Minnistre pouor la Santé
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Gouvèrnément d'JÈRRI

Union Street | St Helier | Jersey |

Deputy Doublet
Chair, Health and Social Security Scrutiny Panel
BY EMAIL

27 May 2025

Dear Chair,

Re: Recurring Overspend in Health and Care Dept

I hope the information provided below will help the Panel to better understand the key drivers of the deficit and hopefully allay some of your concerns.

FY24 £28 million overspend
Please find below a more detailed explanation, which is also available in the December 2024 Health Advisory Board Papers, of the reasons behind the £28m deficit/overspend in 2024, which was driven by the following factors:

- Demand and above inflation rise in costs of social care packages and mental health placements
- Significant rise in tertiary care activity pressures and tariffs by NHS providers
- Drugs and other non-pay cost inflation in excess of budget funding
- Slippage in reducing agency overspend due to challenges of recruiting into hard to fill medical vacancies
- Reduced surgical income due to medical patients need to be accommodated in surgical beds from high winter demand pressures
- Reduced private accommodation income due to higher levels of public activity
- Exceptional one-off costs such as doctors' back-pay and previous year's costs due to the problems encountered post implementation of the Ariba/SAP accounts payable system.

Additional £31 million allocated to the department in the 2025 Government Plan
To aid understanding, clarifying the underlying 'net impact' of additional funding provided in the 2025 budget would enhance visibility of the headline figure of £31m, as follows:
Additional funding provided for 2025 amounted to £22.7m. For GovPlan presentation purposes, £8m was added for FRP savings (grossing-up) and then deducted to recognise the savings delivery. So, £22.7m plus £8m giving £30.7m (rounded to £31m), less £8m returning back to £22.7m. Additionally, the impact of non-recurrent funding provided in the previous year 2024, which was discontinued in 2025, is £10.1m (JCM £4.1m and other £6m) resulting in an underlying net impact of £12.6m (£22.7m less £10.1m) from additional funding for 2025.

FY25 Forecast deficit of £18m

The FY25 forecast deficit of £18m is driven by:

- Cost pressures due to exceptional winter treatment volumes
- Hard to fill clinical positions requiring ongoing agency cover
- Increasing demand for diagnostics and tertiary care (off-island specialist care)
- Rising costs of social care and mental health packages

- Above inflation increases in medical devices, pharmaceuticals, and high-cost treatments
- Shortfall in generating additional surgical private patient income as a result of being unable to ring-fence beds during the winter pressures.

Details are also available in the March 2025 Heath Board Finance and Performance Committee Papers.

Robustness of financial planning processes

- HCJ's financial planning process follows the yearly Government Plan and Budget Planning cycle, with the Government Plan process starting in May, which defines the overall budget available for each GoJ Department for the following year, and then the detailed operational Budget Planning within HCJ, which starts in September.

- This is the commencement of the detailed budget setting process within HCJ. The Government Plan submissions from departments are required in May/June. Baseline budgets allocations are finalised in November following the opportunity for the Sates to submit proposed amendments. The Government Plan process confirms the overall budget allocation for the department by November/ December.

- The annual detailed Budget Planning Process for 2025, which started in September 2024, was discussed and approved by the HCJ Senior Leadership Team (SLT) and followed the budget guidance which was issued to Care Groups/Directorates.

- FY25 Budget Planning was completed with the budgets finalised in Dec-25. The Executive Directors led the prioritisation and allocation of the budget funding available for 2025. Budget Planning for FY25 has required making difficult decisions to recover the deficit in excess of the additional funding available to balance the budget, which has been a challenging process necessitating HCJ to work through prioritising services to be able to live within its means.

- The FY25 Budget allocated to Care Groups/Directorates is £315m after holding back £7m central reserves from the total £322m FY25 Budget funding available. This includes delivery of a challenging £17.1m (4%) of FRP stretch savings, which is almost double the £8m GovPlan target and savings delivered last year £8.9m. However, an additional £10.6m of cost reductions were required to balance the with additional savings/funding schemes including further re-prioritisation of service provision, cost recovery and structural funding changes with other funds.

To help understand the robustness of the financial planning process, the key points from the Budget Guidance and process are summarised below:

Budget Guidance
Purpose
The purpose of the guidance below is to outline the key dates and tasks as part of the annual budget setting process to allocate the available funding defined in the Government Plan 2025 across the service areas of the Department. This budget setting guidance is to define the process by which HCS will distribute these available funds across its service areas.
All directorates are required to undertake this process by following the guidance and timelines as indicated later in this document.

The overall Budget amount for 2025 which HCS is required to work within has been determined through the Government Plan 2025 process.

The purpose of the budget setting guidance is to support HCJ:

- Achieve a consistent 'One HCJ' approach to budget setting through a common understanding and consistent approach of costing and financial planning for annual budget setting
- Use a robust methodology based on:
- Budgets allocated for 2024, and adjusting for:
- Non-recurrent items
- Known variations and agreed changes, e.g. pay awards, inflation, service developments/changes
- Productivity improvements based on internally known opportunities, evidence-based opportunities identified by the FRP work, and external benchmarking such as GIRFT and comparable peers
- FRP efficiency savings targets
- The underlying expenditure run-rate position may also be taken into account where appropriate
- Developing Operational Plans that are based on activity, demand and capacity data at speciality level, for selected specialities, to determine the high quality and safe activity to be delivered within the budget constraints available.

This will be a rolling programme of work covering all the main specialities starting with the 2025 budget setting cycle and continuing throughout 2025/26 to support the 2026/27 budget planning process. There is more detailed guidance is included for information at Appendix 1.

Accuracy of service demand projections

- Our current Budget Planning approach does not explicitly factor in activity projections and hence demand growth. Instead cost pressures related to previous year's activity are used as an imperfect proxy. This approach has serious weaknesses which has been recognised and reported in several Advisory Board reports last year with a proposed improvement to our planning processes, based on demand and capacity planning, in future years which culminates in what is known as an 'Operating Plan' in health planning systems such as the NHS.
- From 2025 HCJ is taking a more robust and evidence-based approach to budget planning for 2026 onwards that builds on the following foundations:
- Activity we deliver
- Demand we face
- Capacity available at our disposal
- Productivity in the way we do things
- Availability of accurate information, BI/Analytics
- Delivery Resources
- Led by Budget Owners and Accountability
- Engaged with by staff
- Continuous improvement

This will provide the basis of evidence-based conversations between ourselves, GoJ, and Treasury colleagues about running and funding a sustainable health service, providing high

quality care to islanders that is affordable, and delivers against political objectives and health policy.

The alternative is to prioritise by reducing the breadth and depth of services provided to fit within the current budget funding.

Underlying structural viability of Jersey's current health and care model

- Sustainable long-term health and care funding has been reported and discussed in successive Advisory Board Reports through 2024 and 2025. It is a key priority for FY25 to consider a longer-term sustainable funding settlement, and HCJ is supporting this GoJ policy project with activity, operational and cost information.

- It is worth noting that financial pressures are driven by different factors such as the economic cycle (e.g. inflation, labour market, agency staff costs), whilst others are structural, e.g. ageing population with increasing health and care needs.

- The ageing demographic is more pronounced in Jersey and will have a significant impact on the health and care budget over the next 10 to 20 years, requiring significant investment in new approaches to prevention. Work is underway to update earlier modelling of future health costs and bring this forward for ministers to consider.

- A 2% health inflation funding uplift has been provided to health and care budgets since 2013 recognising that health and care costs rise at a rate above inflation, before any demographic changes are included, and due to new treatments, drugs costs, and changes in standards. Work is also progressing to understand the adequacy of the 2% Health Costs Formula to fund healthcare inflation and understand which cost drivers are now running ahead of the 2% health inflation factor.

Departmental Cost Transparency

Breakdown of how funding is allocated across the Department –
The breakdown of funding as per the budget allocation across the department Care Groups/Directorates, as reported in 2025 Advisory Board Reports, is as follows:
Areas prioritised for funding, including spending on:

Infrastructure
NHFP – the New Hospital Facilities Programme is under development and regular updates are provided.
The NHFP Programme team are responsible for delivering new healthcare facilities within a funding envelope of £710m and there is a clear breakdown of deliverables within this overall total. Broadly, these projects can be summarised within the following high-level categories although the accounting for these is done at a more granular level spread over 14 projects:

- An Acute facility at Overdale
- A meaningful start on Ambulatory facilities at Kensington Place
- A meaningful start a Health Village at St Saviour

The capital expenditure is managed by the NHFP Programme team with support from a Treasury appointed Finance team. The project finances are managed and consolidated within the main Government accounting system and shared with stakeholders monthly. This includes not only

the relevant NHFP governance groups but also the wider senior Government team both at officer and political level.

The budget for the year is £73m with an additional £45m available related to deferred expenditure in previous years. The latest financial report as at April 2025 indicates that actual year to date expenditure is £5.6m versus a budget of £8.5m with the underspend mainly related to ancillary projects starting later than originally anticipated.

**Note that there were other related projects delivered before 2024 (outside the £710m funding envelope) such as Enid Quenault centre at Les Quennevais and necessary property and land acquisitions which form an important part of the basis for the current NHFP programme.*

Capital Programme – a list of the capital projects and a status summary is shown in the table below.

HoE / Project name	2025 Available Budget £'000	YTD Expenditure £'000	2025 Forecast £'000	2025 (Under)/ Overspend £'000	Commentary on project status
M-250110 New Healthcare Facilities	73,000	4,216	66,283	(6,717)	Within budget
M-250106 Specialist accommodation	696	590	1,196	500	Budget rolled into 2025 from 2024 with further budget in 2026 and 2027
M-100120 Digital Care Strategy	3,201	505	2,845	(356)	Project forecast within budget
P-250025 Equipment Replacement Assets	2,250	100	2,400	200	Additional equipment requested and request to B/F budget from 2026
P-260025 Health Service Improvements	5,000	560	5,000	-	Usual contract negotiations but actuals expected to catch up to budget run rate as previous years
P-250121 Digital Systems Improvements ECR	800	80	1,620	820	Gov Plan budget over 4 years but deliver now over 18 months and will B/F budget into 2025 and 2026 from 2027 and 2028 respectively
P-250122 General Hospital Wi-Fi Upgrade	1,200	70	900	(300)	Reduced forecast now that phase 2 plan is released

- Estates
- The HCJ Estates Revenue budget (£13.2m) is responsible for maintaining the entire HCJ Building Portfolio, not just the General Hospital, and is compiled of Staff Costs (£5,36m (40%)), and six subcategories of non-pay. Estates Management which includes utilities, fleet, and estate management admin (£4.3m (32%)), Medical Equipment Service Contracts (£2.38m (18%)), General Building (£0.5m (4%)), Mechanical Service £0.4m (3%)), Electrical Service (£0.4m (3%)), and the Gardening Service (£0.04m (0.3%)).
- Due to the age of the current portfolio and pending new facilities, the HCJ Estates team are prioritising statutory maintenance across the portfolio, urgent reactive maintenance across the portfolio. Planned preventive maintenance (PPM's) is aligned to available budget on a risk-based decision process. Current budgets are not aligned to a modern healthcare estate.
- A Capital Healthcare Service Improvements fund is required, and run concurrently to revenue funding, so that the well-established essential maintenance programmes can address the most urgent Health and Safety and compliance risks across the health estate portfolio. With particular focus on keeping the General Hospital compliant and operational until new facilities are available 2029.
- The programme of works is complex and extensive, and due to unforeseen delays in delivering the previous two new hospital schemes, it is paramount that funding streams are continued so that the HCJ Estates team can continue to address known infrastructure risks.
- Failure to deliver improvements will make it unlikely to avoid clinical service closures, which will have a negative impact on patients and result in additional off island placements at an increased and unplanned revenue expenditure for HCJ.
- With such known risks in fire safety, water safety, medical gases infrastructure, mechanical and electrical compliance, as well as infection control and ventilation failings the HCJ Estates team plans to continue delivering ward refurbishments in 2025. These sweeping maintenance projects help to deliver improvements on scale, while wards are closed between winter pressures.
- Outside of ward refurbishment there is the risk of key infrastructure failing that supports medical departments, equipment, and devices. With new technology comes improvement in compliance and infrastructure to ready the islands healthcare system in time for the new facilities.
- Capital monies have not been included the latest Government Plan beyond 2025, however, the HCJ Estates team will be submitting a request for funding to cover 2026-28 to align to the delivery of the new acute hospital at Overdale.

Key 2025 Projects Headlines:

- Surgical Ward / Rayner Outpatients Refurbishment - £1.8m
- New Oxygen Creating Plant (PSA) For site wide resilience - £0.9m
- Pathology Laboratory Upgrades - £0.5m
- Fire Compliance Improvements - £0.5m
- Mechanical & Electrical Infrastructure Compliance - £0.4m
- Internal Building Envelope (Asbestos/IPAC etc.) - £0.3m
- External Building Envelope Repairs (roof/windows) - £0.2m
- Water Compliance Improvements - £0.1m

Centralised Buying and Purchasing Function

Investment to establish a central team managing procurement and stock across clinical areas £0.3m to drive procurement efficiencies and stability of supply with immediate focus on shifting £15m of medical supply spend to the NHS Supply Chain delivering 15%–30% cost savings for the same or better-quality products.

- Off-Island and Tertiary Services, and Procurement
  - Investment in enhanced financial and operational controls of £0.3m to manage more effectively a £30m, and steeply rising, off-island and tertiary care spend by,
    - Strengthening tariff compliance, service repatriation, and provider contract management
    - Securing savings through invoice validation, service redesign, and NHS price enforcement.
  - Proactive procurement cost control focused on non-clinical spend (agency, accommodation, supplies).

- On-Island Placements and Packages
  - Contract compliance resource to increase scrutiny over £21m in domiciliary care 'top-up' payments, review provider quotes, and reduction of potential overpayments.

Enhancing public health and Preventative programmes

- A comprehensive proposal has been developed for prevention services for Jersey. These services will support men (women and children) to reduce their risk in developing major long-term conditions such as heart disease and cancer. The proposal includes plans for earlier detection and diagnosis of disease, earlier treatment, and support for lifestyle change. Funding needs to be secured to allow this to happen, both to develop the prevention services and to develop the data infrastructure to identify those at highest risk.
- The Screening Board is looking at introducing and extending screening services such as Bowel Cancer Screening to a wider-age groups introduce new screening programmes such as Lung Cancer Screening. These will come on stream if funding can be secured. Plans to move the cervical and breast screening service from opt-in to opt-out are underway, but capacity is needed to manage data flows so that the new cohorts can be correctly identified.
- The suicide prevention strategy has recently been launched, and this is now being followed up with a comprehensive exercise to identify mental health needs (a Joint Strategic Needs Assessment on mental health). This will be completed by then end of 2025.
- In response to public requests, the roll-out of the Shingles vaccination programme will be accelerated, allowing more rapid access to the programmes.
- Following staff changes and changes to International Health Regulations, a review of the health protection system is being undertaken. Ensuring there is a comprehensive approach to the management of infectious disease will remain a top priority but requires capacity to automate infectious disease reporting.

Digital integration

- Digital Health currently has the following areas of expenditure:
- For revenue there is a budget of £1.5m, this covers the cost of the Hospital analytics and training teams and licensing costs. This is tracking to plan and have no significant risks identified.
- In Capital, the three areas of spend are Digital Care Strategy (the roll out of the Hospital EPR system), Digital Systems Improvements (Roll out of Adult Social Care and Mental

health), and Hospital Wifi. All programs are currently on track with no significant risks currently identified.

Expansion of private health care services

The Private Patients and Income Growth team is being funded to deliver the following improvements:

- The ambitious goal of the strategy is to double private patient income in 4 years through new services and better income capture, to £24m in 2028.

- Private patient income trend has been on an upward trajectory, delivering £10.7m in 2023, £12.5m in 2024, and is budgeted to deliver £18.7m (current forecast £14.3m due to impact of high demand winter pressures in Q1) in 2025.

- Reinvest the additional income generated in enhanced public healthcare. For example, the self-funding investment in a second radiology scanner in 2024 that provided a fast return on investment by successfully generating sufficient income to give a surplus on the investment made and significantly reduced public waiting lists from a high of 18 weeks to 6-7 weeks within 4 months.

- The Private Patients Strategy noted that a leadership team would be introduced in 2024; this is transitioning to substantive posts in 2025.

- The private patients strategy was reported in the HCJ Advisory Board's December meeting (page 8 in HCJ HCS - Part A - Meeting Papers 30012024 v.1.pdf):

- A progress report, including monitoring arrangements, will be brought to the Finance & Performance Committee of the HCJ Advisory Board in June, and to the Advisory Board in July.

- Acute care – please see table showing funding allocation in the next section - 'Cost of running the Health and Care Department'

- Mental health services – as above

- Community care – as above

- Social care – as above

- Staffing – recruitment to substantive posts has been a success area with a significant reduction in agency staff to 95 by March 2025 compared to 140 last year and continues to be a key priority area.

- Pharmaceuticals – The budget for 2025 is £18.5m with a forecast spend of £20.4m. This is an identified key risk area for HCJ with sharply rising costs due to drugs cost inflation outstripping general inflation and high cost drugs and treatments such as cystic fibrosis, oncology, and rheumatology. Please see further explanation of drivers of the cost pressures in next section – 'Main factors contributing to deficit/overspend.'

- Contracts with external providers – these include off-island tertiary care contracts with NHS trusts for more specialist care. The budget for 2025 is £14.5m with a forecast spend of £17.4m. This is an identified key risk area for HCJ with sharply rising costs due to a 15.6% increase in referrals and price increases by NHS trusts. Please see further explanation of drivers of the cost pressures in next section – 'Main factors contributing to deficit/overspend.'

Understanding of Financial Requirements

Cost of running the Health and Care Department

The Financial Performance of the department is reported monthly to the SLT, Finance and Performance Committee, and Advisory Board. A detailed break-down for each Care Group/Directorate is provided at cost centre level and by expenditure type with actual vs budget performance comparison and explanation of variances, including the drivers of the variances and mitigation actions. A forecast for the year is also provided and is updated on a monthly/quarterly basis.

A Care Group/Directorate level summary of the latest April M4 results is shown in the table below (detailed reports are available on request):

Apr-25 M4	Current Month		Year-to-Date			Full Year 2025		
Care Group/Directorate	Budget	Actual	Budget	Actual	Var. Budget vs Actual	Budget	Forecast	Var. Budget vs Forecast
Chief Nurse	596,408	518,813	2,297,928	2,114,607	183,321	6,884,011	6,770,557	113,454
Chief Officer's Department	834,456	1,429,110	3,167,265	4,471,682	(1,304,417)	15,794,601	13,611,883	2,182,718
Community Services	1,310,784	1,258,832	5,278,078	5,024,243	253,834	15,625,358	15,243,222	382,136
Digital Health	138,538	152,191	620,450	580,322	40,128	1,476,465	1,476,460	5
Estates & Hard Facilitie	1,085,802	1,042,007	4,329,132	4,202,816	126,316	13,247,522	13,141,001	106,521
Improvement & Innovation	1,828,992	1,639,931	7,679,968	7,261,533	418,435	22,221,891	22,034,542	187,349
Medical Director	1,173,892	963,431	4,715,159	4,295,189	419,970	13,838,130	14,366,520	(528,390)
Medical Services	5,366,943	5,363,842	22,421,242	23,639,226	(1,217,984)	63,550,141	73,975,780	(10,425,639)
Mental Health	3,521,329	4,081,086	14,111,869	14,977,899	(866,030)	40,691,322	41,602,595	(911,273)
Non-Clinical Support Ser	1,583,432	1,594,847	6,270,789	6,100,407	170,382	18,129,945	17,771,915	358,030
Patient Access & Clinical Administration	734,217	876,268	3,142,851	3,635,817	(492,966)	9,221,884	10,148,583	(926,699)
Social Care	2,343,083	2,255,143	9,907,565	9,879,367	28,198	27,975,625	28,842,867	(867,242)
Surgical Services	3,945,237	4,165,115	15,450,748	17,279,855	(1,829,107)	46,546,082	51,128,184	(4,582,102)
Tertiary Care	1,130,563	1,180,111	5,466,772	6,985,222	(1,518,450)	14,511,270	17,389,481	(2,878,211)
Women Children & Family	1,963,137	2,031,026	7,764,185	7,708,188	55,997	23,077,753	23,568,395	(490,642)
Total	**27,556,813**	**28,551,753**	**112,624,001**	**118,156,375**	**(5,532,374)**	**332,792,000**	**351,071,986**	**(18,279,986)**

* Note: £332.8m budget is made-up of Opening Budget £322m plus pay awards £9.7m and Operation Crocus £1m.

Proposed new "Jersey Health System" model

In accordance with the information previously provided, I am bringing forward proposals to the Assembly to establish a new Partnership Board, which will bring together health and care service organisations (government and non-government) to plan how to improve the health and wellbeing of people who live in Jersey. The proposed Board's activities will include recommending to myself, as Minister, the health and care services that are needed in Jersey (now and into the future) and how those services should be organised – with a particular focus how services will work better together for the benefit of Islanders.

The costs associated with the Partnership Board will be around £70,000 p.a. and will be met within underspend from the existing Health and Care Advisory Board. The Partnership Board will not, per se, generate additional running cost for the Health and Care Jersey – indeed, it is hoped that, over time, more coordinated whole system planning will help contain the Department's increasing running costs through better integrated community and primary care.

In addition to the Partnership Board, I also envisage refocusing a number of existing HCJ roles to focus on whole system service provision (for example, the Digital Director will focus on whole system information and digital requirements, not just Department requirements). This will be cost neutral. Over time it will support better integrated working which, if successful, will also contain the Department's increasing running costs, as per the Partnership Board.
The Partnership Board is a new way of working and, whilst is it modelled in part on similar structures in other jurisdictions which have been shown to deliver tangible improvements to health and care services, we cannot know with certainty that it will result in cost containment or service improvement but, what is known, is that health and care service providers across the whole system have confidence in the ability of the proposed Board to help drive the necessary changes.

In terms of understanding the financial requirements of the NHFP -

- The funding for the infrastructure element NHFP at £710m sits outside of the Consolidated Fund, and Treasury have indicated that the current plan is a mixture of borrowing, usage of Pillar 2 results and some drawdown of the strategic reserve. Whilst there continues to be pressure in Jersey in terms of economic outlook and the demands for services, the Treasury Minister has recently indicated that the plans for funding of the NHFP are in place and there are no plans to change them.

- In terms of the revenue expenditure costs for the new facilities, these have been calculated within the Outline Business Case and shared with stakeholders such as Senior Responsible Officers, Political stakeholders, and the Health Review Panel (Scrutiny). These calculations include assumptions on clinical costs and building maintenance and running costs which have been based on demand and capacity modelling and other inputs from relevant parties.

- The calculations indicate an increase on current levels of expenditure for the Acute facility, which increase primarily as a reaction to the growth in services to meet demand from demographic changes. It is the intention that these costs will be included in the Government Plan for 2026-2029 with the first increases to be included in 2029. Further work will be undertaken within the NHFP Full Business Case on revenue expenditure with further detail available from the development of the HCJ Whole system health and care strategy, workforce strategy and clinical strategy.

Root Causes of Overspending

Main factors contributing to deficit/overspend
Ageing Demographics

- The ageing demographic is more pronounced in Jersey and will have a significant impact on the health and care budget over the next 10 to 20 years. Prevention of illness and a focus on living healthier for longer can reduce the impact, but in the absence of significant investment in new approaches to prevention, the impact on treatment and care budgets will be significant. Work is underway to update earlier modelling of future health costs and bring this forward for ministers to consider.

Adequacy of the 2% Health Costs Formula to fund healthcare inflation established from 2013

- It has been recognised since 2013 that health and care costs rise at a rate above inflation, even before any demographic demand changes are included, as a result of new treatments, inflation on health costs such as drugs, and changes in standards. As well as

a focus on internal efficiency, work is now needed to understand which cost drivers are now running ahead of the 2% health inflation factor.

Increasing mental health and social care demand

- Mental Health cost pressures in 2025 are forecast to be £0.7m due to activity and capacity pressures in ward areas from enhanced patient support needs, and delays in time-to-hire and on-boarding to replace agency psychiatrists.
- Social Care cost pressures in 2025 are forecast to be £1.3m due to growth in number of domiciliary care packages and social care rates inflation running ahead of general inflation.

Specialist contracts – Tertiary care

- Tertiary Care cost pressures in 2025 are forecast to be £2.0m due to 15.6% increase in off-island referrals, high cost treatments, increased patient travel costs, and price inflation £0.6m from cost uplifts applied by some NHS trusts, which are being challenged, and timescale for planned implementation of mitigating demand management schemes to appropriately reduce off-island referrals and costs.
- Mitigating demand management schemes are in development, which will require policy changes with Ministerial approval before implementation.

Medication costs – Drugs costs

- Drugs overspend in 2025 is forecast to be £1.8m due to high-cost patients in Respiratory, General Medicine and Oncology, and consumables in Pathology due to increased demand for tests from GPs.
- Also, the lack of a specialised ring-fenced funding to manage these variations is a key cause of the variances.

- Mitigation actions of above cost pressures.

- Please see response at next section ‘Actions to control costs’.

Actions to Control Costs

Actions to mitigate deficit/overspending in 2025 -

- The now well established FRP Programme has delivered savings of £3.2m vs £3m plan in FY23, £8.9m (recurrent £6.75m) vs £5m plan in FY24, and has planned savings target of £17.1m in FY25 vs £8m plan.
- Efforts are being redoubled to recruit to hard to fill clinical vacancies currently covered by locums.
- Job planning is well advanced to help improve efficiency and value across the medical workforce.
- Patient flow improvements are being identified, with interventions needed to divert admissions and reduce demand on A&E whilst addressing actions needed to reduce Delayed Transfer of Care (DTOC). This will support a winter plan for 2025.
- The Private Patient Strategy group is meeting monthly with care groups to review delivery of income forecasts.
- HCJ is putting in place a centralised buying and purchasing function to deliver more efficiencies.
- In addition, a prioritisation policy is under development to support clinicians in decisions over which treatments to provide and which might be de-prioritised.

- Investing in infrastructure resources to implement firm grip and control and demand management processes.
- Developing strategic partnerships with UK providers to stabilise the clinical model, workforce, and generate income opportunities, and the work on new hospital facilities.
- However, whilst FRP savings are essential, efficiencies alone are not sufficient to curtail future deficits as evidenced by the FY24 outturn and FY25 forecast, where this is driven by the above-mentioned macro and micro factors of future demographics, increased activity, acuity, healthcare inflation, and workforce pressures
- It is worth noting that the accepted benchmark for sustainable recurrent level of savings delivery in the NHS is between 2%-3% year-on-year.

Sustainability of these measures

- The accepted benchmark for sustainable recurrent level of savings delivery in the NHS is between 2%-3% year-on-year. Whilst HCJ has successfully delivered 2.7% (£8.9m) in 2024 against an outturn of £331m, and 2% (annualised) in 2023, the savings plan in 2025 requires a challenging stretch target of 5.4% (£17.1m) FRP savings against a budget of £322m, and an additional 3.2% (£10.6m) of cost reductions (total 8.6%) to balance the budget.

Changes being considered to avoid continued deficits in future years?

- Sustainable long-term funding is a key priority for FY25 to consider a longer-term sustainable funding settlement, and HCJ is supporting this GoJ policy project with activity, operational and cost information.
- HealthCare (HCJ) requires stability with an evidence-based long-term funding settlement to make it financially sustainable and provide budget resilience by building contingency reserves to absorb normal operational variations.
- Balancing the financial position requires a permanent rise in the level of funding
- Three independent pieces of work, FRP Drivers of the Deficit (2023), Jersey Care Model (JCM), and Health Economic Unit (HEU) work on Health Funding Reform (2023), commissioned in recent years are consistent in their findings and conclusion, which show a widening exponential gap between expenditure and income/revenue that is unsustainable without system integration and consideration of long-term funding options.
- Efficiencies alone will not be sufficient. Whilst the FRP efficiency savings reduces the rise in the rate of expenditure, to balance the financial position requires a permanent rise in the level of funding.
- To avoid deficits in future years will require decisions on the level of services to be provided and the funding required to deliver them.
- A long-term funding settlement for Health and Care will address the underlying funding pressures driven by demand vs capacity demographics, the adequacy of the 2% healthcare funding formula, and impact of the JCM non-recurrent funding that has led to more services being established permanently that require recurrent funding to continue at the same level.

Long-Term Financial Planning

Ensuring financial discipline and accountability across a more complex, multi-agency system in the future

- An integrated health and care system led by an Integrated Partnership Board and Service Boards, operating with a consolidated fund for optimal allocation of resources, will be a key contributory factor in the sustainable financing of health and care in future years.
- The role of the Finance Director within and working with the System Leadership Team, and the individual organisations collectively, will be key to bringing together the coalition of partners under common financial control and governance framework, using connected systems, established methodologies, and shared financial disciplines, supported by a system wide Finance Business Partnering Team.

Appendix 1
HCS Budget Planning Approach 2025
Introduction and Background

HCJ is taking a more robust and evidence-based approach to budget planning that builds on the following foundations:

1. Activity we deliver
2. Demand we face
3. Capacity available at our disposal
4. Productivity in the way we do things
5. Availability of accurate information, BI/Analytics
6. Delivery Resources
7. Led by Budget Owners and Accountability
8. Engaged with by staff
9. Continuous improvement

This comes together in an **Operating Plan** used to run a well-planned service that delivers quality and value for money and is progressive, and continuously improving.
Recognising that building such a detailed plan at each speciality level will take time, we are starting with a rolling programme that will prioritise key specialities for 2025 and continue over the year as we cover all specialities to inform the FY2026 Budget.
This will enable evidence-based conversations between ourselves, GoJ, and Treasury colleagues about what it takes to run a sustainable health service, providing high quality care to islanders that is affordable, and delivers against political objectives and health policy.
The alternative, prioritise to reduce the breadth and depth of services provided to fit within the current budget funding.

Budget Guidance
Purpose
The purpose of the guidance below is to outline the key dates and tasks as part of the annual budget setting process to allocate the available funding defined in the Government Plan 2025 across the service areas of the Department.
All directorates are required to undertake this process by following the guidance and timelines as indicated later in this document.
The overall Budget amount for 2025 which HCS is required to work within has been determined through the Government Plan 2025 process. There is scope for some further changes to take place through the States Assembly review of amendments in November and December. This budget setting guidance is to define the process by which HCS will distribute these available funds across its service areas.
The purpose of the budget setting guidance is to support HCS:

- Achieve a consistent 'One HCS' approach to budget setting through a common understanding and consistent approach of costing and financial planning for annual budget setting

- Use a robust methodology based on:
  - Budgets allocated for 2024, and adjusting for:
  - Non-recurrent items
  - Known variations and agreed changes, e.g. pay awards, inflation, service developments/changes

- Productivity improvements based on internally known opportunities, evidence-based opportunities identified by the FRP work, and external benchmarking such as GIRFT and comparable peers
- FRP efficiency savings targets
- The underlying expenditure run-rate position may also be taken into account where appropriate

- Developing **Operational Plans** that are based on activity, demand, and capacity data at speciality level, for selected specialities, to determine the high quality and safe activity to be delivered within the budget constraints available.

This will be a rolling programme of work covering all the main specialities starting with the 2025 budget setting cycle and continuing throughout 2025 to support the 2026 budget planning process.

2025 Budget Setting Process

The Government Plan 2025-28 will be debated by the States Assembly in December 2024 for approval. The approved Government Plan forms the basis of the opening budgets for 2025.

To ensure that opening budgets will be approved and input to the general ledger by January 2025, detailed budget setting is required at both cost centre and general ledger code (expenditure category) bases, and profiled across the financial year.

To support the annual budget setting process, Finance Business Partnering have developed templates which all Directorates need to complete with funding requirements for 2025.

Care Groups will be asked to review and complete budget templates and return for review and consolidation by 8th November 2024.

Upon submission of these templates, should Care Groups propose a budget requirement that fits within the defined financial envelope as determined above, there will be executive review and sign off in line with the December 2024 required completion date.

However, should Care Groups be unable to confirm that they will be able to deliver required services within their budget, they will be asked to follow an activity driven operational planning exercise for those areas that can be defined as acute provision and for other areas such as support functions, a detailed working paper review exercise will be completed.

The operational planning exercise is proposed to be supported by a 'SWAT' team of subject experts working together to triangulate core information in a predefined timeframe and format.

This approach will allow for greater understanding of the link between the activity-driven demand on budgets, empowering Care Groups and executives alike to make clear decisions on the expected future activity delivery to enable a balanced budget throughout 2025.

Additionally, it is proposed that the exercise of undertaking activity-driven operational planning following a predefined methodology should commence concurrently through Q4 of 2024 and into 2025 and beyond. This will allow for maturity of activity-driven budgets and provide richness to this working with the introduction and greater use of PLICS. Refining this service-by-service and year-by-year would see HCS move into a planned cycle of full activity based operational planning for budget setting in 2026 across all areas.

Budget Setting Templates & Guidance

Templates are split by care group and then by cost centre to be completed by budget managers with support from the Finance Business Partnering team, who will upon completion consolidate for a summary position.

The budget setting templates show the overall annual budget for 2024 and current forecast outturn for information only and these figures should not be amended. The two columns titled Recurrent/Non-Recurrent, should be populated with budget required for 2025.

The Recurrent column should include expenditure which is assumed to continue year-on-year whilst non-recurrent will be for expenditure which relates to 2025 only and will not be required in 2026.

Staff Budgets

Staffing budgets in the budget setting template will be populated by Finance Business Partnering to reflect current establishment following review and confirmation by Budget Holders. The budgetary allocation for the agreed establishment will be calculated using the Budgeted Establishment worksheet maintained by Finance Business Partnering.

Staffing budgets should include accurate estimates of allowances payable to staff within the Care Group, these estimates should be worked up between the Care Group and their Finance Business Partner, wherever possible evidenced by roster templates.

Staffing budgets for nursing areas will be expected to be underpinned by completed roster costing templates to verify the establishment required and budgets required for extra duty elements for unsocial hours working.

Staffing budgets for medical staffing should be underpinned by a costing template informed by roster information and in-line the ongoing job planning project.

Consideration should be given to the cover of vacancies and other known absences for the coming year.

Key Non-Pay Expenditure Categories

Some key areas of non-pay expenditure are expected to be supported by detailed and comprehensive workings documents, the following list are those that are expected to have such supporting workings, but this list is not exhaustive:

- Social Care- domiciliary care packages and other placements
- Mental Health- UK placements and other purchased care
- Commissioning & Partnerships contracts
- Tertiary Care contracts including estimated non-SLA activity
- Drugs budget requirements across Care Groups- with collaboration with High-Cost Drugs Pharmacist
- Estates & Hard Facilities Management; Service Contracts and Utilities
- Patient Access: Patient travel costs
- Non-Clinical Support Services; Catering provisions and cleaning products/materials

All Budget lines

The budget setting templates include code combinations where budget is currently allocated or where expenditure has been incurred during the year-to-date of 2024.

When completing the template, the following should be considered:

1. Is the budget still required or can this be reduced in 2025 (review 2024)?
2. Activity data to support budget required
3. Income- tariff or charges review
4. Contractual commitments increase/decrease?
5. Long term vacant posts – are these still required?
6. Staffing changes planned?
7. Economies of scale
8. Supplier changes – impact of Centralised Buying Function / Non-Pay Control Panel
9. Value for Money / Financial Recovery Programme
10. 2025 Planned price/activity changes

Budget Profiling

The aim of profiling budgets over the year is to reflect the timing of expenditure so that meaningful budget monitoring can take place during the year. Meaningful budgetary information requires comparison of actual versus budget on a year-to-date basis by month and overall impact, allowing us to highlight variations between actual and budget and to allow early identification of variations from planned expenditure levels.

When profiling the budget, planned expenditure patterns should be considered. For certain types of expenditure (particularly non-staff costs) it is likely that expenditure occur at particular points in the financial year.

Budget holders/managers should work with Finance Business Partners to establish profiling of budgets.

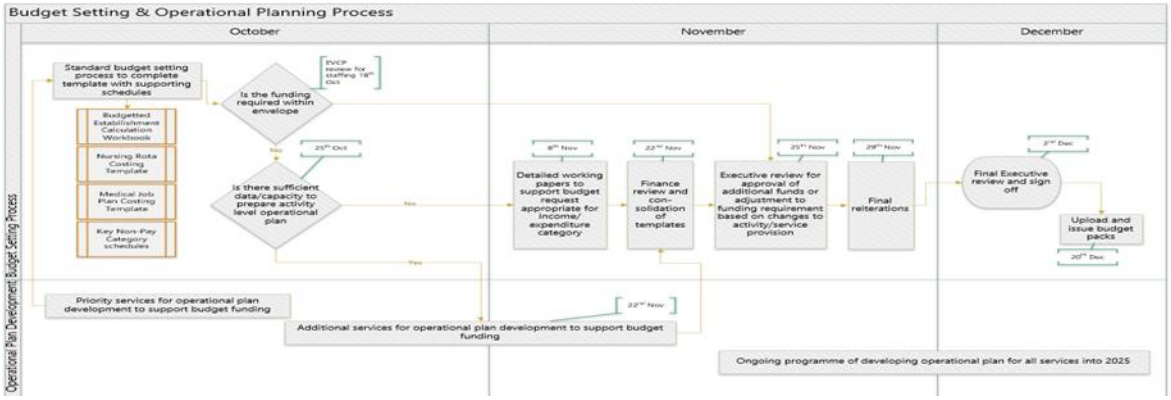
Next steps

- To assist in the 2025 budget setting process the Care Group's Finance Business Partner will set up initial meetings to provide guidance and support for completion of the templates and will be available throughout the process to provide support.
- As part of the 2025 assurance process, budget review meetings will be held in late November and early December between Care Group management teams and the Executive Leads. It is essential for these meetings that templates have been populated, and justification of budget movements is available.
- On completion, HCS budgets will be consolidated to determine the overall budget requirements for 2025, identifying any financial pressures against the available budget allocation, which will required Executives' input to resolve and achieve budget balance.
- For 2025, a budget guide/book will be circulated to each directorate providing details of budgets approved, codes which should be used for expenditure along with an analysis of efficiency targets which will be monitored during the financial year and reported at Care Group/SLT level.

- The key dates are as follows:

2025 Budget Setting Templates Circulated	**w/c 23rd September 2024**
Budget Setting Meetings with Finance	23rd September to 31st October
Care Groups review and confirm staffing	By Friday 18th October [Exceptional ECVP to review establishment changes]
Care Groups review and confirm non-pay / income	By Friday 25th October
Care Group consolidation and review with FBP	By Friday 1st November
SWAT team complete priority specialities' operational planning documentation with Care Groups (SLT to confirm membership of SWAT)	By Friday 1st November
Detailed schedules and working papers complete for areas outside of envelope	By Friday 8th November
Additional service complete operational planning documentation with CG and SWAT	By Friday 22nd November
Revised budget setting templates submitted following operational planning review	By Friday 22nd November
Finance review and consolidation of templates	w/c 18th November
HCS Executive Review with Directorates	w/c 25th Nov 2024 and w/c 2nd Dec 2024
2024 approved budget upload and budget guide circulated	16-20th December 2024

Process Diagram



Please let us know if you have any questions.

Yours sincerely,

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