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Public Accounts Committee

Annual Report and Accounts 2025

Witness: Chief Officer, Health and Care Jersey

Monday, 9th November 2026

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Panel:

Deputy K.M. Wilson of St. Clement (Chair)

Deputy V. Li of St. Helier North

Deputy L.D. Carpenter of St. Helier Central

Mr. M. Oliver

Mr. R. Duncombe

Mr. C. Heal

In Attendance:

Ms. H. Thompson - Deputy Comptroller and Auditor General

Witnesses:

Mr. T. Walker - Chief Officer, Health and Care Jersey

Ms. H. Cunningham - Strategic Director Finance and Commercial, Health and Care Jersey

Ms. J. Hardwick - New Healthcare Facilities Programme Director, Health and Care Jersey

Ms. C. Thompson - Chief Operating Officer - Acute Services, Health and Care Jersey

[14:31]

Deputy K.M. Wilson of St. Clement (Chair):

Welcome, everybody, to this public hearing of the Public Accounts Committee. Today is 9th November and this is our annual report and accounts review hearing with the Chief Officer of Health and Care Jersey. Before we start, I would like to draw everyone's attention to the following. The hearing will be filmed and streamed live. A recording and transcript will be published afterwards on the States Assembly website. All electronic devices, including mobile phones, should be switched to silent. I would ask that any members of the public who have joined us in the room today do not interfere in the proceedings and as soon as the hearing is closed please leave quietly. For the purposes of the recording and the transcript, I would be grateful if everyone who speaks could ensure that you state your name and your role. Before we begin, I would like to convey on behalf of the panel our thanks to all of you for your work during 2025. As we go through our questions, if we could ask you to keep your answers concise so that we can get through the questions to you, and we will interrupt you if necessary. If we can begin with introductions, I am Deputy Karen Wilson, Chair of the Public Accounts Committee.

Deputy L.D. Carpenter of St. Helier Central:
Deputy Lee Carpenter, acting Vice-Chair of the Committee.

Deputy V. Li of St. Helier North:
Victoria Li, Deputy for St. Helier North, panel member.

Mr. R. Duncombe:
Rob Duncombe, lay member.

Mr. M. Oliver:
Mark Oliver, lay member.

Mr. C. Heal:
Clive Heal, lay member.

Chief Officer, Health and Care Jersey:
Tom Walker, Chief Officer for Health and Care Jersey.

Strategic Director Finance and Commercial, Health and Care Jersey:
Hazel Cunningham, Strategic Director Finance and Commercial for Health and Care Jersey.

Deputy K.M. Wilson:
You have 2 members of staff with you.

Chief Officer, Health and Care Jersey:

Do you need them to come forward for the microphone?

Deputy K.M. Wilson:

No, it is all right. It is just so that everybody knows.

Chief Operating Officer - Acute Services, Health and Care Jersey:

Claire Thompson, Chief Operating Officer for Acute Services.

New Healthcare Facilities Programme Director, Health and Care Jersey:

Jessica Hardwick, the Programme Director for the new healthcare facilities.

Deputy Comptroller and Auditor General:

Helen Thompson, Deputy Comptroller and Auditor General in attendance.

Deputy K.M. Wilson:

Thank you. We have 2 hours scheduled for the hearing so therefore I will invite Deputy Li to open the questions.

Deputy V. Li:

Thank you, Chair. Before we turn to the detail of the annual report and accounts, could you briefly outline the scope of your responsibility as Chief Officer of Health and Care Jersey?

Chief Officer, Health and Care Jersey:

Certainly. So Health and Care Jersey is a fully integrated department nowadays. So that means that my responsibilities cover service delivery - that is acute services, community services, mental health services - but also cover public health, so population health, public health protection, the prevention of future illness, also health policy, so the work supporting the Minister on the legislative programme and policy development, and then the corporate functions as well, which are now split between the centre and Health and Care Jersey, so finance, H.R. (human resources), digital, all of the main corporate functions. So it is a job that has a slightly broader span than it used to have a few years ago, but that is just because we are trying to find the advantages of bringing all health-related functions as close together as possible.

Deputy V. Li:

That is very helpful. Could you briefly describe your previous experience of operational leadership of a health and care system and the strategic responsibility you have held in those roles?

Chief Officer, Health and Care Jersey:

So before moving to Health and Care Jersey I was Chief Officer for the Cabinet Office, and at the time that included responsibility for population health and public health and supporting the policy development for the Minister for Health and Social Services as well. So that probably was most visible during the COVID pandemic, where it was my responsibility to lead the Island's strategy and parts of the implementation of the response to the COVID strategy. Before that, in terms of operational experience, I was for a number of years also the Chief Officer for the Home Affairs Department. So I have been responsible for police, prison, customs and immigration, and other operational areas.

Mr. R. Duncombe:

Okay. I think I have the first few questions. So I suppose diving straight into the annual report and accounts for 2025, I think you will agree they kind of paint a bit of a mixed picture, identifying some quite significant weaknesses in terms of access to planned care, some operational performance issues, and again issues around about the financing in year. I guess the question really is - but I will ask you to answer in very broad terms because my colleagues have some more detailed questions to come - with the very high levels of expenditure, healthcare accounting for a significant proportion of spend, why particularly in 2025 were we not achieving all of the operational targets? I think I know that out of the 9 targets only 3 were actually met. So I guess in broad terms what is the background or the underlying issues there?

Chief Officer, Health and Care Jersey:

Yes. So in terms of 2025, that was very much a transition year I think for the service. It had come out of quite a difficult period in 2023 and 2024 where it was struggling with £30 million overspends in both of those years. So 2025 was really about starting the process of bringing the department back into the envelope, back into the operational parameters. That meant that for 2025 that was a large part of the priorities was bringing that £30 million significantly back down again. That just meant we needed to make trade-offs against other areas of organisational performance. So I think in terms of what we were trying to achieve, we managed that main objective pretty well without affecting volumes of patient care, but it did mean that we had to trade off against some other objectives.'

Mr. R. Duncombe:

Okay. I suppose going on from that ... because I suppose the original budget for 2025 I think was around about £322 million?

Chief Officer, Health and Care Jersey:

Yes.

Mr. R. Duncombe:
Yet the outturn at the end was £368 million, which was, I guess, an 11 per cent increase overall during the course of the year and also requiring an additional input of £14 million during the course of that year.

Chief Officer, Health and Care Jersey:
Yes.

Mr. R. Duncombe:
So I guess can you just I suppose detail a bit more what were the pressures? I guess we'll come on to it in a moment but the next question I am going to be asking is around about some of the budget setting.

Chief Officer, Health and Care Jersey:
Yes. So we have been taking Health and Care Jersey on an improvement journey on budgets, from where it was with a £30 million overspend, bringing that down to less than half of that in 2025. I think about £1 million of that was funding for Operation Crocus. The £30 million was the in-year pressures that led to us spending more than was intended. I think the drivers of that are pretty well documented. They came through increased patient volume. Higher acuity cases impact the budget quite a lot. Additional tertiary referrals, so there was an increase in tertiary referrals to the U.K. (United Kingdom) in that year and all of the travel and accommodation costs that comes with that.

Mr. R. Duncombe:
I suppose £40 million is a significant sum not to be seen, I suppose, and I suppose we had the Treasurer of the States with us on Friday and I think one of the questions we posed to them as well was: was none of that foreseen?

Chief Officer, Health and Care Jersey:
I think it was foreseen and we forecast that quite early on in the year and were able to communicate that to Treasury colleagues. We came in pretty close to the figure that we identified earlier in the year, I think from memory, Hazel.

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes. So as Tom said, the risk of overspend was highlighted at the end of quarter 1 in 2025 and discussions were held with the Treasurer and respective Ministers. Then an agreed recovery plan was also agreed at the level of £12 million. So that was reducing the risk from the initial level that had been identified and then in principle funding was set aside then to mitigate that risk of overspend.

We then held that position all the way through to quarter 4 and then there was a small increase, which were a couple of items that hit the books at the end of the year. So we did actively manage that recovery plan throughout the year.

Deputy K.M. Wilson:

Sorry to interrupt, Hazel. Can I just ask you to put your microphone on? Thank you.

Mr. R. Duncombe:

So are you saying that at the end of quarter 1 the overspend was identified as being £36 million because you then identified £12 million of savings? Is that right?

Strategic Director Finance and Commercial, Health and Care Jersey:

No. So the risk was around about £18 million in terms of the overspend and then we held at 12, which was agreed following the recovery plan that was identified by the department and in agreement with Treasury.

Chief Officer, Health and Care Jersey:

So we knew that we could not take a £30 million overspend and safely just completely halt that. That would have been slightly reckless for us to do. So we knew it was going to be a phased, multiyear programme to bring it back into budget. So 2025 was really the first year of bringing that down, and I think we were pretty pleased we came in quite close to where we thought we would come in.

Mr. R. Duncombe:

Okay. So I suppose moving forward from that, as you say there are the in-year elements that were not planned for. You say increased number of tertiary referrals, increased case complexity. Are those now being built into the future budgets or were they genuinely one-off challenges in 2025?

Chief Officer, Health and Care Jersey:

What we found was that there was a structural deficit and that really arose in the post-COVID period with the higher inflationary and hyperinflation period. So the health budget had been reasonably stable in a low inflation environment because of the healthcare inflation formula held at 2 per cent. That had held it prior to COVID in a reasonably stable way. Then what we found in Jersey was exactly what they found everywhere else across the British Isles, is that post-COVID healthcare inflation kicked in on top of hyperinflation. Then the formula was held at 2 per cent when with hindsight you can see that it was running at 3, 4, 5 per cent. That just built up this deficit position. Then we have done a mixture of things around bringing more controls in place over areas of demand-led expenditure so that we can mitigate some of the increases, but at the same time

Treasury colleagues have given us a really good degree of challenge and support to try and get the budget back in the right place and to deal with the structural deficit. So you can see that in 2026 structural deficit funding comes in to rebalance and then combined with the work that we have done to mitigate the increases and the health inflation pressures, that has brought it back into a more stable position.

[14:45]

Mr. R. Duncombe:
I know colleagues will be picking up on ...

Mr. C. Heal:
Could you explain more, please, about what is driving that inflation that you just talked about?

Chief Officer, Health and Care Jersey:
Yes. So healthcare inflation is a thing which is common across all of the British Isles healthcare systems. It gets driven by a few different things. So it gets driven by the cost of healthcare running ahead of regular R.P.I. (Retail Price Index). So people like the Office for Budget Responsibility in the U.K. model this. At the moment healthcare inflation is running at about 3 per cent above R.P.I. That is driven by things like drug costs, which run ahead of regular inflation, and consumables. Sometimes it is driven by increasing healthcare standards, so the number of ... the patient workload that a medical consultant can handle sometimes changes. People take a different view around what is safe and what is appropriate and sometimes it takes more staff to deal with things that in the past you perhaps dealt with with fewer staff. So there is a range of things around standards, around prices, that drive it. Then the big driver, of course, over the top of all that is ageing demographics, increased acuity, ill health among the population, which is also on the rise. So you get demand drivers and then you get price drivers and standards drivers, and you combine all that together. Generally speaking, at the moment that is about 3 per cent above standard R.P.I.

Mr. C. Heal:
So what can you do to focus on ... you talked about rising drug prices. What options are open to you there to manage the cost of the drugs?

Chief Officer, Health and Care Jersey:
So we have done a few things to deal with increasing cost of drugs. So drug prices do go up faster than regular inflation. That means that our non-pay budget, which gets adjusted by the Treasury at a regular inflation rate, does not quite keep up with drug prices. I think generally the things that we have done have been to mitigate the impact of the rise. In the last few years I do not think any

healthcare organisations actually saved pounds and pounds in a structural way out of the drugs budget. Generally speaking, you are mitigating the rate of rise recently in drug costs. The rate of rise is driven by a range of different factors, all of which probably illustrate the complexity of dealing with it. So you have straightforward price increases which just come as a result of inflationary pressures. You have new treatments, things like gene therapies, where it can cost maybe a quarter of a million to half a million pounds for a single person's advanced cancer treatment. You have new techniques that then enhance the cost of the drugs. So a lot of the cancer treatments now work better if they are combined with genetic testing. Then you can modify the treatment accordingly. So now you have genetic testing costs on top of the drug costs, and so it goes on. The mitigations that we focused on have been around looking particularly at high-cost drugs. High-cost drugs generally are recognised as being an area where most healthcare organisations can tighten up their approach to it. So we have introduced a high-cost drugs pharmacist in the last few years.

Mr. C. Heal:
What about the use of generics?

Chief Officer, Health and Care Jersey:
Yes, biosimilars, we have done all of that. The one good thing about medicines is it has a good standard playbook that you can use to work through the costs. So we have done high-cost drugs. We have done biosimilars. We have looked at what we dispense at the hospital in terms of over-the-counter drugs and clamped down on that so that we are really using the hospital pharmacy more efficiently. We have looked at takeaways ...

Deputy K.M. Wilson:
I am just going to stop us there if I can, only because I think we are getting into a bit of the detail. Can I come back to Rob, please?

Mr. R. Duncombe:
I am almost finished my questioning. I suppose my question would be then ... so if you had not received that £14 million from the Treasury to support 2025, what would have happened? Would you have identified further reductions in service?

Chief Officer, Health and Care Jersey:
Yes. In healthcare you do always have the option just to stop. So what we are always trying to do is the responsible thing, so we are trying to reduce costs and bear down on costs safely in a controlled and phased way. But if it was ever to come to the day that we were just simply instructed to stop, then obviously we can. You can just offer fewer treatments to Islanders. You can make less services available. You can focus just on highest priority. Ultimately, if you really, really wanted

to, healthcare could be reduced down to emergency care, maternity, highest acuity only. I do not think that the people of Jersey would welcome that or tolerate it, but ultimately you always have those choices in healthcare to hit the hard stop brakes but that just comes at the risk of harm, clinical care and service provision.

Mr. R. Duncombe:
I will just close off my one question. So would you say now that you are happier that we have greater control now over I suppose the Health and Care Jersey finances than in 2023, 2024, 2025?

Chief Officer, Health and Care Jersey:
Yes, absolutely.

Mr. M. Oliver:
What proportion of the costs of the department are actually fixed? Because you say you can just stop doing things but presumably there is a very high fixed cost base.

Chief Officer, Health and Care Jersey:
Yes. Staffing costs is around three-quarters and so obviously ...

Mr. M. Oliver:
So it does not leave you a lot of scope to pare back services.

Chief Officer, Health and Care Jersey:
No. If you were to bear down on the non-staff costs, then you would be primarily bearing down on adult social care, so the care that people need in their own homes, the ...

Mr. M. Oliver:
But that staff is still there so I am struggling to see ...

Chief Officer, Health and Care Jersey:
Well, with the non-staff costs a lot of the homecare provision and the care that goes into privately run care homes is not on our staffing. That is on somebody else's staffing, so it is a variable cost for us but it is a variable cost that is very demand driven. So if you look at something like adult social care, the long-term care scheme is in place from levels 1 to 4 and increasing pressure on the health budget is topping up level 4 care to the actual market cost of care, which is often above the L.T.C. (long-term care) rates. Then, of course, dealing with people that have care needs at what would be level 5 and above, which all falls on the care budget.

Deputy K.M. Wilson:
Can I just stop you there? Can I just ask you ... because we are talking about what you can do, but what we want to do is understand the position for 2025.

Chief Officer, Health and Care Jersey:
Yes.

Deputy K.M. Wilson:
So in response to what the member has just asked in relation to the things that you mentioned earlier to try and address the underlying structural deficits and what the department would have had to do in order to manage the shortfall in 2025 had it not been bailed out with that extra money, what are the things that you had in place in 2025 to effect that?

Chief Officer, Health and Care Jersey:
That we could have done if we had chosen to? Is that what you mean?

Mr. M. Oliver:
Yes.

Chief Officer, Health and Care Jersey:
So if we wanted to ... at the start of the year if we had decided to take £30 million out of the cost base there and then ... is that the question?

Deputy K.M. Wilson:
Yes.

Chief Officer, Health and Care Jersey:
If we had to have done that, I think we probably would have ended up reducing service provision, and then which service provision would we have reduced? Well, we would have reduced the more outpatient delivered, the more community delivered care, because ultimately we have to deliver acute care. We have to deliver maternity. We have to deliver urgent emergency care, acute care. Beyond that there are services that you could decide not to do and I think that is probably where we would have ended up.

Strategic Director Finance and Commercial, Health and Care Jersey:
Those are ...

Chief Officer, Health and Care Jersey:

Yes. That would not have saved us much money, though.

Strategic Director Finance and Commercial, Health and Care Jersey:
No.

Mr. R. Duncombe:
But I suppose the question is: did you have a plan or was there an assumption that ... given that you received I suppose a bailout in 2023 and 2024, there was already an assumption or an expectation that you would be getting a bailout in 2025?

Chief Officer, Health and Care Jersey:
So this is why we had the discussion really early with Treasury colleagues so that you can get a steer for how colleagues would like you to deal with the issue and you can get a steer from Ministers and others early doors. So that was the whole purpose of the early engagement that Hazel outlined so that we could understand whether there was a desire for us to start to shut down parts of the health service to balance the budget or whether it was better to stay on a phased trajectory of safely reducing costs. The discussions that we had were very much around the latter and so that was what we did.

Mr. R. Duncombe:
You were saying, going back just closing this off, all of that additional funding was not down to poor forecasting, it was all down to in-year effect?

Chief Officer, Health and Care Jersey:
Hazel?

Strategic Director Finance and Commercial, Health and Care Jersey:
I think this was something covered by the Treasurer as well is that there had been ongoing work since 2023 to identify the drivers of deficit within Health and Care Jersey. So conversations had been ongoing from that period of time and we had already been looking at the impact of the higher levels of inflation and structural deficits that existed within the budget for Health and Care Jersey. As Tom has already outlined, that was then recognised through the funding settlement that was approved by the Assembly in 2024-2026. So I think that was part of the discussion and therefore, as Tom has already outlined, recognising that structural deficit and also the conversations with the respective Ministers in terms of the impact of taking short-term measures when we were already having a conversation about what the longer-term investment into Health and Care Jersey required us to anticipate.

Mr. R. Duncombe:
We will come on to that.

Chief Officer, Health and Care Jersey:
Just in terms of the actions, we did ramp up the delivery of the financial recovery programme as much as we could to mitigate the impacts. So you will have seen that in 2025 I think on the F.R.P. (financial recovery programme) we were due to deliver about £9 million, £9.5 million, and in the end we delivered £13 million. That was about us really trying to do everything we could to mitigate the effects of that structural deficit.

Deputy V. Li:
I would like to move on to the financial management in the more operational level. So the annual report acknowledges that delayed transfers to care have affected hospital length of stay. Can you tell us the estimated financial cost of a delayed transfer of care per capita and what proportion of the budget is spent reducing delays? If you could also let us know what improvement can we expect to see in 2026.

Chief Officer, Health and Care Jersey:
So the cost of a hospital bed is usually estimated at around £600 a night, roughly speaking; sometimes £550, sometimes a bit more, but roughly £600 a night. So that is the cost in its simplest terms of delayed transfers of care. Then that just multiplies up according to how much delay you have. Delayed transfers in care at the moment in Jersey are largely a result of a lack of nursing bed capacity in the community, and so the care market in Jersey works very well funded by the L.T.C. but it does not work so well for people with the highest acuity, so people with very serious dementia, which are particularly challenging for commercial care homes to accommodate. So what tends to happen then is they end up staying with us in the hospital for much longer than anyone intended while one of the very few intense nursing beds becomes available eventually. So that means that we have maybe a dozen or so patients usually which are in that position of being delayed transfers and with us for longer than they would like and longer than we would like.

Deputy K.M. Wilson:
How much does that cost the department?

Chief Officer, Health and Care Jersey:
I do not think I have that maths with me.

Strategic Director Finance and Commercial, Health and Care Jersey:
I do not have the specific figure.

[15:00]

Chief Officer, Health and Care Jersey:
I think we have estimated it in the past in response to freedom of information requests. I think we have had a couple of F.O.I.s (freedom of information), so perhaps if we can send the latest F.O.I. we have had on it over to Alex and he can append it to the notes. Because we have attempted to estimate it. We do not measure it in a very ... in a day to day way. It is not a dashboard that we keep because we are focused on providing the care and trying to find those people the right place.

Mr. R. Duncombe:
I think in the annual report 2025 emergency length of stay increased, did it not, versus 2024? I guess the question maybe is: was investment made to try and tackle that?

Chief Officer, Health and Care Jersey:
So, again, the root cause of this is a lack of nursing beds for high-need patients in the community. So we do lots of work within the acute setting in order to improve patient flow because sometimes some of it can be addressed within our entry and exit. So during 2025 and going into 2026 a number of techniques have been introduced by Claire and her team to improve flow. So we have adopted things like red to green methodology. We have adopted the safer flow standards. All of the best practice techniques that are out there the team have adopted and have produced results and have worked really well. There is a ...

Mr. R. Duncombe:
But you could still argue for 2025 an investment was made to reduce emergency length of stay but the cold hard numbers are that it went up.

Chief Officer, Health and Care Jersey:
Well, the only investment that is really going to have a lasting impact on long stay is nursing beds in the community. So that is a capital investment in new capacity in the community. That investment was not made. That is the only investment that would really make a structural difference to people that stay with us longer than everyone would like them to.

Mr. M. Oliver:
So that investment is actually by third parties rather than Health and Care Jersey?

Chief Officer, Health and Care Jersey:
So this is the current debate. You have touched upon a live topic ...

Deputy K.M. Wilson:
In 2025. Focus on the 2025 position.

Chief Officer, Health and Care Jersey:
So in 2025 the position was and is that it needs an investment by somebody, either the private sector or the public sector, in nursing bed capacity for people with the most severe dementia and other serious conditions.

Mr. M. Oliver:
So a third party investor needs a reason to invest, which is obviously a return. So is there an issue there that what Health and Care Jersey is prepared to pay does not match the investment criteria of developers? I am aware that the pub site on the Trinity/Jersey border was bought by Dandara specifically to ...

Chief Officer, Health and Care Jersey:
Oaklands.

Mr. M. Oliver:
... become a care home.

Chief Officer, Health and Care Jersey:
Yes.

Mr. M. Oliver:
Yet there is nothing happened in 3 years.

Chief Officer, Health and Care Jersey:
Yes. So long-term care provides the funding. So the long-term care scheme is the way it works in Jersey. Care homes are not funded; the individuals in the care homes are funded and they are funded through the long-term care scheme. It is a matter of debate as to whether if you were to adjust the long-term care scheme to pay more for people with, say, the most severe dementia whether the market would respond to that or not. Because the market is going to expand anyway and there is only a certain availability of land. So you would think normally that if you just adjust the incentive that you might get more supply but that is not clear in this case because what puts off the care homes is not so much the financial returns, it is the degree of risk for them as regulated providers. So when you talk to them, they say: “I could fill that bed with a less risky patient for the

same financial return and then I would not risk having a really serious incident that then endangers my registration with the Jersey Care Commission."

Deputy V. Li:
We noted the optional improvement in some areas of the service - for example, mental health - but is this sustainable given the increases in referrals? How many patients are currently placed outside of Jersey for specialist mental health care and treatment? What are you doing to get quality and value while controlling the cost of off-Island treatment without compromising safety?

Chief Officer, Health and Care Jersey:
Three different questions. So on the first question, it has proved sustainable. So the objective of the mental health assessment crisis team seeing people within 10 days, which performed really well in 2025, has continued into 2026, I understand against a 35 per cent increase in demand. So that has proved sustainable. I do not have at my fingertips the number of people that we have in the U.K. for the more severe, the more intensive mental health ...

Deputy V. Li:
Do you have the total cost of the off-Island mental health placements in the U.K. in 2025?

Strategic Director Finance and Commercial, Health and Care Jersey:
Not on 2025. We could provide that level of detail following the meeting and we can also update on what the numbers were at that point.

Chief Officer, Health and Care Jersey:
But it is an area that is subject to quite a lot of volatility because obviously there we are dependent ... for people with more intense needs that they cannot be accommodated on-Island, we are dependent on the U.K. market and what they charge. Those costs have increased, as you will know from the national reporting, significantly over the last few years. So there is a cost pressure there. Then also sometimes we are also dependent on the courts, because if they refer someone into secure mental health facilities that can be nearly a million pounds for a single person. That is at the discretion of the courts, not at our discretion. So it is an area of cost pressure. It is an area of increasing costs and it is an area of demand-led vulnerability to the budget.

Mr. R. Duncombe:
I suppose following on from that, as you say, off-Island care is obviously, I suppose, a non-pay cost, which I presume we have some control over in terms of negotiation of contracts. How tightly are we managing those contracts?

Chief Officer, Health and Care Jersey:
Much more tightly than we used to is the short answer.

Mr. R. Duncombe:
That does not fill us with huge amounts of assurance, does it?

Chief Officer, Health and Care Jersey:
But we have had to increase our management and oversight of them quite a lot because the cost has gone up so much. So yes, you are in a market in the U.K. but the whole market has increased its prices. There is not a better value option to go for. The whole market has lifted up and it is a real challenge for everyone. There are some options that we have been exploring around - originally, a few months back - whether we could work with one of the I.C.B.s (integrated care boards) and use their commissioning arrangements. But of course the U.K.'s decision to completely restructure the whole I.C.B. thing has just thrown that into moderate chaos and made it difficult for us to pursue that. But that did look at one time as a potential solution that might help. I do not know whether you want to talk about grip and control in general.

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes, grip and control around particularly if I start with tertiary care. So in the last few years it did peak at about £23 million overall in terms of tertiary care, so that is purchase of care. So the majority of that purchase of care would be through N.H.S. (National Health Service) trusts for different specialties and we pay a U.K. tariff, so N.H.S. tariff, for each of those particular transfers and referrals. The level of control will depend on the nature of that referral. Some will be elective care and they will be planned, but there is also emergency care where we do not have the level of control and it is difficult to predict. So some of that reduction - it has reduced and it did reduce in 2025, as Tom said - is as a result of grip and control, so ensuring that we have much closer monitoring of those referrals. We have established governance around it so an oversight of referrals and an approval process for planned referrals. Then looking at some of the processes as well to make sure that we are tracking and approving any of the costs that were incurred when we refer into N.H.S. trusts.

Mr. R. Duncombe:
Would you say that those initiatives have borne fruit?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes.

Mr. R. Duncombe:

Are you able to give us a number, not now but at some point, to say ...?

Strategic Director Finance and Commercial, Health and Care Jersey:
So I can tell you in general the figure. So as I say, it peaked at about £23 million a couple of years ago. It has been brought down. So it was brought down to £21 million and now it is about £16 million to £18 million.

Deputy K.M. Wilson:
Is that the 2025 figure, Hazel?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes, and then this year we are forecasting in the region of about £17 million.

Deputy K.M. Wilson:
So it is £21 million for 2025 did you say?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes.

Chief Officer, Health and Care Jersey:
Then to pick up on the last part of your question, what could we do about it, we have found some of our patients that are in U.K. care we do have an opportunity to repatriate their care back to the Island. That has involved us taking a case to the States Employment Board to increase the workforce because that means employing more people here to work on the rehabilitation and care needs of those patients currently in the U.K. But we think there is an opportunity there to achieve better value for money through repatriation of some of those patients. Of course, there are groups that cannot be repatriated, but we have found some who are essentially in rehabilitation that we could continue their rehabilitation care here.

Mr. R. Duncombe:
We will come on to that in a bit but I think there is a question around the expanding workforce.

Chief Officer, Health and Care Jersey:
Yes.

Deputy V. Li:

So you were talking about the value for money just now. Out of all the contracts with the healthcare providers, what evidence can you provide us that that provides and delivers the value for money when you are having those contracts? Also, how were the costs controlled?

Strategic Director Finance and Commercial, Health and Care Jersey:
As I mentioned earlier, we are working with ... predominantly in terms of tertiary care, for example, where we have contracts, we are working with N.H.S. trusts. So we do have the surety around the individual pricing of individual referrals through that case management and that will have clinical oversight. Then we have also a tertiary care oversight board that is then reviewing the appropriateness. There is also the question about eligibility for free healthcare. So we have tightened procedures and there have also been policy changes around eligibility, identifying patients early on in the process and whether they are self-payers or whether they are eligible for publicly funded healthcare. So that has also been part of tightening the grip and control around our expenditure but also recovery of our costs and income.

Deputy V. Li:
I am sorry, I am talking about the contracts with the health providers, not about the patients but with the providers.

Strategic Director Finance and Commercial, Health and Care Jersey:
So we are operating in a healthcare system where those prices are already set. So in terms of then the monitoring, there is clinical oversight of the referral and then monitoring of that patient through the system and then when they return to Jersey, and then there is an oversight board that looks at individual cases. If you want to then review contracts more generally, there has been work to look at all of the contracts that are in place across Health and Care Jersey and that has been an ongoing piece of work to ensure that we have oversight of all our third party purchasing and contract management. That has been ongoing so ...

Mr. R. Duncombe:
Is that complete or is that still ongoing?

Strategic Director Finance and Commercial, Health and Care Jersey:
It is still ongoing and I am saying in 2025 it was early days. So that is a piece of work that we have focused further on in 2026.

Deputy V. Li:
To what extent do you have .... do you as the Chief Officer challenge requests for the service expansion when existing services are already under significant financial pressure?

Chief Officer, Health and Care Jersey:
Could you repeat that? I am not sure I understood it.

Deputy V. Li:
So to what kind of extent do you think ... do you believe as a Chief Officer when you are facing the request ... the challenge request for the service expansion when some of the existing services are already under financial pressure?

Chief Officer, Health and Care Jersey:
So we apply the usual disciplines internally that you would externally. Of course, we have good, dedicated staff who want to do the most that they can for patients. I think that is quite normal in healthcare. You get people who can see unmet need that want to fill that need that therefore bring forward proposals for service enhancements, additional services. All of that goes through a single process which Hazel kindly manages for us.

[15:15]

So they all end up essentially on a list of unfunded service improvements, and then each year we look at that and we see whether any of those can be supported. In recent years, as you can imagine, we have supported very, very few, really only the ones that deliver better value for money or enhanced care at pretty much the same cost. So we have a process. We keep a list. Occasionally, we look at it and put it away again. Then if any of those look like we want to advance, then they go internally through the business case process. We ask them to bring forward business cases. That comes to the H.C.J. (Health and Care Jersey) senior leadership team and is subject to clinical review, management review, and we arrive at a consensus.

Deputy K.M. Wilson:
Do you know what the quantum of the request for money was in 2025 and what you accepted and what you rejected?

Chief Officer, Health and Care Jersey:
I think I know the number for 2026, which is burnt on my brain. I cannot remember 2025. It was a little bit less than that, was it not?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes. So I think it is always difficult because in terms of the funding that is available to us generally we will have an excess of need over the funding envelope. As Tom said, we would look at that from

a number of perspectives in terms of impact on services and patients and patient outcomes and then alignment to priorities as well as risk management. So we will go through that process of assessing it.

Deputy K.M. Wilson:
But you cannot tell us the position for 2025?

Strategic Director Finance and Commercial, Health and Care Jersey:
I am trying to remember off the top of my head because ...

Deputy K.M. Wilson:
If you cannot, you can pick it up later on. It is just ...

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes. I can tell you what the number is for 2026. I joined the department in quarter 4 of 2025 so it had already been progressed in quite a lot of detail. But as Tom said, it is ... I can talk more broadly around the assurances the Chief Officer has around financial management and day to day management if that is helpful.

Deputy K.M. Wilson:
We might come back to that if that is okay because what I want to do is move us on. If I could ask Deputy Carpenter to pick up on those next questions, please.

Deputy L.D. Carpenter:
If health spending continues to increase at current levels, what assessment has been made of the department's long-term financial sustainability?

Chief Officer, Health and Care Jersey:
So the work on sustainable healthcare funding shows that as a proportion of total public expenditure healthcare will go from being a third of all public expenditure to being half of all public expenditure. So that is a pretty stiff trajectory.

Deputy L.D. Carpenter:
Yes. In terms of then the department's long-term sustainability, what assessment has been made around that?

Chief Officer, Health and Care Jersey:

So the sustainable healthcare funding programme is designed to look at the future costs of health and care in Jersey. So there is a piece of work that has been ongoing for a few years now that has been carried forward between different Governments and different Government transitions over recent years, which has built a model of what the future health and care costs could be and are likely to be. That was subject to recent review by the Jersey Audit Office who had a look at our model and largely validated that we had done that correctly. But the headline of that is the one that I mentioned earlier, which is that health and care costs, broadly speaking, will increase by 3 per cent above R.P.I. compounded for the foreseeable future.

Mr. C. Heal:
When you talk there about going from a third to a half, over what time period is that?

Strategic Director Finance and Commercial, Health and Care Jersey:
To 2040.

Mr. C. Heal:
2040, okay. Thank you.

Deputy L.D. Carpenter:
As we have already touched upon in the hearing, Health and Care Jersey required £29 million in additional funds in 2024 and a further £14 million in 2025. What evidence can you provide that the department is addressing causes of recurring funding pressures rather than relying on annual budget adjustments? I know you mentioned the structural deficit, but specifically what are you doing to address that?

Chief Officer, Health and Care Jersey:
So in 2026, 2 useful things happened in conjunction with Treasury colleagues. So one was the injection of structural deficit funding, which was designed to ...

Deputy K.M. Wilson:
Sorry, can I stop you? Can you just focus on the 2025 position?

Chief Officer, Health and Care Jersey:
I do not think I can, Chair, because the Deputy has stated the 2025 position and then I thought the Deputy asked what we were doing about it, which of course takes us into 2026.

Deputy K.M. Wilson:
What did you do about it in 2025?

Chief Officer, Health and Care Jersey:
So I think that is the discussion that we had a little bit earlier. We talked about the way that we had ramped up the F.R.P. programme, so instead of delivering £9 million or £9.5 million we delivered £13 million out of the F.R.P.

Deputy K.M. Wilson:
So could you give an example to the member about what specifically you did in 2025 when you ramped up the F.R.P.? What specific operational examples could you give to that?

Strategic Director Finance and Commercial, Health and Care Jersey:
If I talk broadly around the F.R.P. workstreams, there are a number of workstreams that we have been looking at over the period of the financial recovery plan. So workforce is an area that we will always look at. Our use of agency has a premium cost attached to it. We have been working each year to reduce the reliance on agency and recruit substantive staff, and that then gets the cost of our workforce down. So in terms of ... and if I give you cumulative figures, they have been ramping up. As I say, we ramped up ... the target for 2025 was £8 million and we delivered £11.5 million, so we over-delivered by £3.5 million. In terms of the cumulative, in workforce we have delivered over £11 million of savings over the period. Non-pay and procurement we have saved in excess of £6 million. Clinical productivity, which productivity is not necessarily cash releasing but elements do have cash-releasing benefits, and there is £1.5 million in terms of productivity, clinical productivity. Then income over the period has increased by £8.4 million. So those are cumulative totals. The plan was to deliver £25 million over a 4-year period and by the end of the programme we will deliver £27.6 million of recurring cashable savings over that 4-year period. So those will be removed from our base budget. It is actually probably in excess of £30 million in total, more like £32 million, if you also include the one-off same things. Now, some of the 2025 actions would have been one-off savings in order to stabilise the position and hit the target that was agreed, and then those would have been picked up in the financial recovery plan in 2026. So we are continuing to stabilise some of those elements across those different workstreams in 2026 and those will be embedded going forward.

Deputy K.M. Wilson:
So what is the outturn position in 2025, Hazel? Could you give us the outturn position in 2025?

Strategic Director Finance and Commercial, Health and Care Jersey:
So the outturn for the savings plan was £11.5 million cashable savings.

Mr. C. Heal:

Can you give me an example of a one-off saving that you talked about there? Oh, sorry.

Mr. R. Duncombe:

Just a quick one from me. In terms of agency, are you saying that in previous years there has actually been a budget for agency and we underspent on the budget for agency?

Strategic Director Finance and Commercial, Health and Care Jersey:

So there are elements of provision when we budget for staffing. So if we look at nursing, for example, there is what we call headroom built into the budget for nursing because it is a 24/7 service and therefore we have to cover sickness, training and other absences. So that is allowable. Therefore, if we overspend on that budget it means that the figure has been much greater than the headroom that was created in the budget. So it is a combination of different aspects, but because there were quite a substantial number of vacancies in staffing there is the need then to recruit on a locum and agency basis at a premium cost. What we have been doing is reducing that over a period of time. So in previous years there had been a run rate. At the beginning of 2023 the run rate of agency nursing was approximately £1 million a month. Then that has reduced significantly over the following periods. Year on year there has been a significant reduction. In 2025 and also in 2026 there are extremely low levels of agency nursing staff in the department. So that gives you a practical implication.

Mr. R. Duncombe:

I guess so, but I suppose in my previous existence I was never allowed to use reductions in agency as a cost saving. You said you have budget for staffing ...

Strategic Director Finance and Commercial, Health and Care Jersey:

So in this case what we are trying to do in terms of the grip and control and financial recovery programme is to reduce the run rate of cost that has been incurred across the department. So if we look back at the history of spending, it has been a cost pressure for the department and if we do not control that and if we do not manage it and reduce it ...

Mr. R. Duncombe:

That is an overspend.

Strategic Director Finance and Commercial, Health and Care Jersey:

Yes, so what we are trying to do is reduce that overspend in order to live within the envelope, ensure that we have substantive staff that are then within a budgeted envelope. So it is a ...

Mr. R. Duncombe:

So it is staying within budget as opposed to overspending against budget?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes.

Mr. C. Heal:
You mentioned one-off savings. Can you give me an example of a one-off saving? I can understand that you are buying something at 100 and next time you buy it at 95, that is a saving. I got that. But if it is one-off, what are you comparing it against? I am looking for an example of a one-off saving.

Strategic Director Finance and Commercial, Health and Care Jersey:
If we are trying to stabilise the position, say, in quarter 4 of the financial year, there is very little that you can do in order to turn something around. So it might be that you would hold a vacant position for slightly longer and you are just deferring that decision in terms of then building that cost into your base budget going forward. So you might make that interim decision either you are going to delay a decision and then incur that cost at a later point in time. That would be a one-off saving. So really you are deferring the cost.

Mr. C. Heal:
Okay. I get it. You talked earlier about the savings target that you had. The annual report states £8 million was the 2025 Government Plan savings target and you delivered over that.

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes.

Mr. C. Heal:
How is that target set? Is that arbitrarily a number that somebody pulls out the air or where does the target come from? Because targets actually drive behaviour and I am interested to know what happens if you set a target of 20, would you have delivered 25? How is the savings target set?

Strategic Director Finance and Commercial, Health and Care Jersey:
So through the budget-setting process, and ultimately the proposal that goes to the Assembly is proposed by the Council of Ministers. So it will be a balance. So the Government is trying to balance its overall funding envelope and will have to make a number of decisions and prioritise its expenditure and income accordingly. In order to do that, in order to balance the Consolidated Fund, then savings have to be delivered and then agreed through the various ministries in terms of how those savings are distributed across different services.

Chief Officer, Health and Care Jersey:
Hazel and I missed the part of the process where the 4-year F.R.P. saving envelope was determined, so yes, we were not personally involved in that. We cannot give you the blow by blow of how they got to the number.

Mr. C. Heal:
So you are given targets that you then work to deliver against?

Chief Officer, Health and Care Jersey:
Yes.

Strategic Director Finance and Commercial, Health and Care Jersey:
At the beginning of the F.R.P. it was agreed that £25 million would be delivered over the life of the financial recovery plan. So in the early years I think the targets slipped slightly. As you would imagine in any big programme ...

Mr. C. Heal:
What do you mean that it slipped?

Strategic Director Finance and Commercial, Health and Care Jersey:
So the targets were higher and under-delivered.

Mr. C. Heal:
They were reduced?

Strategic Director Finance and Commercial, Health and Care Jersey:
So the £25 million ...

Chief Officer, Health and Care Jersey:
They were extended.

Strategic Director Finance and Commercial, Health and Care Jersey:
So it was extended, so the £25 million was then reprofiled over that period and it was extended by a year. So initially it was a 3-year plan and then extended to a 4-year plan. But this is a large and comprehensive ... there are a lot of schemes within the financial recovery plan. In 2025 there was about 140 different schemes of varying sizes. They are not all big; some of them are quite small. So there is a lot of governance and there is a lot of tracking and control of the financial recovery plan. As Tom and I have both mentioned, when we came into the department that programme had

already been running for a number of years but those targets for future years had already been set. So £8 million for 2025, £9 million for 2026, and 2026 is the last year of the financial recovery plan in its current format.

Mr. R. Duncombe:
Can I just ask one quick question? In that, as you say, 104 different plans would scare the bejesus out of me in terms of how you manage that or monitor that and I guess going forward in the future how you would ever be able to say all of those or how many of those delivered what the ask was. Were there any big ticket items in there?

Strategic Director Finance and Commercial, Health and Care Jersey:
There have been, yes.

Mr. R. Duncombe:
What were the big ticket items, apart from outside of the agency piece?

Strategic Director Finance and Commercial, Health and Care Jersey:
So there is a broad range across the workforce. It covers nursing, which was about £4 million, medical staffing was about £4 million, and then some other workforce savings which make up the remainder. Then we have private patient income.

[15:30]

So generating additional income recovery was about £5 million, but also looking at other income opportunities and also cost recovery. Again, this is about tightening our grip around some of our processes that were already in place to make sure that we cover those. Medicines we have already talked about. Medicines optimisation has delivered in excess of £2.5 million over the period. Central buying, so we have created a central buying team. So that was taking posts that already existed within the department and then bringing them together to create a central purchasing team. So to date, bringing those individuals together and controlling our ordering and purchasing and ensuring we have a grip on charges that are applied by suppliers, to date we have saved about £2 million. Then generally around improved contracting there is a further million pounds of savings.

Deputy K.M. Wilson:
All of that happened in 2025?

Strategic Director Finance and Commercial, Health and Care Jersey:

So that is the cumulative, so there would have been elements of that in ... so all of those things have existed in every year of the F.R.P.

Deputy K.M. Wilson:
So can you give us ... if you cannot give us this today, could you give us the position for the outturn for 2025, Hazel, please?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes.

Deputy K.M. Wilson:
I am just going to allow Deputy Carpenter to complete his line of questioning.

Deputy L.D. Carpenter:
Yes. So when budgeting for H.C.J. services, how do you account for individual exceptions such as very expensive treatments and who is responsible for deciding whether those costs are absorbed within existing budgets or whether you request additional funding?

Chief Officer, Health and Care Jersey:
Do you want to talk about T.I.P.P. (Treatments and Interventions Prioritisation Policy)?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes. So a policy for treatment, intervention and prioritisation was introduced, so that will look at new treatments and new medicines in a similar way to the N.I.C.E. (National Institute for Health and Care Excellence) framework in the U.K., so looking at both the clinical need for treatment or new treatments but also looking at affordability so there is now a framework in Jersey to look at that. There is an approval board with lay members sitting on it as well and each case will come forward to T.I.P.P. for a prioritisation decision that sets out both the benefits and the cost and that goes through an approval process.

Deputy K.M. Wilson:
When was that set up?

Chief Officer, Health and Care Jersey:
In 2025.

Strategic Director Finance and Commercial, Health and Care Jersey:
In 2025.

Deputy K.M. Wilson:

What month?

Chief Officer, Health and Care Jersey:

I would have to look at my board papers.

Strategic Director Finance and Commercial, Health and Care Jersey:

I would like to say …

Deputy K.M. Wilson:

It is the difference, is it not, between …

Strategic Director Finance and Commercial, Health and Care Jersey:

It was towards the end of the year.

Deputy K.M. Wilson:

… month 1 and month 12. So you have not had a full year effect.

Chief Officer, Health and Care Jersey:

No.

Strategic Director Finance and Commercial, Health and Care Jersey:

I think it was in the latter part of the year around October.

Mr. R. Duncombe:

Do you think that has brought more equity to the process?

Chief Officer, Health and Care Jersey:

Yes. It enables us to moderate the N.I.C.E. recommendations and guidelines approach so that we can make it fit better for Jersey.

Mr. R. Duncombe:

Does that also include, I suppose, exceptional cases?

Chief Officer, Health and Care Jersey:

Yes.

Mr. R. Duncombe:

For unlicensed medicines, for unlicensed indications which are very high cost but are not N.I.C.E. approved, for instance?

Chief Officer, Health and Care Jersey:

Yes. So we had one case which was for a cancer treatment which was not yet N.I.C.E. approved but was approved in Scotland and that went through the process and was determined to be reasonable value in a Jersey context. It was a single patient, not likely to have a lot of volume given the size of our population, so that went through based on the Scottish approval and their modelling, rather than N.I.C.E.

Deputy L.D. Carpenter:

So in terms of the 2025 financial pressures, you mentioned that they were first identified in Q1, I believe. What corrective action was taken at the time to try to remain within budget, if any at all?

Strategic Director Finance and Commercial, Health and Care Jersey:

We refer to a number of actions that were taken in terms of can we accelerate or can we increase the level of savings and is that on a one-off basis, particularly in terms of ensuring that they do not have a detriment to patient outcomes or services. So that was a lot of the consideration at the time, particularly in terms of where we can ensure that we are particularly recovering as much of our expenditure as possible, so looking at, for example, testing, diagnostic testing, if that is paid for through other funds, for example. So that was an area that we looked at in terms of enhancing our cost recovery and then ensuring that we can progress with some of the other areas such as procurement, for example. It is where we can make additional savings in the non-staff-related areas, so a range of different actions some of which would have been impacting our base recovery and reducing our run rate overall but also some of those one-off measures as well.

Deputy L.D. Carpenter:

Thank you. I know you have spoken around inflation being one of the key drivers. Were there any other pressures that you consider to be genuinely outside of managerial control?

Chief Officer, Health and Care Jersey:

Yes, our cost pressures are a mixture of demand, so increasing ill health. As a population we are less healthy than the generations that went before us so we have increasing ill health, added to which we have ageing, so more chronic disease, people living longer but not healthier. So it is that increasing health years but not healthy life years prices we have talked about, the price of medicines, the price of U.K. tertiary care where again we are a price taker. The price is what the U.K. wish to charge for it. I think I touched on standards as well, so clinical standards sometimes enhance the

costs and drive it. Perhaps the one that we have not mentioned and we might get on to it a little bit later in the questions is around some of that historic under-investment in facilities and in digital, which again have driven cost pressures which if the Island had been able to afford higher levels of investment in some of those areas then you would not have got the cost pressures on the revenue budget. I think those are the main ones.

Strategic Director Finance and Commercial, Health and Care Jersey:

There is also social care. Tom has already touched on long-term care, which we have seen increasing significantly year on year. So if we look back, so in terms of some of the trend analysis, that cost for above level 4 in 2021 was about £9.3 million and in 2025 was about £18.5 million. In 2026 we expect that to be about £20 million so that has increased significantly year on year. The other area is transition from Children's Services we have seen in the last 2 years. So individuals transition into adult social care but they do not have some sort of budget attached to them as individuals, so Health and Care Jersey will then have to pick up the cost of placements in terms of that transition. We have seen I would say on average ... so if I look at 2025 into 2026 and then 2026 into 2027, we try to keep a track of that by talking to colleagues in Children's Services and getting an estimate of the numbers that are transitioning and the cost, but I would say year on year it is an additional £1 million so cumulatively it is an extra £1 million every year that comes with those high-cost places.

Mr. C. Heal:

You mentioned digital. Digital is an opportunity to drive productivity improvements, maybe help with your forecasting as well in terms of patient demand and so on. You said that there was an under-investment in digital historically. Who controls that? How can you influence that?

Chief Officer, Health and Care Jersey:

I think the position has improved in recent years. One of the things that we did in 2025 was to do a H.I.M.S. (Health Information Management Services) maturity assessment. So we got the H.I.M.S. people in and that was really useful because that showed us that in the hospital we were about 3 out of 5 on the H.I.M.S. scale, which was middling, that was okay, but you can see there is lots of opportunity where we could go further and could have gone further. Then we had a separate H.I.M.S. assessment done for the whole system and that showed us on the maturity model to be at 0 out of 5 and that is because there are not things such as a single patient record. A lot of the opportunity, the big opportunities, are at a system level so how acute care joins up with community care, how that joins up digitally with primary care, how that joins up, so there are a lot of future opportunities to come at a system level in digital investment. But you can imagine that if there is a system and you are at 0 out of 5 on the H.I.M.S. maturity model you are losing a lot of opportunities for enhancing care, for productivity. You are also, I think as we have documented, causing clinical

harm, which again drives cost because then you are repairing problems that you could have dealt with earlier.

Mr. C. Heal:
The second part of my question was: who is responsible for the budget setting for digital for you? How is that process managed?

Chief Officer, Health and Care Jersey:
As Hazel said, that is budget setting through the Assembly ultimately. Proposals come forward from departments with the support of Treasury. That then has to go through a process with each Council of Ministers to work out what is affordable and then the Council of Ministers will then propose spending plans to the Assembly and the Assembly decide.

Mr. C. Heal:
Sorry to interrupt. If I have heard you correctly, an under-investment in digital in 2025 costs you in terms of productivity, in terms of improvements you could have got, because you did not get sufficient funding in 2025. Is that right?

Chief Officer, Health and Care Jersey:
At a system level, yes.

Deputy K.M. Wilson:
What was the gap?

Chief Officer, Health and Care Jersey:
Well, if you talk about where the gap is, a single patient record so there is no joined-up patient data.

Deputy K.M. Wilson:
In terms of the finances that you would have needed to address those system issues.

Chief Officer, Health and Care Jersey:
Yes, so that got addressed in 2026. Sorry, I know I am supposed to talk about 2025 but in 2026 that is roughly about £8 million a year over the next 5 years to make that investment and to plug those gaps.

Mr. C. Heal:
That is £40 million over the next 5 years.

Chief Officer, Health and Care Jersey:

Yes, but we will get huge benefit out of that as a community, a huge benefit. It will be transformational in terms of our ability. You will know better than the rest of us, that is really about the data so the lack of integrated patient data, the lack of data sharing. The single patient record is more about the data than anything else and that data foundation layer just enables so much. If we are ever going to get really good results out of A.I. (artificial intelligence), out of robotics, out of wearables, out of all of the new technologies, then the data foundation that we need to do the single patient record is the absolute key and totally transformational.

Mr. C. Heal:

I agree.

Mr. R. Duncombe:

It is one of my questions further down the line but I may as well ask it now because it is absolutely ... you have said that if we do not do anything then we are moving from 30 per cent in taxpayers' revenue to 50 per cent of budget for health, so this digital transformation, A.I., workforce transformation, public health, how much do you think that is going to reduce that need?

Chief Officer, Health and Care Jersey:

It is a speculative question. I do not know.

Deputy K.M. Wilson:

Based on the 2025 …

Chief Officer, Health and Care Jersey:

I do not know is the answer. To some extent how much of it is truly optional? Technology and healthcare are bound together and so if we are going to deliver the care that Islanders need, that they should rightly demand, then those digital foundations are essential. We will get productivity improvement out of it, we will get significant enhancements to what we can do out of that, but I think we are going to have to do it anyway. Even if you take some simple example such as once there is a good data foundation and all the data for a single patient, all of my data is together in one place and I have access to it and other people have access to it, the ability just to do simple things like risk-based profiling means our screening programmes no longer need to work then on the relatively blunt tool of age and gender and you can do tailored individual risk assessments.

[15:45]

I can have a personal risk assessment and that means I do not need to waste money on screening that I do not need but screening that I do need I can have perhaps at the right time and that will save so much money in treatment later on. You can see that there but we have not attempted to put a figure on it.

Deputy K.M. Wilson:

Okay. I am going to bring us back to financial recovery and savings if I can. Could you tell us, Tom, in terms of the savings that you do achieve that they are not simply transferring costs elsewhere in the healthcare system? How do you ensure that they are not? When you save in one area how do you know that there is not a consequence in another part of the health system?

Chief Officer, Health and Care Jersey:

Yes. That is probably where the quality impact assessment comes in.

Deputy K.M. Wilson:

Yes, so if you could give us an example of where that might have happened in 2025.

Strategic Director Finance and Commercial, Health and Care Jersey:

We touched earlier in the meeting about a discharge to assess pilot that was running in 2025 and has continued in 2026. So as we have indicated, some of the initiatives are system wide, they are intended to be system wide, so we engage with other partners. We are trying to assess that at the beginning. So if I take the F.R.P. in terms of a programme management approach, each initiative as it comes forward we will work with the team or individuals to identify what it is they are proposing, how they are going to do it and also the impacts. So we do a quality impact statement and that will look at a number of different factors. So it will look at the unintended consequences from a system perspective, so whether that is within the department or external to the department. It will also look at impact for patient-centred care as well so we are trying to see the benefit. This is not a cost-cutting exercise. It is a quality-led programme so it is about clinical delivery and quality of care as well as trying to reduce our run rate, improve our productivity and to ensure that we get better value for money out of our expenditure.

Deputy K.M. Wilson:

So if we were to look at some of the schemes that you just alluded to, would we be able to see the financial savings that have been made and the benefits associated with those savings and whether they would or would not have had an impact on other parts of the healthcare system in financial terms?

Strategic Director Finance and Commercial, Health and Care Jersey:

Yes. So what we are trying to do in terms of there is a programme management office and they are responsible for oversight of tracking the savings and productivity gains and benefits and so they would be assessing that. Sometimes an initiative will come forward and the savings will not be made in the area that is initiated. So the saving will be somewhere else rather than the other area that has been identified but it may feel an impact and it may feel a benefit so we also try to track that. We are trying to look at it from a whole system perspective in order to track those benefits.

Deputy K.M. Wilson:

Okay, so if I could just talk about workforce, because I would imagine there will be workforce savings as a consequence of some of those initiatives. We know that workforce remains the largest over-spend and you have already alluded to that earlier on but we note that in 2025 the workforce increased by approximately 300 full-time equivalents between 2023 and the end of 2025 and that was including 60 full-time equivalents which were part of interdepartmental transfers; so we are talking about the Ambulance Service. It does say in the annual accounts and report that there were some decisions taken to reduce outpatient activity because you had some pressures within the accident and emergency department, and one of the things that we wanted to understand is if you are moving people or clinicians or staff into pressure areas what kind of impact does that then have on the broader systems operating effectively and not building in any additional pressure elsewhere along the system? How do you track that? If you have to divert resources because you have got the pressure in another area is it not the case that what happens is that you create the pressure in the area that you have left behind?

Chief Officer, Health and Care Jersey:

This is a perfect question for our Chief Operating Officer.

Chief Operating Officer - Acute Services, Health and Care Jersey:

Yes, you are describing some steps that we took particularly around winter at the end of 2025 where we recognised where we had gaps in the inpatient areas and obviously it is really critical that we maintain safe patient care within the inpatient care environment. So outpatient clinics were reduced to allow us to concentrate our medical staff on those areas. We were not asking them to do jobs that they do not do but we were asking them to spend more time within the inpatient environment rather than outpatients. It was particularly to support general medical wards rather than emergency department, that urgent and emergency care that you were alluding to.

Deputy K.M. Wilson:

Thank you, Claire. Does that mean that it will have translated that more money will be needed to cover the waiting list and the waiting times that have been generated as a consequence of that happening?

Chief Operating Officer - Acute Services, Health and Care Jersey:
It will not have helped our ability to reduce outpatient waits because obviously that is capacity that we are diverting, but at this point we have continued to reduce our outpatient waiting list this year. Yes, you obviously want to deploy the capacity in the way …

Deputy K.M. Wilson:
So there was in 2025 a cost while you were trying to cover the activity but there was a cost to that because you shifted resources into another area of need.

Chief Operating Officer - Acute Services, Health and Care Jersey:
We moved the staff. However, if we had got the agency staff that we would have had we would have spent more money on agency staff, so there was a capacity impact but perhaps not a cost impact.

Deputy K.M. Wilson:
Thank you. Could you just explain to us to what extent has the investment in the permanent staffing reduced the reliance on the agency workers, locums and overtime in particular?

Chief Operating Officer - Acute Services, Health and Care Jersey:
In many areas because of the ability that we have had in order to recruit to some significant longstanding vacancies, both in medical staffing, therapy staff, nursing staff, that has been a significant success within the F.R.P. alongside oversight measures.

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes, so those are the figures that I referred to earlier, which were the cumulative £4 million in nursing, £4 million in medical. So we made really good progress in 2025 around permanent recruitment, particularly in terms of medical staffing. We had a number of positions that were vacant for a long period of time so there was an increase, and some of that headcount as I mentioned earlier you would have seen an increase in both medicine and surgical services. There are still some areas where it has been difficult to recruit but there were some successes in terms of respiratory, stroke and frailty, which were all areas where recruitment was progressed and, as I have mentioned in terms of nursing, nursing staff was substantially reduced.

Deputy K.M. Wilson:
If I come back to the waiting lists and the waiting times, and clearly they are consultant-led services, one of the things that we have noted in 2025 were the rate of vacancies in some of those specialties. Could you tell us how you are ensuring that the consultant workforce is being deployed safely and

effectively when they are having to move from various specialties, from one to the other, to cover the demand, to cover the need, but also what was your target for 2025 in terms of the recruitment for consultants and did you hit it?

Chief Operating Officer - Acute Services, Health and Care Jersey:
In terms of how we ensure that is done safely, Chair, which I think is one part of the question, ultimately that decision is made by our clinical directors and chiefs of service. We have set rotas which are then obviously describing the amount of staff that we need in an individual area, such as a ward. They are the rotas set and then our consultant body are job planned in reflection of that. Ultimately, operational and tactical decisions are made by our clinical leaders and escalated up to the Executive Medical Director ultimately as we navigate those scenarios. In terms of hitting targets for recruiting consultants, as Hazel was alluding to, we were able to improve some of our most stubborn areas I think to address, such as in 2024 into 2025 we reduced 3 out of 6 obstetric and gynaecology consultants who had been vacant for up to 3 years. They went and that has led us to deliver the improvements in maternity safety and some other singlehanded specialties that I think Tom has already alluded to in respiratory, being able to recruit for the first time a stroke consultant and a frailty consultant. With some of our priorities we have been successful. That is not to say that there is not more to go at, but I think we were pleased with how we were able to end 2025. Some of those have been really played out in terms of the financial control, particularly in obstetrics and gynaecology, and also in children's mental health there were some real longstanding posts where we had been reliant on agency to ensure that we were delivering safe care but we needed to recruit substantively.

Deputy K.M. Wilson:
Where we have still got vacancies could you just give us an indication of what the position was in 2025 around those vacant posts? What was the cost to the public purse of recruiting locums or agencies to cover those posts?

Strategic Director Finance and Commercial, Health and Care Jersey:
I do not have the medical split but that is something that we could provide. We have got an overall figure but I would have to split it between the different codes.

Deputy K.M. Wilson:
Is it the cost of that workforce is at the higher end?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes, absolutely.

Deputy K.M. Wilson:

So the question is how much in the 2025 performance was taken up with the need to employ agency and locum doctors and is that going to be the case going forward? What is the prediction around whether you are going to be able to recruit some of those specialist areas because no doubt you will be continuing to incur the cost of the locum and agency costs going forward?

Chief Officer, Health and Care Jersey:

Locum and agency costs will of course be enduring to some extent in the budget because of singlehanded practitioners. They go on holiday. You do not want to lose 2 or 3 weeks of medical cover in that specialty, you do not want to lose the clinical activity, so we are always going to have a need for locum and agency and that is good. We have some very good people that come and cover leave in certain specialties and have done for many years. That will always continue. I think what we have really been focused on is where we have had locums as essentially cover for a permanent vacancy, so where we have had a locum for 12 months or so because we have not been able to recruit. You are right, Chair, generally speaking when you are in that position you are probably spending at least a third more than you would if you had a substantive member of staff filling that on a permanently employed basis. That is expensive. I think the areas where we continue to have challenges are fairly well known. It is not particularly a 2025 point but it is well documented that we have been out many times to recruit neurologists and that has proved very difficult. They are very difficult to recruit at the moment. They are very difficult to hire right across the health system and so that has caused us quite a lot of difficulties. It has been very challenging for patients who have not had that continuity of care, which does not make us very happy and it does not make them very happy. We have been trying to address that and we have gone about that with vigour, repeatedly trying to get the right kind of recruitment, trying to get people to come to Jersey, but it is just a very difficult speciality. I think we have a few. Care of the elderly, frailty, even though we have done well and we have managed to get some people into post, that is a very rare specialism as well as you can imagine with an ageing population. They are going to prove hard to recruit for the foreseeable future.

Deputy K.M. Wilson:

I think the question is really to look at certainly on behalf of the public, which is, given that position as an outturn in 2025 that there were consistent vacancies what can the public expect to see differently in terms of improving the opportunity for recruiting a particular post holder to a particular specialty? Or is what you are saying that it looks as though given the market workforce around clinical specialty that that pressure or that financial cost that Health and Care Jersey is going to have to continue to factor into its financial planning going forward?

[16:00]

Chief Officer, Health and Care Jersey:
Possibly.

Strategic Director Finance and Commercial, Health and Care Jersey:
So if you want to understand the recruitment progress that we have made particularly in terms of medical staffing between September 2025 and September 2026, we have increased the medical staffing headcount by nearly 22 whole-time equivalents, so around 8 in surgical services and 13 in medical services, and currently we have got a campaign running at the moment for consultants. So as Tom has mentioned, it is something that we are continuing to progress but there is good progress in this area and we are looking more broadly at our workforce strategy, looking at terms and conditions as well, to ensure that we can recruit and retain medical staffing.

Mr. R. Duncombe:
I suppose that feeds into and continues that theme from 2025 in terms of service transformation and workforce transformation. Are we looking at those services in their entirety to how we can reduce our dependency particularly upon utilisation of advanced nurse practitioners, prescribing pharmacists and others to just remodel this away from what I guess is a very historic workforce model, which is always going to present these challenges where you are very much dependent upon a sole practitioner?

Chief Officer, Health and Care Jersey:
Yes. I do not know if you want us to talk about areas like endoscopy and some of the insource services.

Chief Operating Officer - Acute Services, Health and Care Jersey:
Absolutely, yes. We have identified areas where we know that we can do that and we have done that in some areas. So, for example, in-year - apologies, Chair, but it started in 2025 - an area that we were looking at and it delivered into 2026, which was where we have reduced spend in haematology consultants because we have created a clinical nurse specialist post in that specialty. Absolutely nurse endoscopies being recruited, yes.

Deputy L.D. Carpenter:
The Committee notes that improvements in some reported performance measures, particularly theatre utilisation, was up from 63 per cent in 2024 to 76 per cent in 2025, however still remains below the target of 85 per cent. However, performance has deteriorated in other areas and circa 1,300 patients were still waiting more than 52 weeks for a first outpatient appointment. How does Health and Care Jersey assess whether increased staffing and investment are delivering the

intended improvements and why have improvements not been initiated consistently across all K.P.I.s (key performance indicators)?

Chief Operating Officer - Acute Services, Health and Care Jersey:
We have not particularly invested in those particular areas to reduce outpatient waiting lists per se. We have been taking steps to ensure that we are fully recruited into the existing budget that we did have and we identified that we had productivity improvements to make such as you describe. So from 2024 into 2025, I think in 2025 we delivered around 600 more procedures through that improved utilisation within a smaller budget in some specialties such as general surgery and trauma and orthopaedics. We know that we are in the journey of improving our productivity so it is then very challenging to reliably and defensively request more resources into an area where you know that you have productivity gains to make so, yes, we have set out to do those and to achieve those. While the outpatient position did reduce by the end of 2025, that then brought pressure within our elective waiting list because once you have seen someone in an outpatient clinic then the surgeon may list them for surgery. So we saw an improvement in our outpatients at the outturn of 2025 but that then caused pressure within our inpatient waiting list. They were reduced initially at the start of 2026 so we are improving our utilisation. We can see in cold hard procedures we have increased the amount of public procedures from 2024 into 2025 and that has continued into 2026.

Deputy L.D. Carpenter:
With inpatient admissions increasing to around 34,000 and outpatient attendances increasing to over 252,000 during 2025, how do those activity increases compare with growth in staffing costs and workforce numbers?

Chief Operating Officer - Acute Services, Health and Care Jersey:
I suppose with my previous answer we are still yet to fully realise the benefit of complete recruitment into those specialties and we do know that we have opportunities to further modernise our outpatient profile. So one of the digital impacts we know that will bring benefit is in patient-initiated follow-up, which is something we need the digital infrastructure for but with considerable consultant overview and a set of advice to a patient. We know that we could discharge patients from outpatient review and allow them then to come back with a safe framework which will be delivered by one of our digital improvements that has been set out. Similarly, the previous discussion about moving some consultants from medical consultant led into a nurse-led consultant so we could then look to see the same amount of activity but with a different workforce model, which would be more sustainable and not necessarily require investment. That is one of the pieces of work that we are looking at, at the moment. I am not sure if I have answered all of your question.

Deputy L.D. Carpenter:

Yes, that is great, thank you. What proportion of the waiting list is attributable to consultant availability or diagnostic capacity or scheduling constraints? Are you able to break it down?

Chief Operating Officer - Acute Services, Health and Care Jersey:
That is a complex question. In terms of direct specialties that are directly attributable to a vacancy I would say that they are few. Perhaps around 20 to 30 per cent of our outpatient pressures are because we have got singlehanded specialties; for example, neurology or where we have had a long-time vacancy such as gastroenterology. Others are due to then either pressure in our demand or the fact that our demand has changed. What we can demonstrate across 2025 is that our triage of referrals have increased. So we received more referrals from primary care that are tagged as a suspected cancer or an urgent and we can demonstrate that we are meeting that demand but there are consequences on our routine patients. We are seeing that activity that is more clinically urgent but that has had impact on our routine waiting lists. I think I have forgotten the third part of your question, sorry.

Deputy L.D. Carpenter:
That is fine. The third part was scheduling constraints.

Chief Operating Officer - Acute Services, Health and Care Jersey:
Again, we know that we have had improvements that will deliver a significant change for patients in respect of that, so ability around our outpatient booking. We have lots of modernisation that we have got planned in relation to that. Again another digital programme that is planned is Patients Know Best, where patients will be able to see their appointments that they have got booked and have more control. Again, we know that we have still got improvements in our D.N.A. (did not attend) rate to make and having appointments that are more accessible for patients at the time when they are able to attend will also help our efficiency in that.

Deputy L.D. Carpenter:
Finally, what benchmarking do you undertake against comparable healthcare providers to assure yourself and Islanders that Health and Care Jersey is delivering good value for money?

Chief Operating Officer - Acute Services, Health and Care Jersey:
So one of the metrics that you alluded to was the theatre utilisation, so we have used that, which the N.H.S. and G.I.R.F.T. (Getting It Right First Time) set at 85 per cent. They are not meeting it in all areas. We are meeting it in some and absolutely have that data at a surgeon level so we can have those conversations, understand whether it is our processes, our policies, what it is so we can support our clinicians to achieve 85 per cent, which is what we want to do. We are using other national programmes set by G.I.R.F.T. around outpatient productivity. We have had G.I.R.F.T. over

for invited reviews that have looked at specific specialties such as trauma and orthopaedics, ophthalmology, so that we can ensure that we are benchmarking and that we use that as an important way to improve the standards of care that we deliver. We absolutely do look to the U.K. and other island jurisdictions as well because we do recognise that Island medicine can have a different context. So we work very closely with colleagues in Guernsey or the Crown Dependencies but also look to N.I.C.E. and use all of that that is available to us.

Mr. M. Oliver:

I think we have established that the 2025 budget was not sufficient and I think we have identified quite a few of the reasons why it was not sufficient. The question is really: given that it was identified as early as Q1 how do we improve forecasting going forward or is there a tactical thing going on here whereby we request a budget that we think the States Assembly will accept in the full knowledge that more funds will become available later as they have done in many years past?

Chief Officer, Health and Care Jersey:

No, we do not prefer that option.

Mr. M. Oliver:

You might not prefer it but it might be a well-worn tactic.

Chief Officer, Health and Care Jersey:

No, we are not attempting a tactic here. I think that you can see in the 2026 budget, sorry, Chair, we have got much closer to what we think are the real underlying costs allowing for the efficiencies that can be achieved, and we are expecting that that will therefore increase or will continue the trajectory in bringing us closer and closer to hitting the envelope. So we are anticipating that … we inherited a position of a £30 million drift of envelope. We reduced that down to more like £13 million and then this year we expect to reduce that down again so that we are much closer to the envelope, and hopefully next year we can complete the process and get fully within the envelope. It is about everyone having a shared understanding of where healthcare costs are. One of the things that I think will lead to a closer outcome this year is the really helpful recognition by everyone in government that healthcare inflation is running at more like 3 per cent above R.P.I. rather than the 1 or 2 per cent, and so that kind of shared analysis through the sustainable healthcare modelling work, that understanding of how demographics, how the cost base, is driving healthcare costs has helped get to a much closer estimate. Having said that, I do not think we ever expect that healthcare is ever going to be perfectly forecastable. I think there is just too much demand led and there is too much which is dependent on the price set by other people outside of Jersey for us to be absolutely confident. We continue to get closer and we continue to get a better shared view with Treasury colleagues and others of the forecast and the expenditure, but health is one of those budgets that

is hard to hold within a departmental expenditure limit. What you want in a departmental expenditure limit is entirely predictable expenditure which is within your management control and where you do not have that generally you take part of that expenditure out and manage it differently, which of course is what happens with things such as unemployment benefit.

Mr. M. Oliver:

Sorry, I am conscious of the clock and we are running out of time so if I can move on. The Comptroller and Auditor General's report on the sustainable healthcare funding and Strategic Plan recommended modelling wider social care costs to support the long-term funding decisions, yet that recommendation was rejected. How can the Ministers and the Assembly who are making a decision on healthcare funding feel that they have a sufficiently complete evidence base on which to make decisions if we are not carrying out that work that is recommended by the Comptroller?

Chief Officer, Health and Care Jersey:

I think the discussion there is around the frequency with which the model is revisited and re-updated. Obviously that is not cost free. That comes with significant costs every time that you renew that model and revisit it, and so the recommendation was and is supported because we recognise that the model needs to be revisited every so often. It is simply a debate about how often.

[16:15]

Mr. M. Oliver:

But the executive response was not agreed. There is no "Ah, but."

Chief Officer, Health and Care Jersey:

No. I think from memory it was around the frequency. Let me just bring that up so that I have it in front of me as well, then we can have a look at it.

Deputy K.M. Wilson:

I think the recommendation was about to model care costs and the question we are trying to get an answer to is why is that a problem modelling care costs and why is frequency an issue for you? Should that not be part of your regular assessment of what you do in terms of …

Strategic Director Finance and Commercial, Health and Care Jersey:

I think only a small element of L.T.C. is healthcare.

Chief Officer, Health and Care Jersey:

I was thinking that was recommendation 1.

Strategic Director Finance and Commercial, Health and Care Jersey:
There were different elements of the recommendation.

Mr. M. Oliver:
It is recommendation 3.

Chief Officer, Health and Care Jersey:
I was thinking it was recommendation 1. My apologies. Let me have a look at recommendation 3. Yes, social care.

Strategic Director Finance and Commercial, Health and Care Jersey:
So it was to do with the proportion of which sits within the health and care sector and system and that which sits outside. So it is trying to define the scope of the modelling in order to move it forward at a pace that is appropriate in terms of getting a decision around sustainable healthcare funding. Then if we widen the scope, then it brings in other factors that have limited impact in some of those ... is that not the ...? I do not have it in front of me.

Chief Officer, Health and Care Jersey:
Yes, it is the L.T.C., is it not?

Strategic Director Finance and Commercial, Health and Care Jersey:
Yes. So in the analysis it is the social care costs and healthcare as they are defined under the O.E.C.D. (Organisation for Economic Co-operation and Development), and the proportion of which would impact in terms of that overall decision making. So it was deemed to be a low risk in terms of the modelling impact.

Mr. M. Oliver:
Could I suggest that in future if something is not agreed that there is a little bit more of an explanation behind it?

Strategic Director Finance and Commercial, Health and Care Jersey:
Sure.

Mr. M. Oliver:
The previous Public Accounts Committee noted that the Ministerial Health Funding Reform Group has met but governance arrangements remain under development. What decisions has the group taken to date and when will Islanders begin to see some tangible reform proposals?

Strategic Director Finance and Commercial, Health and Care Jersey:
I think that is probably in relation to the timing of the new Council of Ministers coming into being, so it is a sort of timing issue. The group has been formed so the programme of work can then move forward. The cost modelling has been completed. It has been reviewed technically. We have had independent peer review of modelling and then that builds the basis for consideration of policy options. Going forward obviously would be the space that the Ministerial Oversight Group would then need to be considering. Given the timing of elections and then positions being allocated, that has really been the reason why they have only met recently.

Mr. M. Oliver:
Well, we are nearly 6 months past the election so when are we likely to see something?

Strategic Director Finance and Commercial, Health and Care Jersey:
I think the plan is to bring something around March 2027 in terms of initial considerations that will then be fed into the medium-term planning process for 2028 to 2030.

Mr. M. Oliver:
Finally from me, within the reported accounts overall there was a very big underspend on capital expenditure, and a large chunk of that actually sat within the new healthcare facilities. I wonder if we could understand why that was.

Deputy K.M. Wilson:
Jessica, just for the record can you give your name and role, please?

New Healthcare Facilities Programme Director, Health and Care Jersey:
Sure. Jessica Hardwick, the Programme Director of the new healthcare facilities programme. You are correct, there was an underspend in 2025 in relation to the healthcare facilities. It was entirely related to the placement of the main contract and it was decided through governance groups that the procurement process would be extended, and that meant that the main contract was not placed and, therefore, the spending came later. It was deferred cost rather than underspend, as it were. We are anticipating spending that money, we are just expecting to spend it a little bit later. Of course, that brings an inflationary effect but that was covered within the budget set out within the new healthcare facilities programme. So really the reasons for that extension were to make sure that we delivered good value for Islanders and the best possible contract that we could. We wanted to extend the period in which there was competitive tension to absolutely secure the best possible contract terms.

Mr. M. Oliver:
Okay, thank you.

Deputy K.M. Wilson:
We are going to move on to digital.

Mr. R. Duncombe:
Yes, very quickly, we have not got a huge amount of time. As you alluded to, we are not as digitally advanced as we would like to be, and if we had the system in place in 2025 then potentially we would have more productivity and more efficiency. My experience of digital healthcare programmes is that they always cost more than you expect them to, they are always more resource intensive both in terms of I.T. (information technology) staff and actual clinical staff as well in terms of their delivery, and they are never delivered on time. I guess in terms of the programme you have identified today, how confident are you that what you have alluded to is not going to cost more, is not going to require more people, and is going to be delivered on time?

Chief Officer, Health and Care Jersey:
It does require people. People are a big part of the business case and that is because we are trying to learn from previous programmes and do things better. Previous programmes have lent very, very heavily on external resource brought in, contract resource, and that means that we have not built the capacity, knowledge and experience that we need to have in sufficient breadth and depth in our own team. One of the parts of this new approach, which we hope will be better than previous initiatives, is to build our own team to create the capacity and capability in a more enduring way so that we do not have this traditional I.T. pattern of hired-in team arrives, does “wow” things and leaves, that we have people that are invested in making it work. The people are a really important part of this. The budget is fixed and set and so it does need to sit within the budget ...

Mr. R. Duncombe:
I suppose based on our earlier discussions it seemed to be that the budget in health is more flexible?

Chief Officer, Health and Care Jersey:
Has been in the past, I think perhaps we would say.

Mr. R. Duncombe:
But I suppose the economies will be ...

Chief Officer, Health and Care Jersey:

But on a programme like this, this is more within management control and so there is an element in which you are dependent on the market but it is a more controllable element through procurement and the usual methods that you use to control digital investment costs. The one variable that I think is vulnerable is time, and so if I was to say which of those is going to give I think it would be the time variable.

Mr. R. Duncombe:
We had this conversation on Friday and also on Wednesday, that the delays in doing big digital projects has an opportunity cost attached to it.

Chief Officer, Health and Care Jersey:
Absolutely, yes.

Mr. R. Duncombe:
As you say, every year that we delay ... this case also has a safety implication as well.

Chief Officer, Health and Care Jersey:
It does, yes.

Mr. R. Duncombe:
But you are saying that you are not confident in terms of delivery?

Chief Officer, Health and Care Jersey:
I am saying that if any of those 3 variables that you have outlined is going to give I think it would be the time one.

Mr. R. Duncombe:
I suppose the other bit which follows on from this - and you mentioned Patients Know Best as well - so much of this is dependent upon patient uptake, that you only start to gain the benefit if you get 80 per cent to 90 per cent of people using it.

Chief Officer, Health and Care Jersey:
Yes, absolutely.

Mr. R. Duncombe:
When we spoke to the guy from the Treasury or the income person, at the moment I think only 50 per cent of residents of Jersey fill in their tax returns online. So if only 50 per cent of the population choose to use Patients Know Best you are going to have all the expenditure but none of the benefit.

Chief Officer, Health and Care Jersey:

Yes, and with that what we are hoping to do is to roll it out service by service. Rather than trying to go big bang, like every service all at the same time, we are hoping to do it service by service and learn as we go. I think we are starting in physiotherapy and then we will learn. If we are not getting the uptake among patients that we would like to get then we can adapt our approach, but it is a phased and evolving rollout. But I absolutely agree, getting the maximum benefit depends upon getting maximum uptake.

Mr. R. Duncombe:

There would be no benefits if you still have to employ the same number of back office staff to run the system because you have only got 50 per cent uptake.

Chief Officer, Health and Care Jersey:

Absolutely. The entire Patients Know Best investment is around empowering patients with their own information. If patients do not take it up, then of course the investment ultimately would be very poor value. But that is not what we are aiming for, we are aiming for good uptake and then we will learn as we go. If it turns out that the people of Jersey are more resistant to having their own health information than other citizens are, then we will have to adapt, but I would imagine that having access to your own patient data is hopefully quite different to filling your tax return online.

Strategic Director Finance and Commercial, Health and Care Jersey:

As we mentioned earlier, this is also where we are looking at whole system. This is a systems investment. Patients Know Best is one element as well of it but it is about creating a core platform for clinicians across different parts of the system to enable us to manage patient care and pathways much more effectively, and have better outcomes for patients.

Mr. R. Duncombe:

Okay. Well, I am sure we will come back to that.

Chief Officer, Health and Care Jersey:

I suspect we will be talking about Patients Know Best a lot over the next couple of years.

Deputy K.M. Wilson:

Finally, the annual report shows increased expenditure, additional in-year funding, growing demand - as you have alluded to - and substantial investment in service transformation. If the Committee was sitting here again in 12 months' time, what 3 measurable indicators would you expect to be able

to point to as evidence that Health and Care Jersey is becoming more financially sustainable, more productive, and delivering better value for money?

Chief Officer, Health and Care Jersey:
Financial sustainability, what would I look for? I would look for us to continue to come closer to the envelope. As I said, parking the ship exactly in healthcare is challenging because of the demand-led nature of the budget, but I would expect that £30 million and £13 million ... I think you would expect to see it getting closer and closer. It is going to get closer partly as a result of us doing everything we can to put control and oversight into demand-led budget areas so that we can get a grip on them as they start to increase, and partly because of the budget-setting process being much more closely aligned to the reality of the cost drivers. As long as the budget-setting process continues to be well aligned to the cost drivers, and our grip and control measures continue to be developed and stay in place, then you should see that coming closer and closer together. On areas like productivity, that will be much more obvious through the data. Claire talked about some of the areas earlier. You can see that something like do not attend rates should improve as things like take-up of Patients Know Best continues. At the moment our do not attend rates have got better for people not attending appointments, but they are still below where we would like them to be. We know that digital investment is part of the key to making that work so people can see their own appointments, ask to change around appointments. It has that empowerment and visibility to it. It moves us away from sending people paper letters and things that we are still doing. Those kind of measures of productivity should be pretty clear. If we are doing that you will see that, and if we have not done it, that should be obvious as well.

Deputy K.M. Wilson:
Okay, thank you. Hopefully we will see some plan that describes those targets and your progress towards those over the next 12 months or so. If the Committee has finished ... we are coming to the end of our scheduled time ...

[16:30]

Chief Officer, Health and Care Jersey:
Is this your Colombo question?

Deputy K.M. Wilson:
This is my Colombo question, but I think I have just asked that, which is about how we are going to see improvement in the next 12 months. We still do have a number of questions that we did not get through today, and thank you for offering to respond to those. Can I just say thank you for attending the hearing today and for addressing the Committee's questions, the supporting officers for their

contribution to the hearing today, and also to the public who have been watching this hearing. We will look forward to seeing you again in due course.

Chief Officer, Health and Care Jersey:

That is very kind. My thanks also. I think that having an interested and engaged Committee to work with is really important and really helps us and keeps us focused and motivated. I have taken from today, yes, good probing questions which I appreciate, but also I have appreciated the understanding and the desire to get under this and to help the Island move forward. I will certainly take that back into the department. I am also grateful for your comments at the outset with thanking everyone for all of their work because, as you know, delivering healthcare is not an easy thing and it is difficult to do well and to do consistently well, so that is really appreciated. Thank you.

Deputy K.M. Wilson:

Thank you.

[16:31]