Island providers. Are you able to tell us who they are and then what those funds and services are that those partnerships cover?

Financial Recovery Director:

Yes, I can tell you which categories those fall into. So there are workforce, so they will be on-Island agencies that supply us with workforce, with people. That is one of them Care homes. That is another big one. Mental health facilities that are on-Island. A lot of it is care homes. Then there is community services. That is another.

Chief Officer, Health and Community Services:

So we fund, we commission family nursing, okay.

Mr. G. Kehoe:

Do you have any sort of like, is there a standard like service level agreements with each of these to understand what they do and how is that managed for each level of that sort of service that is provided?

Financial Recovery Director:

Good question. I think that is where we have the areas of opportunity where we can performance manage much, much better to get better value for money.

Mr. G. Kehoe:

Okay, that is enough for me.

Deputy R.S. Kovacs:

Can we just ask as well, do service level agreements exist with these providers and commissioned work?

Chief Officer, Health and Community Services:

We have service level agreements, so, for example, we commission, not just family nursing, but the hospice and various other charities to provide services to the people of Jersey. The reviewing of those commissioning arrangements and reviewing of the contracts or the S.L.A.s (service level agreements) with all those organisations is important for all parties, so everyone is clear about what is expected of them.

[14:45]

Deputy R.S. Kovacs:

How are these managed, these S.L.A.s?

Chief Officer, Health and Community Services:

They are they are managed, we have a small commissioning team. When I say team, it is 2 people that will work on commissioning. There has been a review undertaken recently by the auditors and I think again the Minister for Health and Social Services is also looking at how those arrangements should be for the future. But, at the moment, H.C.S. commissions those services on behalf of the Government.

Deputy R.S. Kovacs:

We are moving to the overall budget and Graeme will ask some questions.

Mr. G. Phipps:

Sure. Some of these questions you may be able to answer and some are in the context of the executive. So, from your context, I will get your feedback. So, given the ever increasing pressures for additional healthcare expenditures we see worldwide, what is the process for determining your overall budget allocation for health and which is directly impacting people and other categories? How does how does that process work and do you feel you are being heard fairly and getting it right?

Chief Officer, Health and Community Services:

Yes. So from our, internally within H.C.S., we go through a budget-setting process as you might expect to see anywhere. Obi will lead that on my behalf and will undertake a budget-setting process and there will be a challenging process. Ultimately, of course, it is a matter for the Government Plan and the Government to decide how much funding needs to go or they would like to put into health services. So we will say: “This is what we need for next year based on our budget setting”, and indeed this is what the process is at the moment around the infamous £24 million that we talk about. This is part of the process of the Council of Ministers deciding whether we get that or not. So, for 2025, as part of the Government planning process, there will be a decision about the funding that we will get, not just to cover the cost of this year, but what our budget will be for next year, and we will be expected to obviously live within the budget set by Government for H.C.S. next year. So it is very much a Government decision. So we work closely with the Treasury so they understand what we are we are looking for, and I suppose inevitably we are probably always looking for more than is available, like most Government departments, I am sure. So that would be the process of this year, the Government planning process will determine what we get as in Health, in H.C.S., for next year. This is through the Government.

Mr. G. Phipps:

So it says item by item specific, it is not just year over year as we did last year and it is rolling forward, it is very specific?

Chief Officer, Health and Community Services:

Not as specific as perhaps you would see say in the U.K. when health services are commissioned in detail, so I would know, for example, as the chief executive of a hospital, how many hip replacements I would be expected to do, at what quality, at what cost. It is much more of a block contract, you would say, rather than something that is specific. So it is more here is £300 million, you need to provide the services for £300 million. We then have to work out how we best do that.

Mr. G. Kehoe:

What happens if it is not enough? So it is not going to be enough, what do you do?

Chief Officer, Health and Community Services:

If it is not enough, then we have to cut our cloth, I suppose. So what it means is that quite often, I think, what we have seen in the past is there has been requirements for service developments, things that Health would like to do, and there has just not been enough money, so you just do not do them. So we do not necessarily modernise something because we cannot. There is not the funding for it. It would be nice to have an obesity dietitian in a particular specialty because that is best practice, well we have not got enough money for that, so we cannot do that. So it generally feels to be things that, at the moment, because we have got opportunity to make savings without impacting on clinical service, as we describe, that £25 million does not impact on clinical service, and what suffers is service development. Now, clearly, if we did not get enough to the point where the £25 million planned, we would have to start finding cost reductions elsewhere. At the moment the expectation is, with the £24 million that we have asked for, that we can continue to provide what we are providing now, no more, but what we are providing now. Alongside that, we need to deliver over the next 3 years the £25 million savings. So we would just have to make decisions, as anyone, any other Government department would, about making cuts to fit the money that is available to us.

Mr. G. Phipps:

Do you think you have made enough changes so that you will not? Because you are responsible for putting a budget together and seeing that it is met, and when you have all these busts, that is really an internal thing of not forecasting correctly. Do you feel now that you are in place that we should not have a lot of surprises?

Chief Officer, Health and Community Services:

Rises, yes. Obi, what is your view?

Financial Recovery Director:

We have now much tighter process. It is not perfect still because we are still reliant on systems being up to date and being accurate to pull the information from to be able to do it. But we have learned enough about the inaccuracies in the system to be able to allow for those. But that is what we are working on at the moment, but we have a lot more control.

Mr. G. Phipps:

Do you think you get a fair shake? This whole budget allocation, you are saying if we do not get this money, here is the trade-offs, we have to give that up. The Government is looking at other arguments, are you getting a fair understanding, enough time, so they really understand the implications of not putting more money in towards Health versus other kind of things that are out there?

Chief Officer, Health and Community Services:

I am pretty confident that, yes, we have made the case clearly. The Minister for Health and Social Services has made the case. We obviously have been working with the Treasury so that the Treasury understand the situation. So I think we have done certainly, as officers, done everything we can to ensure that politicians are aware of the challenges and the Minister for Health and Social Services has been incredibly supportive in that regard.

Mr. G. Phipps:

Okay, thanks. I'll pass it on.

Deputy D. Warr:

Can I just ask one real quick question? Do you think there is going to be major savings through the new multi-site hospital? Do you see that as a major saving opportunity at all?

Chief Officer, Health and Community Services:

I am not sure it will be a major saving opportunity. I think it will be a huge opportunity for improved healthcare for the people of Jersey. What might be is that the better facilities, and Obi spoke about income generation, whether we can exploit it. We have got increased capacity in the new plan for private patients and therefore private patient income, and being a nice shiny new building that might make some sense.

Chief of Service, Surgery:

So one of the things we are constrained by is the estate. So we have to segregate patients from gender. We have to segregate through elective versus emergency. Then we also have to segregate if people have infections. We have very minimal numbers of cubicles and very old-fashioned style set up of wards. So that handicaps us in terms of how we can get our efficiencies through theatre and we end up with cancellations just because we do not have the bed base. The split sites has its faults, but one of the things we need is we need a fit for purpose healthcare facility with modern wards, modern facilities for managing patients. That flexibility will result in better productivity. Now, the costings, it may not help the costings, but in terms of our ability to maintain and increase our productivity and throughput will definitely be benefited by that.

Deputy R.S. Kovacs:
Just to mention, I see we have about 8 more minutes up to the end of our scheduled time for this hearing. However, we do have a few more questions. Is your team still available for another 10-15 minutes to carry on with the questions?

Mr. G. Kehoe:
Yes, yes.

Deputy R.S. Kovacs:
Perfect, so Vijay will address our questions.

Chief Officer, Health and Community Services:
We would like to stay longer, Chair.

Deputy R.S. Kovacs:
Sure, we have more questions. Vijay will address our questions on reporting on and quantifying risks.

Mr. V. Khakhria:
Thank you. So we would like to move on from the financial side of things on to risk measurement and risk reporting, please. The Hugo Mascie-Taylor report listed some 61 recommendations, all of which have been adopted. Could you let the panel know, please, what further progress you have made in achieving these recommendations and what impact they have had on risk?

Chief Officer, Health and Community Services:
Yes. Shall I start off, and I am sure Simon will join me later. So you are right, 61 recommendations particularly focused around governance and the lack of it. We have made, I think, significant

progress. So just to give some examples from top of my head. Last year in June, we made a decision as a senior leadership team, of which Simon is part of, that we would adopt NICE guidance, the U.K.. clinical guidance, as a baseline for all clinicians to use. They have the opportunity to use other evidence-based guidelines, whether it be European or American, but only with the permission of the medical director that that is acceptable. So our expectation now is that all clinicians follow evidence-based guidelines. That was not in place before, some did, some did not. I am afraid you only need to see the tragedy of the rheumatology situation, where guidelines were not followed and what that leads to. So that was a very firm decision last year. We have strengthened our process of investigating serious incidents and particularly the learning from that. We do that on a weekly basis now. We have strengthened the requirement for services to take part in audits, particularly U.K. audits, so that they can benchmark themselves. Not just so the clinicians can understand where they sit with the national benchmarks, but also the Advisory Board, which I will talk about in a second, and indeed the people of Jersey, because they should be transparently made available publicly, can see what the quality of service is that they are receiving. I guess the other progress is there is an expectation that services undertake audit. Of course we established the Advisory Board, the Independent Advisory Board, last year. Its first meeting was in October. For those of you that have either attended or listened to it on tape, that makes everything very, very transparent, and so lots of information produced that is in the public domain. We publish all the papers a week before the board meeting. So, again, the level of transparency, which is something that Hugo was keen to see improved, has improved. We have certainly established stronger governance arrangements. So the small example would be that we have a monthly care group governance meeting, which Simon would be involved in with his team, and we challenge on governance and review and provide support. There are subcommittees of the board, there is a quality and safety subcommittee that is chaired by Dame Clare Gerada, who was a non-executive director, and also was the President of the Royal College of General Practice in the U.K. So we have got generally stronger structures in place. We are addressing the issues of poor behaviour and culture. Now, cultural change, as we all know, takes time. But confronting poor behaviour, whether that is racism, and racism from both the public but also the hidden racism that happens between colleagues that is not reported. You do not see it in the stats but it is there. We have established the Freedom to Speak Up Guardian. So people are starting to come forward. It is an incredibly difficult thing to do, particularly in a small jurisdiction, is to raise concerns, often raising concerns about your colleagues who you may know, whose children may go to the same school, but a very difficult thing to do, but essential. We were only able to address the issues in rheumatology, and more recently you will be aware of radiology and mammography because people spoke up and went to see more senior colleagues in the executive and said: “I have got concerns”. So, while we have got a long way to go about culture, I think the green shoots that we are seeing people raising concerns, whether it is about clinical services or about behaviours, and whether they go to the Freedom to Speak Up Guardian or to me

as Chief Officer or to the medical director or to Simon as the Chief of Service, we are starting to see people speaking up and that is, I have been told, a change. It was not like that. Because, remember, these issues that we have seen in the media around rheumatology have been going on for years. These are not new issues. These are old issues that have been exposed in a new environment. So I think the speaking up, but a long way to go with that. Different departments have different levels of morale, some are high, some are low. We have been making certain interventions and targeting sort of cultural change capacity into areas where they are struggling with relationships and multidisciplinary team working. So we have started that process as well. So I'm sorry, I'm slightly rambling with things in my head, but is there anything that I have missed, Simon, or that you want to say as a doctor?

Chief of Service, Surgery:
No. The Hugo Mascie-Taylor report was of fundamental importance in order for us to embed governance structures into our services. We are not part of the N.H.S. Chris referenced NICE. NICE was established 25 years ago. We said that we want to align to NICE. We have not got 25 years of experience of embedding that process into the infrastructure of the organisation. We have sort of gone, okay, well we need to do something.

[15:00]

I will give you just one example. So NICE for head injury is the access to CT scans, we have radiology consultants who provide an on-call service overnight. If we have somebody who needs a CT scan overnight, the radiologist gets woken up to come in and support decision-making in the scanning process. They are still scheduled to work the next day. So, as we adopt NICE, our numbers of scans go up, then our ability for those consultants to work the next day is negated. It is just not safe working. So then going to procurement, we have then procured teleradiology to support our services overnight. We managed to get that implemented, up and running, within 3 months. We did that because we had the right people in the room for the discussions to make the change happen, because of the clinical argument that drove that based on the governance processes. So that unfortunately has not been replicated across the whole piece, because the scope of NICE crosses every single department, and so we are starting to embed that. So when people talk about governance, yes, we know we need to improve things. It is a journey. It is being embedded from the ground up.

Mr. G. Kehoe:
Do you have a timescale for that sort of thing to take place? Is there some sort of vision of knowing when we are going to have this is it across all departments?

Chief of Service, Surgery:
It is an ongoing trajectory. If you said to the U.K.: "Are you there with governance?" they would say: "No". It is a continual process.

Mr. G. Kehoe:
No, I understand that, but obviously you just mentioned that you have got one particular department that has done that.

Chief of Service, Surgery:
Yes. On one particular element.

Mr. G. Kehoe:
One element, yes. So it is just how has that been fed out then to ensure that this risk is not there? I am just speaking on personal experience on this particular matter.

Chief of Service, Surgery:
Sure. I do not have a specific answer for you for that. All I can say is that the goal, the drive of governance is embedded in everything we do, certainly for my care group. We now have an insight day where our elective services are stopped. So every member of staff, be it allied health professionals, nurses, clinicians, support staff, can attend that to get trained and to be exposed to audit and guideline development. Then the teams have time to propagate that service development. Part of that is embedding the structures from NICE or any other international guidance for their service delivery. So it is part and parcel of what we do and then it is embedded in our business cases. So somebody will come to me with a business case for a service, one of my questions will be: "Is this evidenced by NICE or not?" If it is, then the remit is this is what we want to deliver as an organisation. Similarly with drugs, somebody can come along and say: "There is this fantastic drug. It costs this much money." "Is it NICE approved?" "No, it is not." Okay, well my default position is you have to have a very, very good argument why we are going to adopt that drug if it is not NICE approved. If it is NICE approved, then all that sort of validation work has already been done and then the premise is on me, I need to be able to support that and to try and make it happen because we are trying to adopt NICE. So it is part and parcel of everything that we do on a day-to-day basis, whereas prior to Hugo Mascie-Taylor it was seen as, is there a benefit or not?

Chief Officer, Health and Community Services:
Yes. But I think your question is, I think those things that I have just been rambling on about, inevitably reduce the level of risk. It clearly has not mitigated it completely because healthcare is a

risky business. So we are in a better place now than we were in 2022 as regards to strengthening governance, we are not where we want to be or need to be, and certainly around organisational culture we are not. But I think that the risk level around all this is far less now than it was in 2022.

Mr. V. Khakhria:
How would you measure it?

Chief Officer, Health and Community Services:
Measuring it is difficult. We have a risk register in H.C.S. and both at corporate level and at departmental level. We have got a Risk Committee that will look at risk. So we will look at trends over time. The Quality Committee, the Assurance Committee will also look at that risk and look at the level of risk that is associated with clinical care, for example, financial risk put aside. So there are various assurance groups like this that will challenge and look at that risk and we have, as I say, risk scores against various things on our risk register.

Mr. V. Khakhria:
So what would be the key risks for 2023?

Chief Officer, Health and Community Services:
For the last year?

Mr. V. Khakhria:
For the last year, yes.

Chief Officer, Health and Community Services:
Well, one of the big ones would have been finance, because we knew that that was a big problem. I think the 2023 risk would have remained the risks around the 61 recommendations of the Hugo Mascie-Taylor report. So as you entered into that year, we obviously saw some leadership changes that happened as well during that year. So there would have been a level of risk associated with that happening. The change team coming in. I am trying to think about other risks that would have been, there is plenty on the 2020. The implementation of MAXIMS, the new electronic patient record, there would have been various risks around that, that would have been on the risk register. What other risks? Obviously we have risks around our estate, current estate, we are falling down. So we spend about £5 million a year just keeping it going until we get to the new hospital. So there are always estate risks wrapped up in our risk register. So they have been finance, clinical, estate, and digital would have been the sort of broad areas of risk. That would have been broken down into a lot more detail.

Mr. V. Khakhria:

So, in terms of publication of results and progress against this, is there a single place that you report the progress against the 61 recommendations just in one place, so the public can see this progress?

Chief Officer, Health and Community Services:

Yes. We did that, I am trying to think of the date, there was something established called We Are Best programme which basically took the 61 recommendations. During the course of last year, we closed that programme down because so many of the issues that were on there had now become business as usual, so had been taken on as part of other programmes, so not to keep it as a separate project because we wanted to embed it within the clinical services. So you will have seen, we have produced a report and I think it went to the board. I am trying to think when, probably at the end of last year, maybe November's board, I would have to check. That sort of showed the close down and where we were at and which things went on to B.A.U. (business as usual). So all of the 61 recommendations have either been closed, we have established the board, that has happened, or are ongoing, which are the more sort of general ones around culture and embedding best governance.

Mr. V. Khakhria:

Okay, I think I understand that. So can you tell me more about how data and information is gathered at the departmental level to inform the risk register?

Chief Officer, Health and Community Services:

Do you want to talk about how you do that in surgery, how you talk about risk, because that sort of shows the sort of bottom-up approach and you would discuss the risks?

Chief of Service, Surgery:

So you can look at it at different levels, so we have a thing where, if somebody wants to alert us to a problem, they fill in a thing called Datex that is used for good things and for bad things and for near misses. So the number of Datexs gives us an idea of where our sort of level of concern in any particular area is. So if there is a theme of Datexs that are coming through that suggests that we need to look at a particular area. Now, there will be some themes that come through that inform our risk register. So one of the risks to us being on an Island, and we sort of touched on this about using tertiary services, is that we have the Jersey Emergency Transport Service jets which take our patients who are critically ill or need tertiary care to the U.K. Now we have a service level agreement contract with the provider. But that limits us to the number of planes that we can have at the sort of touch of a button, and then we go into best endeavours. The staffing for that from a medical

perspective has to be relatively ad hoc because we do not know when we are going to need it. So there is always a pressure on us to be able to deliver that team. Now, if there is a delay in the provision of that team, that automatically gets Datexed. If we find that the number of Datexs are going up because we have difficulty in producing that team, then obviously that becomes more of a risk on the risk register. So the provision of jets is always on our risk register because we do not have a supernumerary team of clinicians on standby. But we do have a plane on standby with the 2-hour notice. So the premise at the moment is that, because of the activity on the Island is relatively static, that we have the ability to pull a team from our cohort of staff from a day-to-day basis. However, if things start to increase, then we pick that up through Datexs and then we put the case through to say we now need a supernumerary team for jets specifically to facilitate our off-Island transport.

Mr. V. Khakhria:

So how many members of each department are entitled or able to add new risks into the system?

Chief of Service, Surgery:

So anybody can do a Datex. So again that is part of our insight day is informing people about Datexs and about risks and also how they do that. One of the premises was everybody thought you needed to login to Datex. You do not. You can just go to it. It is like a 2-step process from MyStates on the intranet, so anybody can do that. But also we have very good reporting lines, both professionally and operationally, within each department. So it all ultimately comes up to me. So if somebody has a concern, they do not have to necessarily go to the Datex, they do not have to necessarily go to their reporting lines, but they know they can come to me directly. So we have a good feel, both from subjective and objective reporting of concerns, and then we use those to inform our risk register. Anything that goes on the risk register then gets a risk analysis and a risk review to try and find out what is the real objective risk to the organisation. Then I get held to account by that.

Chief Officer, Health and Community Services:

As Chief of Service, you would ultimately make the decision, would you not, as to whether it goes on the risk register or not?

Chief of Service, Surgery:

Yes, and also the level of risk.

Mr. V. Khakhria:

How do you assure completeness of recording of risks? How do you make people step up and record these matters?

Chief of Service, Surgery:

So when we have to review the risks on a regular basis, that feeds into the governance reporting where I get challenged on our governance every month. We will be asked to review our risks. Now, some of those risks remain static because we are an Island. We are not going to be able to change that. We are not going to be able to change the service that we can provide. We do not have neurosurgery on the Island. We are not going to have neurosurgery on the Island. That remains a risk. So we mitigate that against our S.L.A.s with tertiary providers and with our off-Island transport services. There are other risks that will score highly because they have been identified and then the challenge back to me and my group is to mitigate that risk, to bring the risk down. If we bring the risk down enough, it then comes off the risk register. So that is the sort of feedback loop system that I am held to account for the risks that are on the register. Some of those we have to accept and some of those we will mitigate against and remove.

Mr. V. Khakhria:

So moving on to where a risk, a serious clinical risk does materialise, how do you evaluate the cost to the Island of the these risks, what is the process when a risk materialises, a serious risk?

Chief of Service, Surgery:

So when you mean cost, you mean a financial cost?

Mr. V. Khakhria:

Financial cost, yes.

Deputy R.S. Kovacs:

Like in the findings of rheumatology.

Chief Officer, Health and Community Services:

Yes, so there is a good example. So if I use rheumatology as an example because it is in the public domain, we knew that dealing with the fallout of the rheumatology would require costs because we needed lots of rheumatologists from the U.K. to come across to do the work, specialists. So that was going to be expensive. It was an extraordinary cost that we could not obviously contain within our existing budget. So the process was that we made an application through to Treasury for extraordinary costs to do with what would be considered quite a significant incident on the Island, and submitted a business case for it. It did not stop us. We were still spending the money because we needed to do something quickly to safeguard patients. But, in parallel to that, we submitted a business case and indeed the Government gave us the funding that we required last year and we

will do this year for the additional costs of dealing with that big risk. If it is smaller issues, then we would take a discussion through to our S.L.T. (senior leadership team), and Simon, as an example, would bring a paper to that discussion. The senior leadership team is chaired by myself, has the Chiefs of Service, so Simon's equivalents from the other areas of medicine, women and children's, has the executive directors on there. So including medical director, chief nurse, and it is the sort of executive decision making body for H.C.S. We would then decide with Obi there whether we would fund that risk. So we need to find the money. That would mean, if we fund that, we are going to have to cut something else because there is no more money, but we would have to have that debate. Or we say we are going to live with that risk and accept it and mitigate it as best we can, but realise that it is not something we can address. So we would have that debate at the senior leadership team.

Chief of Service, Surgery:

It is quite a complex question to answer. I approach it from a slightly different way, so if we take the M.R.I., for example, so M.R.I. wait got up to 52 weeks for a routine M.R.I. So that means that there is potential harm in the community of somebody having a delayed scan for 52 weeks. So we did a capacity demand exercise and worked out where is the threshold, where do we feel comfortable with having our routine scans, and we wanted to get it down to about 8 weeks. What is the number of minutes of imaging that we need to do to be able to bring that down? So we have got a backlog, but then we have got a run rate. So we wrote a paper saying, if we invest this much as a sort of 3-month targeted increase of activity, it is going to cost this much.

[15:15]

But behind that, we have to have an increase of staffing to meet our run rate. So we proved that we could reduce our wait down to 10 weeks, I think we got it down to 7 weeks, and then in parallel to that, we have increased our recruitment to make sure that we can match our run rates. But the challenge back to me was we do not have the money, how are you going to fund that? So we did a second piece of saying, well, if we increase our private capacity to this level within that target, then we will pay for it, and that is what we did. Now, for me, the challenge is I want our 8 to 10 week target for routines. I do not think anybody on the Island should be waiting longer than that. Once we have got all our staff embedded, we should be able to match that. If we did not do that, what is the hidden cost in the community by a delayed diagnosis? I do not know, but I know that 52 weeks is unacceptable. I know that I can put in place to bring the target down to something that is acceptable based on national and U.K. targets, and that is how I approach it.

Mr. V. Khakhria:

So, is there a process, when looking at serious risks, is there a process for a financial evaluation of the potential liabilities associated with those risks?

Chief of Service, Surgery:
So I would say that is beyond the scope of my expertise.

Chief Officer, Health and Community Services:
Now, I suppose, if you take rheumatology, for example, obviously we work with the Law Office and insurers and they make a judgment about the level of liability. So it tends to sort of sit outside of H.C.S. directly.

Mr. V. Khakhria:
So that should be in the Island's corporate risk register and what is the process for informing that corporate risk register?

Chief Officer, Health and Community Services:
We would inform through our H.C.S. risk register, our risk manager works with the corporate risk lead and they would have discussions about what would go on to the corporate risk register.

Mr. V. Khakhria:
Can you tell us more about the process for doing that, how often the costs are reevaluated?

Chief Officer, Health and Community Services:
I must admit, I am not sure about that, how that happens at the Government level.

Deputy R.S. Kovacs:
Can I ask, what measures are put in place to make sure that you prevent or reduce as much as possible these risks, because we have seen recently at least 3 important cases in the public domain that happened with the rheumatology, the death of a baby, maternity with the breast cancers, misdiagnosis.

Chief Officer, Health and Community Services:
Yes, those really important issues would be reviewed at my S.L.T., which is every fortnight. We would also review that at the Care Group governance meetings, the clinical issues, and where there are specific, such as rheumatology, major issues, then the separate group would be established to meet on a weekly basis to ensure that progress is being made. So depending on the situation, it would either be dealt with through the business as usual mechanisms or we would establish

something very specific, as we did through rheumatology, as we did for radiology, just because of the need to really focus on it and get things done quickly.

Mr. G. Phipps:
Are you comfortable you have processes in place now that you will not get these kind of surprises or incidents or you will be able to mitigate them significantly?

Chief Officer, Health and Community Services:
I think from the point of view of what work, as I say, but I think what we are seeing now is that, as we review, and it is good practice of course to review services and specialties, that is what you would expect, to audit them, we would expect to find issues. It is inevitable that you do. We were alerted to issues for both rheumatology and radiology through whistleblowers, people who were willing to speak up. So again, if there are concerns that staff have and then they should speak up and we will ensure that that is then investigated and dealt with. So can I promise that we are not going to find issues in the future? I think probably not because we are bound to find issues in the future. I am just hoping that we will not ever experience something as serious as the rheumatology situation again and I think we now have mechanisms in place that would stop that happening, because clearly if H.C.S. had had good governance in place, the rheumatology issue would have not happened because it would have been stopped.

Mr. G. Kehoe:
In the world I come from, there would normally be an instant recovery plan or business recovery plan in case major incidents arose and there would be people who would be called in to deal with it. Do you have that?

Chief Officer, Health and Community Services:
We do for the bigger issues, yes, we do.

Mr. G. Kehoe:
They have a checklist of things they have to work through. Okay, thank you.

Deputy R.S. Kovacs:
Yes. We just have a couple more points.

Mr. V. Khakhria:
Just one last question, if I might, turning to the annual accounts for the Island, in terms of reporting of risk, uninsured risks for H.C.S. were seen as one of the principal risks of the Island and also on

an increasing trend. Are you able to report from recent communications with insurers whether the governance changes you have made have already had an impact on the insurers' appetite?

Chief Officer, Health and Community Services:
I think it has, but not in the right direction. Because I think of course what we have done is we have exposed issues that were not there in 2023 because of our strengthening governance. That has made insurers nervous. So there are current ongoing discussions that are not led by me, but through the Treasury, with insurers about our policy as the Government for Health next year. But clearly the things that we are finding makes insurers nervous so there is an issue about obviously that risk, it remains a risk as regards to ongoing cost to Jersey of the premium.

Mr. V. Khakhria:
Is there a dialogue between your Department and the insurers themselves?

Chief Officer, Health and Community Services:
Yes, through the Treasury, so we have been meeting about that and explaining all the things that we have put in place.

Mr. V. Khakhria:
So what you are saying is that you have exposed previous governance shortcomings that have alerted them to the fact that they perhaps undervalued the risk or underpriced the risk, but is there a process going forward that satisfies the insurers that you have got a grip of the situation?

Chief Officer, Health and Community Services:
There is a process and obviously they need to make a judgment about whether they feel confident or not. I think we have explained about the arrangements that we now have in place that were not there before, so hopefully that is strengthened. But I just think the issues that we found that we have been very transparent about that have come to the board has made insurers anxious.

Mr. V. Khakhria:
What steps would you take to satisfy the insurers that the future trends should be downwards?

Chief Officer, Health and Community Services:
One of the things, of course, is that we will be next year regulated by the Jersey Care Commission, which is not something we are at the moment, not acute services, the social care is. I think insurers will look to the Jersey Care Commission because we have to meet particular standards and they

will regulate us to those standards, is another area of assurance that I think insurers could get. But it is a very live debate at the moment with insurers.

Mr. V. Khakhria:

But their attitude is effectively a market determination of the quality of the governance of your department.

Chief Officer, Health and Community Services:

Yes, I am certainly no insurance expert, but we have to continue to strengthen our governance to help our premiums.

Mr. V. Khakhria:

So, is there a feedback mechanism whereby they provide processes that they would like to see put in place?

Chief Officer, Health and Community Services:

Yes, there is, and I mentioned the Jersey Care Commission as an example, because some insurers said: "We would like you to comply with x-standards", and we said, "We do not think that is appropriate, but we will be complying with the Jersey Care Commission standards". They have sort of accepted that as an alternative.

Mr. V. Khakhria:

Right, okay, so there are not any unaddressed issues at the moment that the insurers have put forward and said: "Look, you need to do this for us to be able to continue or we are going to have to stop insuring you are going to have to massively hike premiums", or whatever else it may be?

Chief Officer, Health and Community Services:

Those discussions, it is interesting, are live as they are today or yesterday. So it still needs concluding.

Mr. V. Khakhria:

When do you think you will be able to report back to us?

Chief Officer, Health and Community Services:

I think it is probably more that Treasury would need to report back because they are the people that are running those discussions. We are parties in it, but it is a Treasury matter. So anytime now I would have thought, it is just a matter of ...

Deputy R.S. Kovacs:

We can follow up more on this subject as it seems like it is of interest. In the interest of time, because we took advantage of them saying that they can stay longer, but longer is enough, we are just going to address 2 more points, one from Graeme around the Advisory Board performance.

Mr. G. Phipps:

Sure, they will be pretty quick as one of our themes is value for money. I note that H.C.S. Advisory Board was formed in 2023, that was the year when costs were going up significantly. What is the cost of running this board?

Chief Officer, Health and Community Services:

The cost of running the board, of course, is the cost of the non-executives that attend, which they do not get paid a great deal.

Mr. G. Phipps:

So maybe the follow up for that will be, well, there is a cost. The point is there is a cost.

Chief Officer, Health and Community Services:

Yes, we can find that out.

Mr. G. Phipps:

So what impact, more importantly then, value for money, what impact has the board had on your performance in 2023?

Chief Officer, Health and Community Services:

I think the feedback certainly to me as Chief Officer and to the board out to the Minister is that those that attend the public board meetings, so those that attend are pleased and find it refreshing, the level of transparency that is now available to the people of Jersey about Health. They very, very transparent. All the papers are in the public domain. So the feedback I am getting is that is good. The non-executives, of course, are there to challenge the executives and hold me to account. Of course, as a board, it is a unitary board, so executive and non-executive jointly hold H.C.S. to account. So the first meeting was in October last year and we still have one vacancy for a non-executive director. We have 4 non-executive directors and obviously people will be aware that the chairman we did have departed. So we do not have a chairman at the moment of the Advisory Board and the Government will be reviewing, as I understand it, the board in the spring of next year to decide on its continuation or not.

Mr. G. Phipps:

There is a process in place to measure and see that there is value for money, and it is not just something you stick in and leave it forever.

Chief Officer, Health and Community Services:

To formally review that. Yes, and I think it is next spring.

Mr. G. Phipps:

Okay, thanks. Maybe you can respond to this one in writing because of the time. But getting back to the big increase in 2023, maybe if you can give us a bit of an understanding, a factor analysis of the costs, the value of that, are you comfortable with it, that sort of stuff.

Chief Officer, Health and Community Services:

Yes, we will provide that in writing.

Mr. G. Phipps:

Thank you. That is all I have. Thank you.

Deputy D. Warr:

Sorry, just one point here, are you saying that in April there is a potential review of the board and the board could be scrapped if it was determined politically that it was not doing its job?

Chief Officer, Health and Community Services:

When it was decided to do it, they said there would be a review.

Deputy D. Warr:

Right, sure.

Chief Officer, Health and Community Services:

I do not know whether that review comes to the Assembly or whether the Council of Ministers, but I suppose a review technically means that if it was seen not to be adding value, could equally be closed down.

Chief of Service, Surgery:

I think it is in the terms of reference of the board.

Chief Officer, Health and Community Services:
It is in the terms of references, is it?

Deputy D. Warr:
Thank you.

Deputy R.S. Kovacs:
Talking about the overspending area, I want to refer a bit to the performance healthcare facility at Clinique Pinel in St. Saviour and what was the final cost of this facility and how does this compare to the budget? How much was the project overspend and why?

Chief Officer, Health and Community Services:
I have got this written down. So when it began in 2020, there are 3 aspects to the work, essential upgrade works to Orchard House, refurb at Clinique Pinel, and works to Rosewood House, to relocate. The original budget was £8,194,000 and the final estimated cost is going to be £10,760,000. Delays due to the changes in specification relating to safety and flexibility. So there were some changes made by the client, H.C.S., which includes the seclusion room and Article 36 suite. This is the suite which severely ill patients come or get brought by the police. Availability of labour and then availability of fittings. So those issues to do with correct fire doors as I understand. So Orchard House closed last week and patients are now transferred into Clinique Pinel, so £8.1 million, £10.7 million.

Deputy R.S. Kovacs:
What was the reason of overspend?

Chief Officer, Health and Community Services:
It was generally through changes in the specification, so the original spec change, and then there was some labour availability, labour issues, and then delays associated with various fittings, such as there were not the correct fire doors installed. So this was a programme run by Infrastructure.

Deputy R.S. Kovacs:
As a closing question, what are the learnings from this overspend against budget for this project, but also overall in H.C.S.?

[15:30]

Chief Officer, Health and Community Services:

I think from the point of view, as I say, this was an Infrastructure project, so we do not run the project, so we are the client to that. But I think that with all these things, and it is a lesson for anyone that has been involved in building anything from an extension to your kitchen or a billion pound hospital, is freeze the brief and do not change your specification once it is frozen, is the lesson to be taken away.

Deputy R.S. Kovacs:

Thank you, Chris, and officers, for attending our hearing today, for giving us so much extra time. I am sure that the public appreciates your extra answers. There were a couple of points that you committed to follow up during the hearing. We are also grateful for the assistance of the officers and they will be in touch for that. Thank you as well for the supporting officers have contributed today. Thank you to the members of the public who are watching this online. I will now draw the hearing to a close.

[15:31]