Government of JERSEY

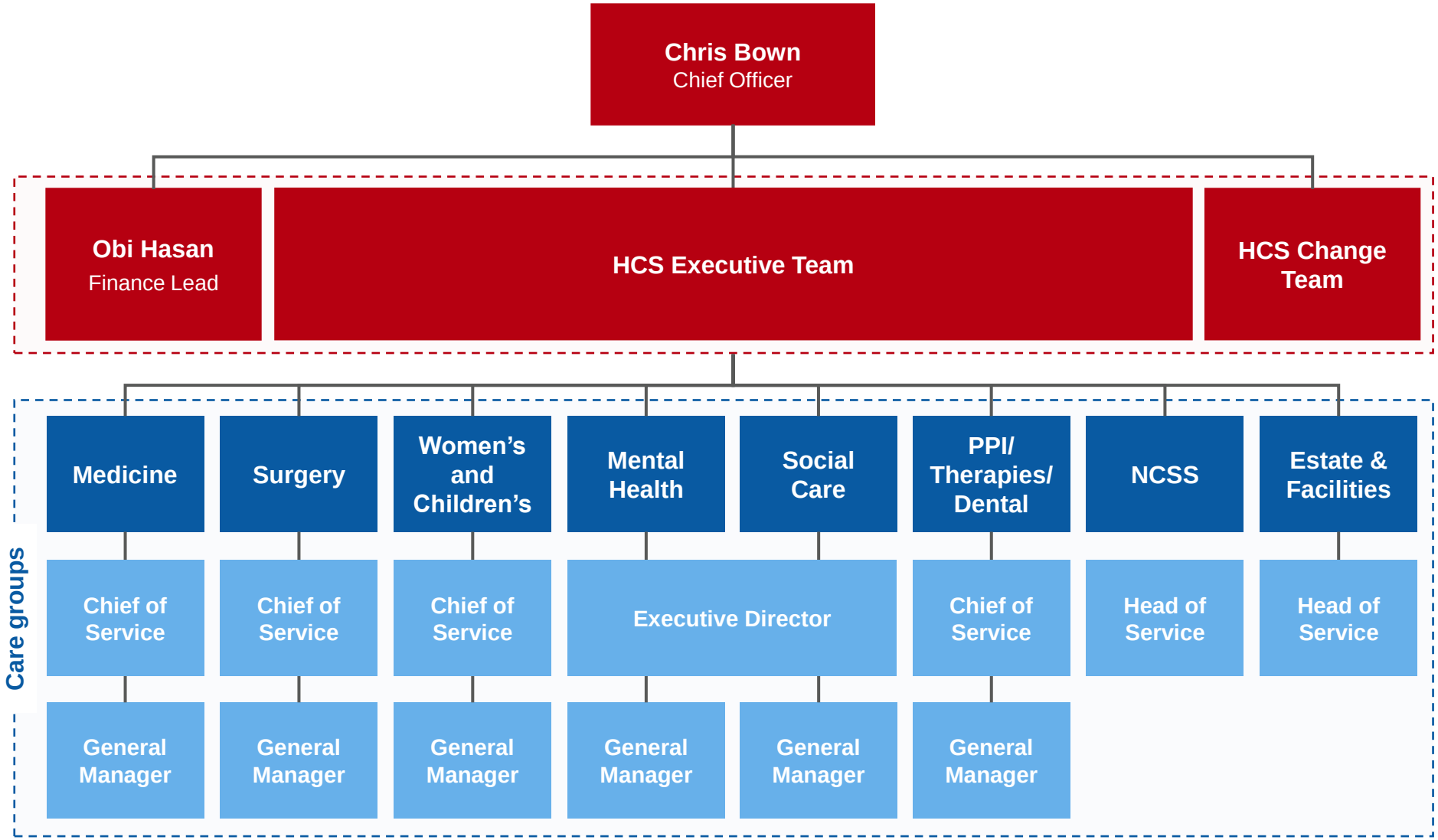
Gouvèrnément d'Jèrri

HCS Financial Recovery Plan (FRP)

September/October 2023

Commitments

This plan has been built up at a care group level and has been signed off by the Board and Executive team. This HCS is committed to the delivery of this plan, the delivery of which will be reflected in the goal setting for our senior leadership team



Introduction to the report

Jersey's Health and Community Services (HCS) form a vital pillar of support for all our people, enabling Islanders to live longer, healthier and productive lives. In order to deliver this, we need to provide safe, sustainable, affordable and integrated services for all.

This quality-led Financial Recovery Plan (FRP) is built on a set of core values that combine patient focused quality improvement, financial recovery, clinical, staff and stakeholder engagement, teamwork, and inclusive leadership to deliver sustainable improvements. This journey of improvement will take 3 years.

In recent years the affordability of care has become more challenging, creating a risk to the future sustainability of services as they are currently delivered. Jersey is not unique in this, with many health systems globally challenged by the Covid pandemic, health worker shortages, inflationary pressures and changing demographics driving increased demands and rising costs. These, together with a number of unique island factors, have resulted in a current underlying financial deficit of £34m for HCS that necessitates urgent action to stabilise, and a comprehensive plan to address.

This situation has not arisen overnight, with problems compounding over several years. Many of these may not have been immediately obvious, and whilst identifying improvements that are in the direct control of HCS to deliver, it is equally important to recognise that a number of distinct factors are outside of its control. Such complex issues will now take several years to fix, and this detailed plan clearly sets out our 3-year roadmap to deliver the necessary efficiency savings and income improvements identified of £25m that are within its control:

- £3m the current financial year
- £12m in FY24
- £10.6m FY25

To deliver this requires a proportion of the total deficit due to factors outside the control of HCS, known as the 'structural' deficit, to be funded. Importantly, we will also need to change our ways of working too, updating practices and improving our governance and culture to ensure our work benefits the islanders we serve.

The Change Programme is an integrated approach to improving the quality of care, operational performance, and financial recovery, which are inextricably linked. As part of this, the approach taken in developing the FRP Programme demonstrates that the money measures the financial consequences of the actions taken in delivering care. The better and more efficiently those actions are delivered the greater the improvement in the quality of care and the money used to deliver it.

Many colleagues and stakeholders have contributed to developing this comprehensive plan, and we thank them for their support in helping us provide the sustainable health system the people of Jersey deserve. In particular, we are grateful for the support provided by the Change Team who have worked closely with the Executive Team, clinicians, and staff in developing the major improvements identified in the 7 workstreams of the FRP.

The approach to the development of the FRP has been to engage widely with clinicians and staff to involve them in shaping the solutions at the frontline and co-developing our challenging FRP Programme. It has ensured joint ownership by Executive Leads, Care Group leadership teams, clinicians (doctors, nurses, AHPs), and operational staff for delivery and meaningful accountability exercised through the Governance structure now established.

Delivering this plan will not be easy, and much of this task still lies ahead. We have already started to build our capacity and capability to sustainably deliver these improvements, actively recruiting a Programme Management and Delivery Team (PMDT) to work alongside the Care Groups and Directorates.

As we enter the 'Delivery phase' of the FRP Programme, successful delivery will require culture change. That means a culture of Ownership for delivering improvements with a can-do attitude, and a culture of Accountability, supported by the PMDT delivery team working alongside the frontline teams, and making it happen.

We look forward to updating you on our progress.

Chris Bown
Chief Officer
Health and Social Care
Government of Jersey

Obi Hasan
Finance Lead - Change Team
Health and Social Care
Government of Jersey

FY 2023 forecast deficit of **£29m** and a 2022 budget deficit of over **£12m**

Outpatient referrals grew **24%** from 2021-2022

This Financial Recovery Plan sets out savings of **£25m**

Theatre utilisation **66%** as at December 2022

Agency spend increased **26%** from 2021-2022

Elective waiting lists grew **30%** from 2021-2022

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Executive Summary

Executive summary

HCS has an underlying deficit of £35m. Urgent action is needed to reduce the underlying deficit and return the system to a financially sustainable position. This quality-led Financial Recovery Plan sets out how HCS plans to tackle the challenge through a comprehensive financial recovery program.

Headline Financials

- **HCS's financial position has deteriorated from £1.5m surplus in FY19, to a forecast of £29m deficit in FY23, and the underlying position is currently £35m**
- Some of the key drivers of this deterioration in the financial position are inflation, higher spend on agency staff, increases in non-clinical staff compared to the front line, non-delivery of efficiency targets, activity pressures and business case pressures, and provision of unfunded services
- To address the challenge, HCS plans to deliver £25m savings (£3m in FY23, £12m in FY24, and £10.6m in FY25).
- This is a significant target and equates to 3.6% recurrent savings Y.O.Y in real terms
- The structural deficit (unfunded services) is £15m
- The Financial Recovery Plan, by delivering £25m savings, will address £5m of the structural deficit
- The remaining balance of £10m requires additional funding or decision on continuity of services

Key Challenges and Success Factors

HCS faces several challenges, which are being addressed as part of the FRP in order to ensure successful delivery. These include:

- **Clinical and other stakeholder engagement**: whilst clinical engagement is increasing, this requires continued development so that clinical leaders across HCS are fully engaged in supporting the programme to deliver the improvements at pace.
- **Development of HCS capacity and capability**: delivering this FRP requires significant cultural change. The approach adopted to support the delivery of the Financial Recovery Programme is using a combination of temporary capacity and skills to commence and drive the recovery, with upskilling of the existing workforce to deliver change long after the temporary capacity has ceased providing support, and recruiting an internal Programme Management Delivery Team (PMDT) to provide the permanent capacity and capability which is essential to make it sustainable.
- **Cultural state of readiness**: a quality-led financial recovery programme is a complex undertaking for any organisation, it requires a cultural maturity in behaviour, governance, accountability, and leadership across all levels. Successful delivery requires whole-system thinking powered by teamwork and ownership.
- **Leadership development**: the Financial Recovery Programme enables leadership to shift towards a cost-conscious culture, where in every decision that is made, value for money is kept top of mind, whilst also prioritising patient safety, quality and access.
- **Clinical engagement, ownership, and accountability (incl. doctors, nurses, AHPs)**: engaging the clinical body is an integral component to ensure the culture change from the top-level permeates through the entire organisation.
- **Data for evidence-based decision-making:** developing greater data maturity and transparency to make informed decisions in a timely manner.
- **Increased support from Shared Services**: additional targeted resources in direct support of HCS to support the frontline staffing challenges to rapidly reduce the significant reliance on agency spend. For example, more dedicated support is required in order to speed up recruitment and reduce time to hire, in order to displace premium agency.
- **Political support:** HCS will need the full support of and buy-in from politicians in delivering this challenging FRP and managing powerful stakeholders, including making bold decisions in prioritising limited resources.

Executive summary

Our quality-led financial recovery program takes a bold approach to engaging staff and wider stakeholders in ensuring that this program is understood and supported across our community. A number of carefully considered initiatives have been put in place, and a different approach has been adopted to involve stakeholders to ensure buy-in. Taken together, we believe this will ensure a sustainable program of work that is set up for success.

What's different this time?

- **Senior HCS Executive level Programme leadership**
- **Developing a quality-led Financial Recovery Programme** – this financial recovery plan aims to ensure the optimal quality of care delivery and services; this is not a slash-and-burn approach, investment may be required in certain areas to support improvements such productivity gains, as well as efficiency in both clinical and supporting services.
- **Governance and accountability** – improved governance and accountability through the leadership of the Change Team, by establishing a robust structure and process to ensure accountability of named owners who are given the support to deliver the improvements.
- **Clinical engagement** - engagement with clinicians and stakeholders, as further detailed below. Considerable time has been invested to meet, discuss, and engage stakeholders in the development of this plan to ensure their understanding and buy-in.
- **Building HCS capacity and capability** – capacity and capability building is critical to ensure timely delivery. We are recruiting a Program Management Delivery Team (PMDT) consisting of a dedicated number of individuals who will provide program management and delivery support for the improvement schemes that have been set out in this report.

Engagement

This Financial Recovery Plan has made particular efforts to engage and align stakeholders to ensure successful implementation:

- **Active engagement** – over 16 weeks, we actively engaged with over 100 stakeholders throughout HCS through various forums to ensure the timely identification of schemes, the operationalisation of opportunities, and the development of capacity and capability to promote sustainability in HCS.
- **Shaping the solutions with the front line** – the contents of this plan have been developed through over 90 'Support & Challenge' meetings and 60 'Cross-cutting theme' meetings with HCS frontline teams to ensure they are based on real-world practices and incorporate their ideas, testing, and inputs.
- **Communication and engagement strategy** – The capacity of the HCS communications team has been increased, which will support the ongoing communication and engagement required to successfully deliver the FRP. The engagement strategy aims to build awareness and empower ownership across staff (including front-line staff) and a range of stakeholders. This takes the form of a multi-channel communication approach, regular workshops, and engagement events to maintain momentum and celebrate progress.

Next Steps

The FRP plan described in this report concludes the planning phase and provides a detailed and clear roadmap towards financial recovery. All the aspects mentioned here are the critical success factors to advance the delivery of the programme. In addition to the above, we strongly recommend to continue with embedding the outcome focused commissioning approach developed with stakeholders and published in the Commissioning Strategy, and as described on page 33.

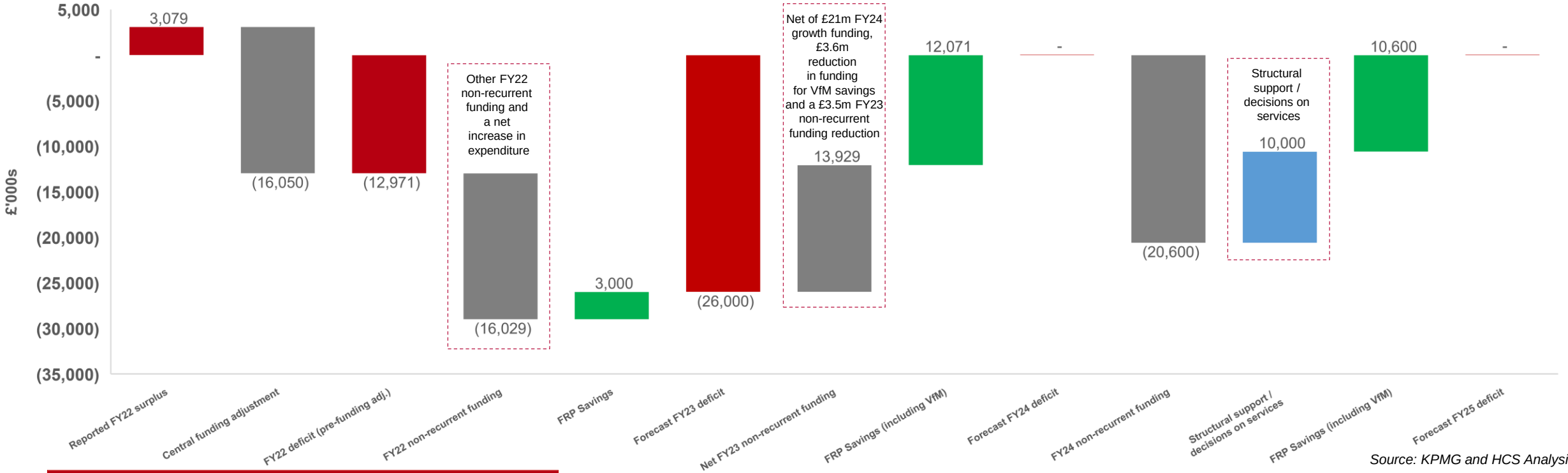
As we enter the 'Delivery phase', successful delivery requires a culture of Ownership and Accountability, with frontline teams supported by the PMDT delivery team working alongside them to drive forward at pace the improvement schemes that are set out here, while managing the associated risks.

Active two-way communication and continued socialisation of this plan with stakeholders across all domains is essential for engagement and support.

We will communicate and engage regularly with the Council of Ministers, ensuring any risks and issues requiring support are flagged quickly and addressed. This plan will require ongoing support from Government Ministers in jointly owning this program in order to drive the changes that are needed.

Executive summary

The financial challenges and cost pressures in FY22 are expected to continue and increase in FY23-25, but through the FRP programme, HCS expects to deliver a total of £25.7m recurrent savings over 3 years, with £3m FY23, £12m in FY24, and £10.6m in FY25. The Financial Recovery Plan, by delivering £25.7m savings, will address £5m of the structural deficit. The remaining balance of £10m requires additional funding or decisions on continuity of services

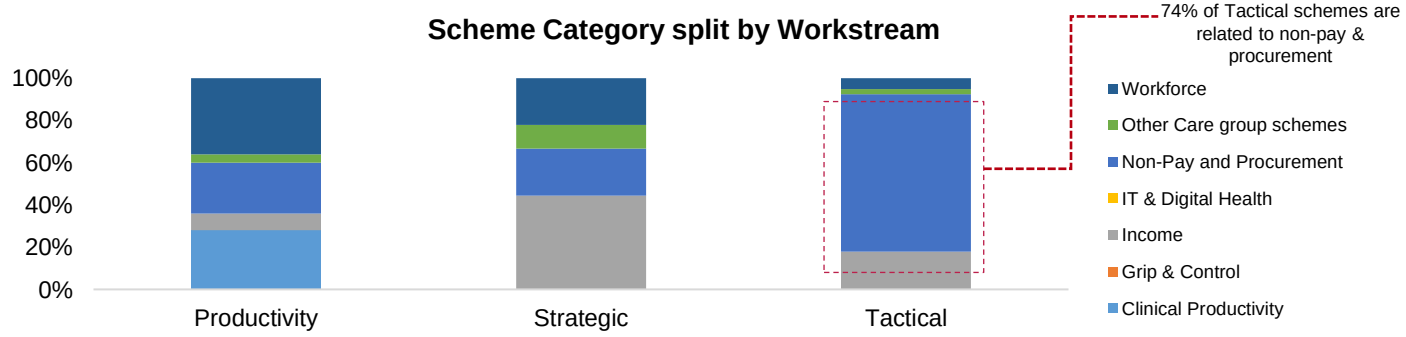


Source: KPMG and HCS Analysis

Forecast performance summary			
£'000	**FY23**	**FY24**	**FY25**
Funding	249,032	270,575	270,161
Non-recurrent additional support	-	16,000	-
Costs	(278,032)	(301,646)	(305,832)
Net Deficit - pre FRP	**(29,000)**	**(15,071)**	**(35,671)**
VfM savings	-	3,571	3,571
FRP efficiencies	3,000	11,500	22,100
Structural support	-	-	10,000
Surplus / (Deficit) - incl FRP	**(26,000)**	**-**	**-**

n.b. on a cumulative basis

Source: KPMG and HCS Analysis



Source: KPMG and HCS Analysis

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Context - how did we get here?

The current financial position

Underlying financial position

The recent drivers of deficit report indicate that HCS's deficit has deteriorated significantly, from a deficit of £1.5m in FY19 to a forecast of £29m in FY23. From an underlying perspective, whilst the reported position remained relatively stable until FY22, the underlying position has deteriorated consistently since FY20, and is forecast at £34.2m for FY23. This is partly driven by increased expenditure due to inflation, higher spending on agency staff, and recruitment in non-clinical posts. It was also expected that HCS would deliver material savings in FY22 which have not materialised. Furthermore, there have been a number of activity pressures and business case pressures across the period, driving the deterioration in the deficit position.

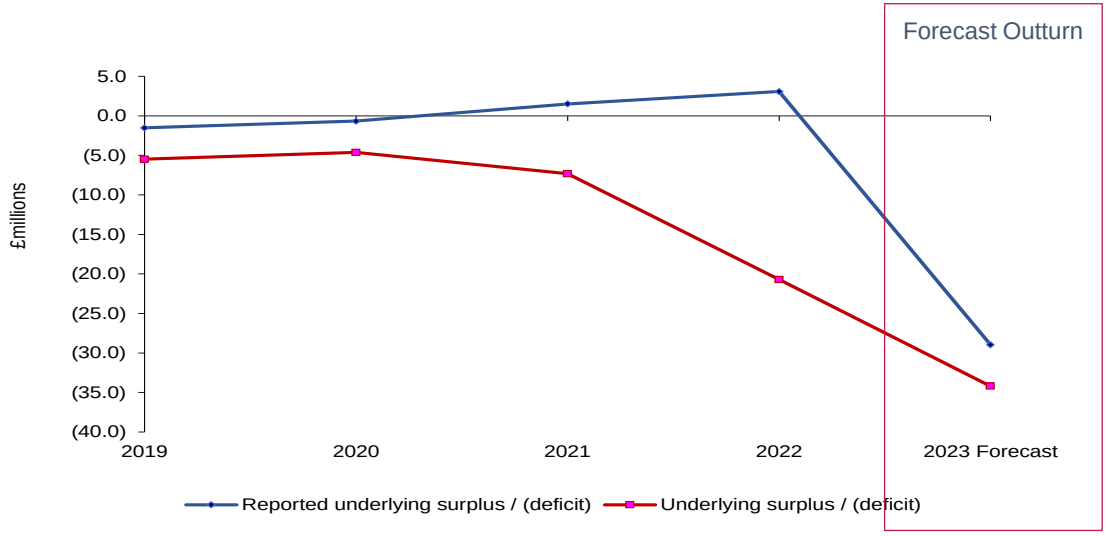
The drivers were classified into the following three categories:

- **Operational:** relating to inefficient ways of working, which can be addressed by HCS via tactical schemes and initiatives.
- **Strategic:** relating to service delivery models including the way that services are organised across sites.
- **Structural:** relating to challenges outside HCS's control, which are driven by structural issues such as Island factors, demographic factors, national workforce shortages, or impacts of policy decisions.

The drivers of deficit report identifies the extent to which the deficit is within HCS's control against what is not and will require external support/decisions. The report identifies £15m as the total underlying structural deficit, representing the portion of the deficit outside of HCS's control. The full report is included in Appendix 3.

This FRP document sets out how the overall underlying deficit can be addressed, including the structural deficit with outside support / decisions on continuity of services, to return HCS to a sustainable financial position by the end of FY25.

Reported and underlying surplus / (deficit) (FY19-FY23)



Underlying adjustments (summary)

Underlying surplus / (deficit)					
£m	2019 ACT	2020 ACT	2021 ACT	2022 ACT	2023 F'CAST
Reported surplus / (deficit)	**(1.5)**	**(0.7)**	**1.5**	**3.1**	**(29.0)**
Less: Non-recurrent income	(0.2)	0.0	(1.1)	(3.3)	(1.5)
Less: Covid-19 costs	-	(4.7)	(0.2)	(0.0)	-
Less: other costs / funding	(3.4)	0.7	(7.5)	(20.4)	(3.7)
Underlying surplus / (deficit)	**(5.5)**	**(4.6)**	**(7.3)**	**(20.7)**	**(34.2)**

The above underlying items have been adjusted to inform the baseline deficit / surplus for HCS. There are a number of on-going business case expenditure, which would need to be funded in the short term, but would not form part of the financial baseline.

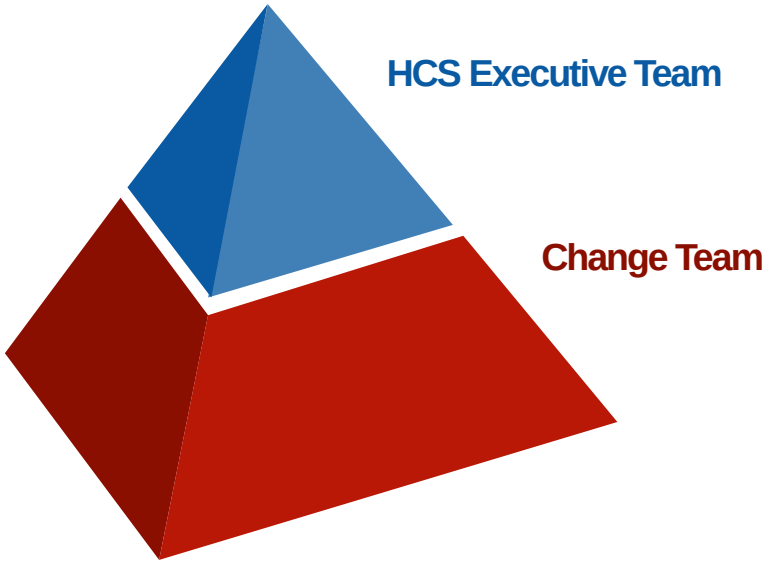
How did we get here – what is driving the deficit?

The below summarises the operational inefficiencies, strategic factors and systemic drivers contributing to the increase in HCS's cost base and increasing deficit (net of incremental funding received) between FY19 and FY22. The chart provides a breakdown of the various drivers of the deficit and how they have exacerbated the financial position overtime.

	Operational			Strategic			Structural			Total	
	Driver	Expenditure	Deficit	Driver	Expenditure	Deficit	Driver	Expenditure	Deficit	Expenditure	Deficit
Workforce	**Increased use of overtime**	£1.3m	Nil				**Higher use of Agency**	£0.9m	£0.9m	£6.4m	£0.9m
	Increase in non-clinical staff	£2.8m	£0.7m								
	Higher use of Agency	£2.1m	Nil								
Non-Pay	**Drug cost** increase	£1.9m	Nil	**Increase in patient air travel costs**	£2.3m	£2.3m	**Non-pay inflation**	£8.4m	£8.4m	£19.4m	£17.5m
	Efficiencies not met	£6.3m	£6.3m				**Energy cost rises**	£0.5m	£0.5m		
Productivity	**Productivity metrics**	£3.9m - £5.9m	£3.9m - £5.9m	**Outpatients in higher cost setting**	£4.8m - £5.6m	Nil - £0.8m	**DTOC – lack of community beds**	£0.9m	£0.9m	£19.0m - £22.1m	£9.5m – £12.6m
	Patient Flow – Non-elective LoS	£4.7m	£4.7m	**Services from other providers**	£2.6m	Nil	**Demographic driven OP demand**	£2.1m - £2.4m	Nil - £0.3m		
Income	**Reduced private patient activity**	£1.0m	£1.0m				**Unfunded activities**	£11.1m	£11.1m	£13.1m	£13.1m
	Unchanged private patient tariffs	£1.0m	£1.0m								
		£25.0m - £27.0m	**£17.6m - £19.6m**		**£9.7m – £10.5m**	**£2.3m – £3.1m**		**£23.9m– £24.2m**	**£21.8m– £22.1m**	**£58.6m - £61.7m**	**£41.7m – £44.8m**

How are we tackling the challenge?

The Financial Recovery Programme, supported by the Change Team Finance Lead and the Chief Officer, has commenced across HCS. It includes the development of the present Financial Recovery Plan (FRP) to address the forecast deficit of £29m this current financial year.



7 workstreams

1. Grip and Control
2. Patient Flow and Discharge/LOS
3. Theatres Efficiencies
4. Outpatients Efficiencies
5. Workforce Productivity (Medical, Nursing, AHPs, Ops/Admin, Non-Clinical)
6. Non-Pay (incl. Medicines Management and Procurement)
7. Income, IT and Digital and Care Group/Directorate schemes.

Bottom-up

PMDT Team

Top-down

Care Groups & Non-Clinical Support Functions:

- Medical Services
- Surgical Services
- Women's and Children's
- Mental Health and Social Care
- Primary Care and Prevention
- Non-Clinical (NCSS) : Estates and Facilities

1 Establish the **financial baseline**

2 Determine the correct overall levels of **HCS budget** required

3 Identify **savings opportunities**

4 **Ensure clinical engagement and staff** involvement

The FRP purpose was to support **Care Groups and Non-Clinical/Corporate functions in developing efficiency schemes to achieve the necessary cost savings**

Recent actions taken

We have started taking a series of actions this year to set up HCS for cost-recovery success

Resourcing for Recovery

Action

- Change team appointed, comprising interim Chief Officer, Financial Recovery Programme lead, Nursing change lead, Workforce change lead, and Medical change lead
- Engaged KPMG to support on baselining, drivers of deficit and Financial Recovery Programme development
- Program Management Delivery Team (PMDT) set up to manage savings delivery and continuous improvement efficiency and productivity initiatives
- Recruiting underway for substantive PDMT delivery team supported by extended KPMG support and handover

Getting the right Governance in place

Action

- Programme governance set-up (incl. Financial Recovery Group, Pay Control Panel, Non-Pay Control Panel etc.)
- Care Groups Support & Challenge meetings scheduled
- FRG Steering Committee established
- Change Programme Board established

Stabilising the run rate

Action

- Two savings opportunities workshops conducted and schemes generated by Care Groups.
- Grip and Control measures established through WCP and NPCP to rapidly reduce expenditure run-rate through:
- Introduction of approval process for all agency/locum/temporary staffing and overtime expenditure to be approved by WCP Panel.
- WCP Dashboard development to provide visibility of forward staff planning of rotas and workforce optimisation.
- Stopping non-pay discretionary spend and tightening delegated authority levels and financial controls.
- Several FRP Schemes in delivery

HCS Ownership & Accountability

The RFP has been developed with clinical and operation buy-in and ownership at the forefront. This has resulted in the establishment of a process that takes staff on a journey of Financial, Clinical, and Operational improvements. Some examples have been listed below:

Routes to driving ownership		Impact
Recruitment of Change Team	• The change team was recruited between January and March 23 with the interim Chief Officer from April 23 to advice, challenge and drive buy-in (Financial, Clinical and Operational) across HCS	• Through support from the Change team, various quality, cost and workforce initiatives have been set-up such as the Clinical productivity programme to drive improvements
S&C meetings with Care groups	• Regular Support and Challenge (S&C) meetings have been set-up with all care groups to co-develop ideas, quantify impact, develop plans and drive front-line ownership	• Through the support and challenge meetings over 120 improvement ideas have been reviewed and over 60 ideas quantified, with clear delivery plans behind them
Medicine Care group	• For the Medicine CG, regular Flow improvement, Pay control and S&C meetings have involved senior leadership and front-line staff in making improvement decisions	• Currently, there is over £300k in delivery for the Medicine CG where locum staff have been converted to substantive • Overall over £1.1m is in delivery in FY23 for HCS
Workforce and Recruitment	• This cross-cutting programme of work is supported by a multidisciplinary group, led by the HR Director to improve the recruitment process and develop workforce strategies	• Over £11m of agency spend reduction has been identified through this programme, driven by reduction in time-to-hire and alternate workforce models
Establishing a PDMT	• The PMDT team was set-up to run the FRP and drive ownership of savings delivery and continuous improvement • Recruiting underway for substantive PMDT team	• The PMDT team are instrumental in running the Cross-cutting programmes and the S&C meetings • The PMDT manage the savings tracker and support delivery
Clinical Engagement and Medical Staffing Committee (MSC)	• The previously established MSC is being used for clinical buy-in and ownership of this FRP. Regular updates have been provided to the MSC to seek feedback	• Through this engagement, a range of ideas, specifically around recruitment and retention of clinical staff have been identified and buy-in generated on productivity schemes

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FRP overview

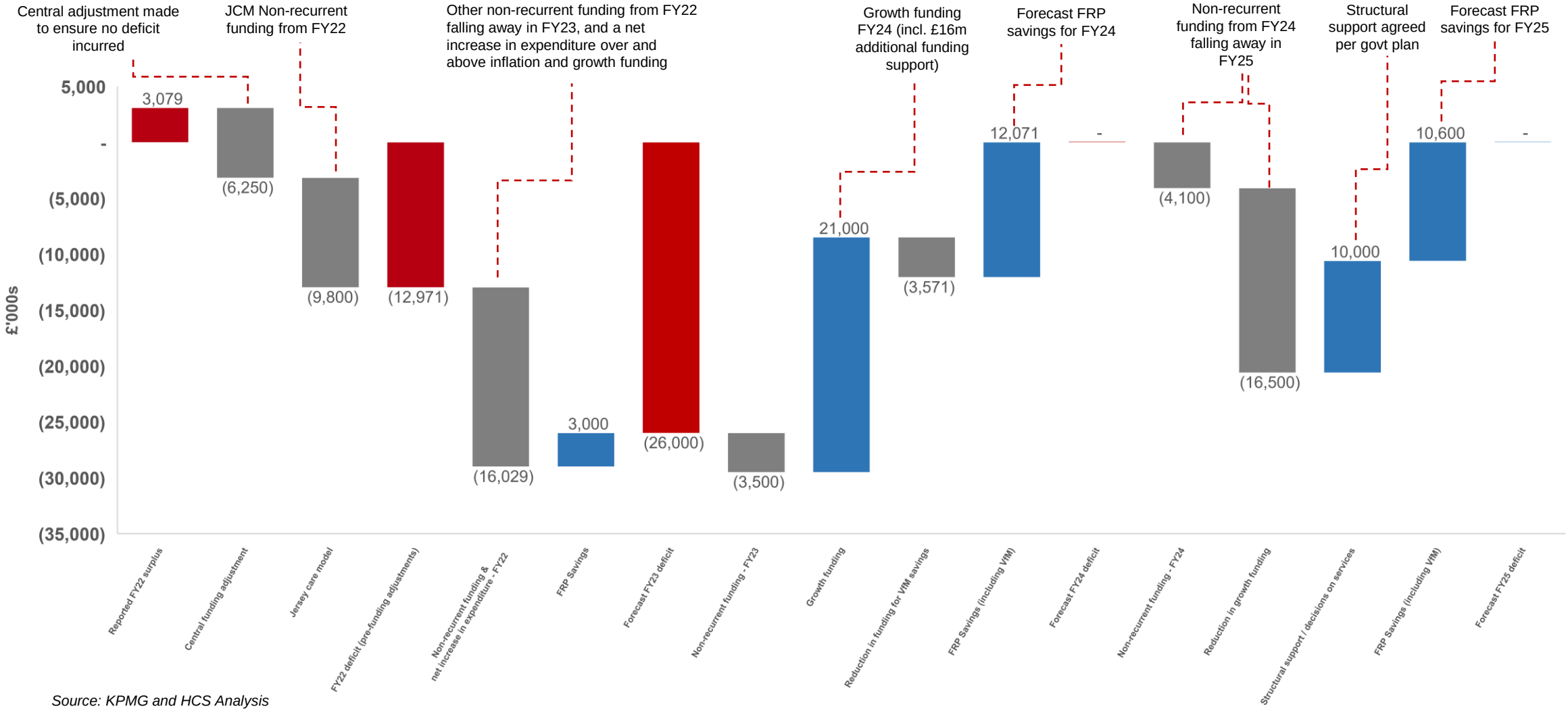
FRP overview

The plan includes a range of actions from short-term tactical wins through to full transformational change. This is intended to illustrate the major themes of the FRP across FY23 – FY25, with more detail provided on specific schemes on pages 18-19, and in Appendix 1.

Stabilise	FY23	Optimise	FY24	Sustain & Improve	FY25
Getting the basics right		***Maximising efficiency across HCS***		***Transforming Care and service delivery***	
• Grip actions (stop and defer) • Agency run rate reduction • Control actions – Pay and non-pay control panel • Rapid impact Efficiencies e.g. locum conversion • Efficiency development e.g. contract reviews • Recruitment to PMDT FRP resource gaps		• Grip actions to Business as Usual • Efficiency and productivity – Flow, Theatres and Outpatients • Workforce optimisation – Reduce time to hire • Recruitment of substantive staff to displace agency • Service reviews including demand and capacity and robust operating plan • Private patients income optimisation • Maximise Laundry service as a commercial offering		• Further workforce transformation and recruitment initiatives to fill vacancies and reduce reliance on expensive agency roles • Service redesign e.g. clinical pathways • Remaining decisions on unfunded services • Continue to develop the health and care commissioning function across the system as described in the co-designed Health and Care Commissioning and Partnerships Strategy. • Build on the commissioner provider relationships that exist to move to a mature integrated system.	
FY23 Impact: £3m		FY24 Impact: £12m		FY25 Impact: £10.6m	

FRP Financials (FY23-25 waterfall)

The financial challenges and cost pressures in FY22 are expected to continue and increase in FY23-25, but through the FRP programme, HCS expects to deliver a total of £25m recurrent savings over 3 years, with £3m FY23, £12m in FY24, and £10.6m in FY25. This, combined with additional non-recurrent funding of £16m in FY24, and structural support of £10m in FY25, results in a break-even position by the end of FY25.



Source: KPMG and HCS Analysis

Income and Expenditure Position – incl. FRP

HCS net deficit (post FRP efficiencies) is forecast to be £26m for FY23, £16m in FY24 and break even in FY25. The FY23 and FY24 deficits will be eliminated by non-recurrent additional funding provided.

Forecast performance summary				
£'000		**FY23**	**FY24**	**FY25**
Funding		249,032	286,575	280,161
Costs		(278,032)	(301,646)	(305,832)
Net Deficit - pre FRP		**(29,000)**	**(15,071)**	**(25,671)**
VfM savings		-	3,571	3,571
FRP efficiencies		3,000	11,500	22,100
Surplus / (Deficit) - incl FRP		**(26,000)**	**-**	**-**

Key drivers of Budget (HCS Government Plan)

Income

- Budgeted Total Income relates to revenue earned through operations
  - Revenue is prudently budgeted to remain flat at £23.7m given the wider rules about increasing charges beyond 2.5%, which would require Treasury Minister approval.

Pay costs

- Pay costs are driven by the following:
  - **Inflation:** a £14.9m inflationary increase in FY24, which is flat thereafter, and not replicated in FY25-27.
  - **Service transfers[3]:** leading to increasing staff spending for HCS given covid-related expenditure was previously allocated outside of HCS's central budget. From FY24, covid-related expenditure is now bought into HCS.
- Budgeted Pay costs also include a flat £63k social security benefit year on year.
- Note, there are no allowances for pay awards (e.g., growth increases) in the staff pay.

Non-pay costs

- Non-pay costs are budgeted to steadily increase year on year. This relates to a Treasury allocation to HCS over and above central budgeting (equates to c2.5% annual budget).
  - These costs relate to higher levels of cost inflation on consumables and service improvements.

Offsetting

- Cost increases are partially offset by (a) value for money savings assumed to be c£3.6m year on year, and (b) fixed term funding (Jersey Care model) which terminates by FY25.

**Note: These forecasts assume any non-pay inflation will be fully funded.*
Source: KPMG and HCS Analysis

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FRP Engagement, Governance and Accountability Framework

Stakeholder Engagement

Engagement of key stakeholders fosters a sense of ownership and commitment, leading to increased support and cooperation throughout the project lifecycle. Over 16 weeks, we actively engaged with over 100 stakeholders throughout HCS through various forums to ensure the timely identification of schemes, the operationalisation of opportunities, and the development of capacity and capability within HCS.

2

Workshops

- **FRP Change Ideas Workshop** (June 28,2023): over 40 attendees, 120 schemes identified.
- **FRP 2nd Workshop** (Sept 12, 2023): 74 attendees, improvement plans presented and reviewed

90+

Support & Challenge meetings with Care Groups

- Meetings with CG to identify priority schemes and steps to delivery
- Data collection, scheme generation, identification and escalation of risks, validation of schemes costings, etc.

60+

Cross-cutting meetings

- To cover cross-cutting schemes with relevant stakeholders and progression of workstreams
- Ex: workforce productivity, clinical productivity, non-pay control panel, etc.

Weekly or bi-weekly engagement with clinical leads

- To ensure progress of scoping and delivery of priority schemes
- To identify key risks and operational issues, validate assumptions and ensure buy-in.
- Ex: Surgery, Medicine, etc.

Engagement with medical staff and physicians

- To ensure capturing of medical staff and physicians priority schemes, challenges and ensure prioritisation
- Ex: Medical Staff Committee, Medical Leads Dinner, etc.

Collaboration with GoJ central project management team & HCS PMDT

- Sharing and alignment on standard operating procedure, templates and material developed for handover
- Incl: Change Programme Board, Finance Recovery Group, PDMT Internal Touchpoint.

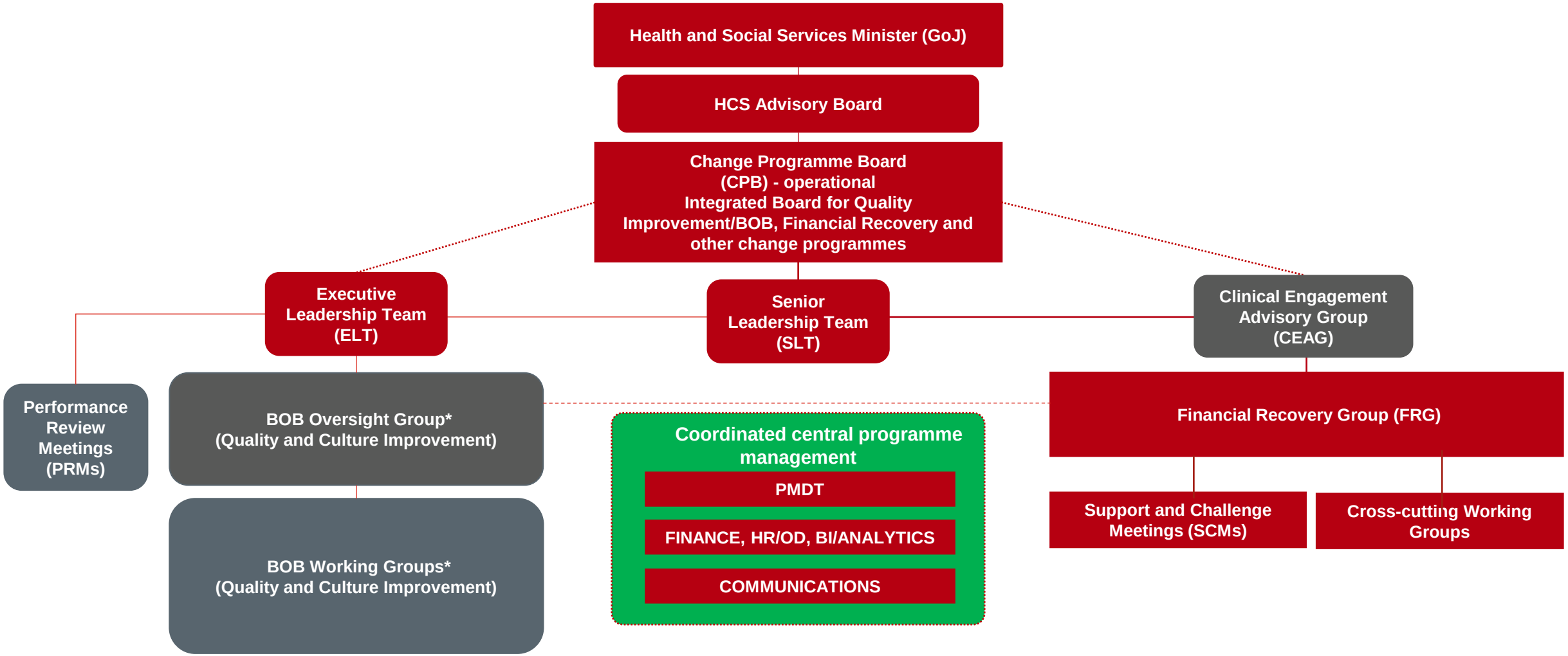
Coordination with senior leadership

- Coordination and collaboration around project delivery and progress
- Through both regular and Ad Hoc meetings
- Incl: Senior Leadership Team, Executive Leadership Meeting, Senior Leadership Team Meeting.

FRP Workshops

FRP Governance and Accountability Structure

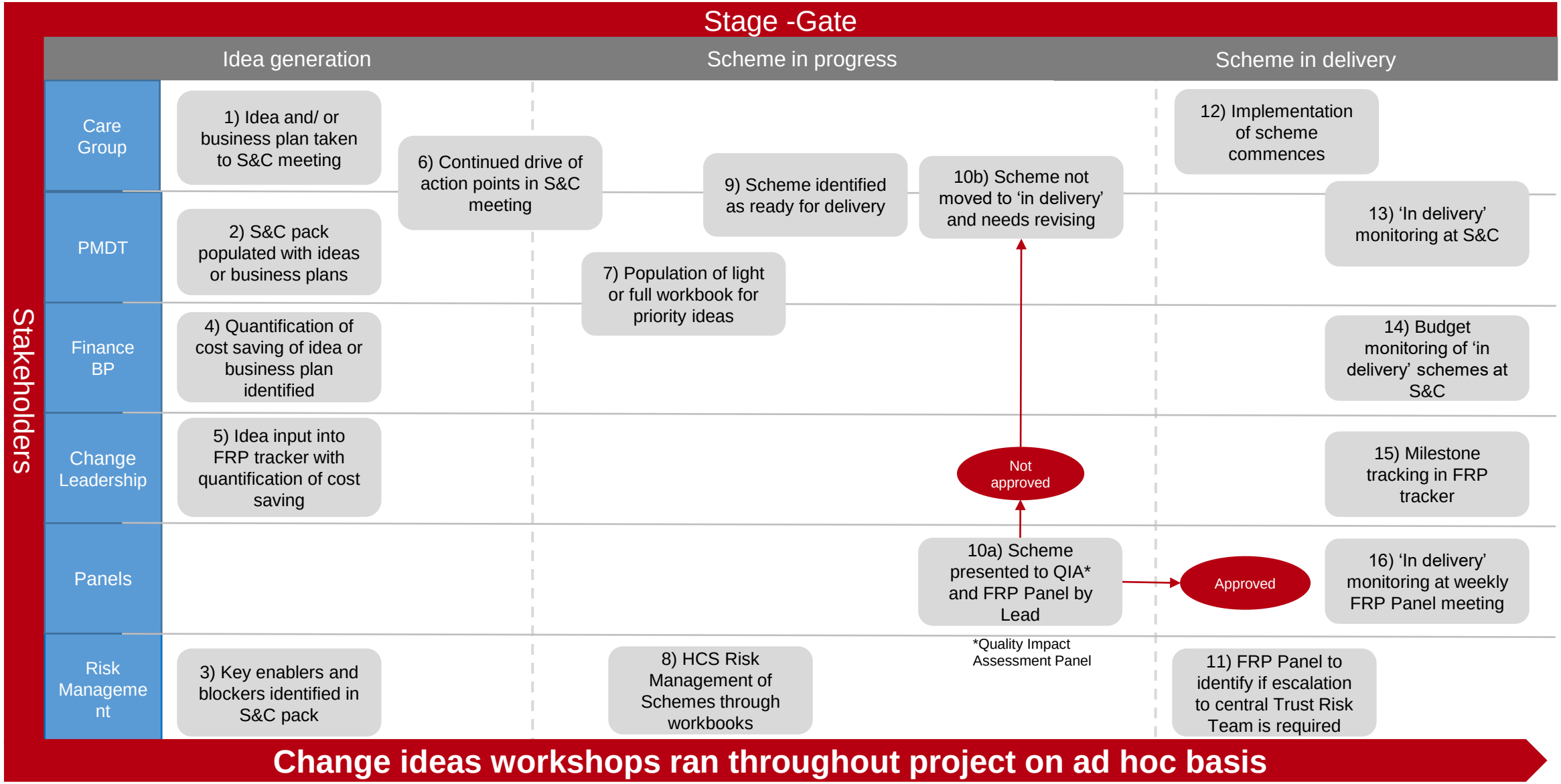
A robust governance and reporting structure was established to ensure transparency and accountability through clear lines of authority and oversight mechanisms. This structure provides the capacity and capability to support the development and delivery of key strategic projects, mitigation of risks and dedicated frontline support to Care Groups/Specialities/Non-Clinical and Corporate Function for long-term sustainability.



*Grey sections under review internally by HCS

The Journey from Scheme Idea to Delivery & Implementation

To support the FRP, the process map below demonstrates the standard journey and stages associated with the generation of an idea to delivery and implementation. This process was rapidly embedded from the outset of the engagement to provide an effective and standardised model for Care Groups to follow.



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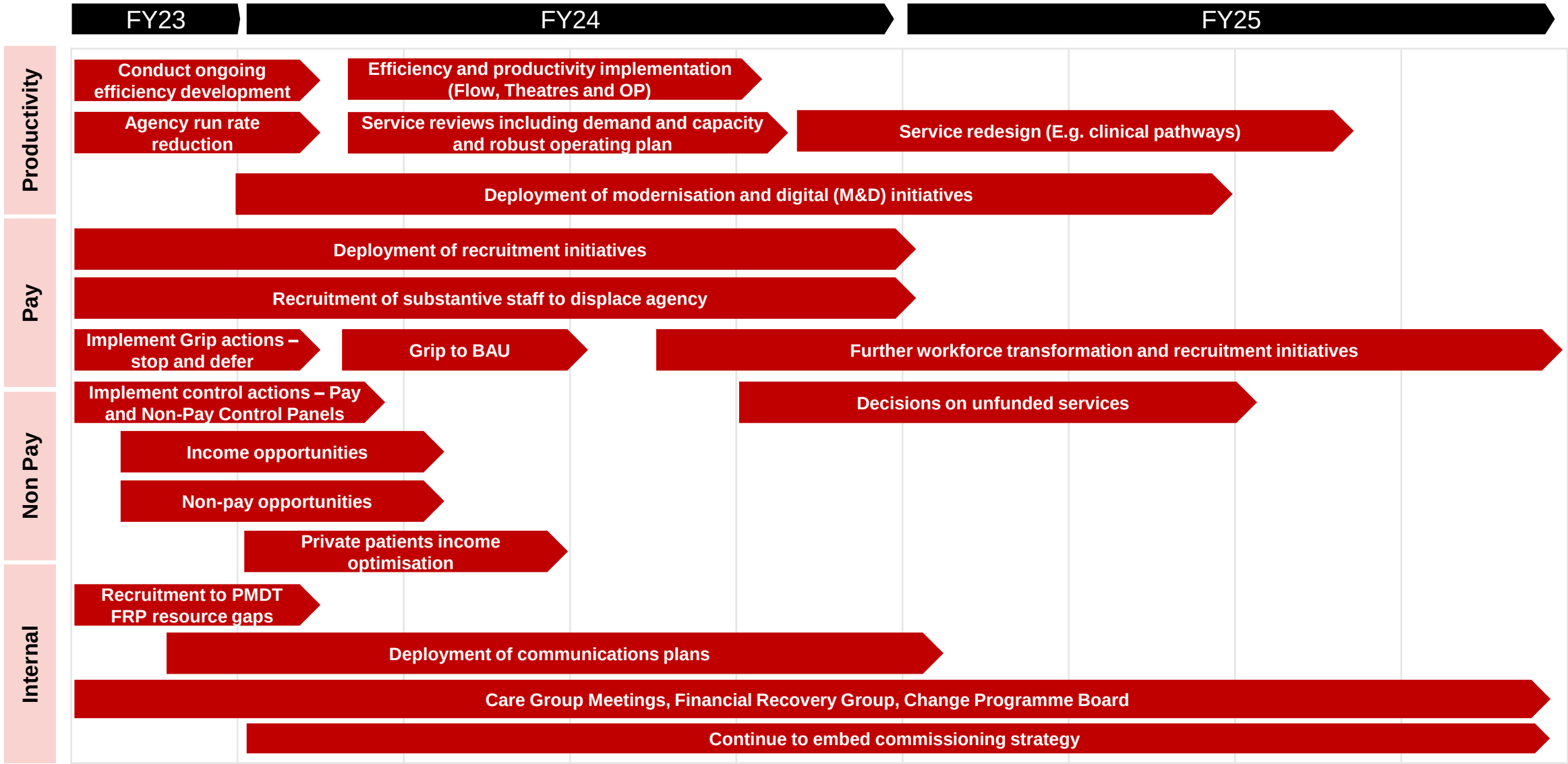
Next steps

Next steps in to delivery

The following chart illustrates the series of activities that will be undertaken over the coming fiscal years to advance progress of FRP across the areas of Productivity, Pay, Non-Pay, and Internal (PMDT).



Next steps – commissioning approach

A new system-wide service commissioning process needs to be established that ensures the procurement of properly funded services, and avoids the provision of unfunded services that have contributing significantly to the structural deficit outlined in this report.

An integrated commissioning model as described in the co-designed Jersey Health and Care Commissioning and Partnerships Strategy will move from the annual business case cycle to a mature integrated system. This new way of commissioning needs to be expedited.

As a critical next step, GoJ-HCS should consider the commissioning approach as described, which includes reviewing existing services in relation to population needs, delivery of services including formal tendering process as required, and implementing monitoring mechanisms. Another consideration is where the strategic commissioning function should be based to best serve all of health and care services.

The commissioning approach would cover the following aspects:

1. Strategic planning: assessing needs, reviewing current service provisions, and deciding on priorities.
2. Implementing and delivery of services: designing services, shaping the structure of supply and planning capacity, and managing demand.
3. Monitoring and evaluation: Supporting choice, managing performance and seeking public and patient views to realign services if necessary.

By determining how best to use local resources to address the full range of factors that contribute to health and care, this commissioning approach will enable the development of more integrated care where services are better coordinated across the health and care system.

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Appendix 2

Review of Health and Community Services Leadership and Management Capacity Paper Discussed at the States Employment Board

Report authored by Chief Officer, June 23

1. Introduction

This paper sets out the outcome of the Chief Officer's review of the Government of Jersey's Health and Community Services (HCS) Department including the numbers of managers currently providing the leadership and management of the services provided to Jersey residents. It should also be noted that there will continue to be a robust approach to identifying management / administration cost savings as part of the HCS Financial Recovery Plan. This report does not consider leadership/management capability.

2. Context

a) Whilst Jersey's health system is small relative to many other jurisdictions, the level of complexity is very similar to much larger systems. Globally healthcare organisations are seen as some of the most complex with much academic literature supporting this assertion. HCS like other modern health systems has high levels of interdependence and connectivity, competing and changing demands, unpredictability, uncertainty, a myriad of relationships and power bases as well as the need to work with emergence. Also, Jersey like many other jurisdictions must manage within the complexity of a mixed health economy i.e., public and private services. Being an island adds another layer of complexity, as Jersey must cooperate with and use other healthcare providers off-island, including the management and coordination of transport, accommodation, clinical exchange and information sharing.

   Leaders in healthcare must have the capability to operate in this challenging and complex environment, however, the investment in leadership and management must provide value for money. Those health systems that are largely funded by taxation, in addition to ensuring high quality services, also need to have the capacity to ensure public accountability through supporting the democratic systems of that jurisdiction. In larger jurisdictions much of the capacity needed to effectively support and service the democratic processes is provided by 'intermediate tiers' e.g., in the UK this is the Department of Health and its supporting structures such as Integrated Care Boards. In small jurisdictions it is unrealistic and unaffordable to establish such structures. This means that HCS needs to have the management capacity to not only lead and manage health and community services but serve the important government accountability frameworks which in larger systems would often fall to the non-operational structures. The HCS Chief Officer and other executives spend significant time carrying out these important government accountability roles compared to larger jurisdictions such as their counterparts in the NHS. This must be taken into account when reviewing the management capacity of HCS.

b) HCS clearly requires significant transformation and there is a need for continuous quality improvement beyond the twelve months that the turnaround team are with the department and therefore HCS must have the ongoing leadership and management capacity and capability to deliver improvement over the coming years for the people of Jersey.

c) The HCS leadership Team must also undertake the responsibilities of 'client' to a major healthcare estates programme that will increasingly require additional capacity and a portfolio of services that HCS must directly commission and manage contracts from other on island health and social care providers that cover community health services, emotional wellbeing, end of life care, advocacy and some primary care. This again requires management capacity to do well.

d) Benchmarking management costs is always problematic. For example, when comparing with the NHS due to point a. above or indeed other jurisdictions due to their differing requirements for their management structures e.g., those that operate in an insurance- based system tend to have relatively high management costs to those that don't. However, the report does consider HCS management costs in its conclusions.

The report has taken the above context into account in the review.

3. What is a ‘manager’?

Being clear about this question is important when considering capacity i.e., numbers. Like many health systems HCS aim is to be a clinically led organisation which means that many of the leadership roles are undertaken by clinicians of differing professions. It is true of many healthcare organisations that this aim is initially achieved through the appointment of clinical staff into key leadership e.g. Chiefs of Service, Specialty Leads, Lead Nurses, AHP professional managers, Ward Managers (previously known as ward sisters/charge nurses) etc. but there is always a need to support and develop these leaders (as with non-clinical managers) so they can be effective in these critical roles. The HCS clinical leadership structure is similar to what you would find in many health systems in other jurisdictions and therefore is, in numbers, not an area of concern.

In HCS there has been some leadership development/training but there is a need to continue this investment to ensure all leaders/managers are able to perform effectively. The 3000 people employed by HCS deserve outstanding leadership as do the people of Jersey.

This review has focused on HCS’s non-clinical leaders/managers which is often the focus of political and the public interest. Therefore, the report considers the following definitions:

- Executive Directors i.e., Tier 1 and 2
- General Management e.g., operational managers who support the Chiefs of Service and the day-to-day management of services- Tier 3 and 4
- Specialist Managers i.e., Estates, Health and Safety, Complaints – Tiers 3 and 4

Note: This report does not include a review of administrative support staff such as medical secretaries, medical records and waiting list staff, PALS, quality and safety admin support staff, MTD co-ordinators etc.

a) Executive Directors – HCS has 5 executive directors who are accountable to the Chief Officer as follows:
    i. Medical Director (part time)
    ii. Chief Nurse
    iii. Director of Clinical Services
    iv. Director of Mental Health and Social Care
    v. Director of Improvement and Innovation

HCS does not have either a Finance or Workforce (HR) Director as these services like Digital Services are centrally provided by GoJ corporate services. This is seen as a weakness for HCS by the Chief Officer, Change Team and wider HCS SLT and subject to further debate. The Chief Officer and executive directors form the HCS Senior Leadership Team (SLT) along with the Chiefs of Service (consultant medical staff) and key senior staff, e.g., Chief Social Worker. The SLT is the key decision-making committee for HCS and accountable to the Advisory Board

b) General Management

HCS has 17 general management roles who provide operational management support to the Care Groups or provide management for HCS non-clinical support services such as facilities, housekeeping, and estates.

These roles are:

- Head of Access
- Head of Operational Resilience
- Head of Non-Clinical Support Services
- General Manager – Unscheduled Care
- Speciality Manager (x 2) – Unscheduled Care
- General Manager - Mental Health
- General Manager – Primary Care, Prevention and Therapies
- General Manager – Adult Social Care
- General Manager – Women's and Children's Care Group
- Planned Care Lead
- Speciality Manager (x 2) – Planned Care
- Change Delivery Lead
- Operations Manager – Non-Clinical Support Services
- Soft Facilities Manager
- Head of Housekeeping

c) Specialist Managers

In addition, the following 24 posts require specialist knowledge and/or qualifications to undertake their roles.

- Director of Culture and Staff Engagement
- Deputy Medical Director (part time)
- Head of Nursing, Midwifery AHP Education
- Estates and Hard Facilities Manager
- Head of HCS Business Intelligence
- Head of Quality Improvement
- Head of Quality and Safety
- Policy & Quality Improvement Manager
- Risk Manager
- Information Governance Lead
- Legal Services Manager
- Chief Pharmacist
- Service User Manager
- Head of Service Alcohol and Drug
- Compliance and Sustainability Manager
- Deputy Divisional Lead Operations
- Health and Safety Manager
- Catering Services Manager
- Safeguarding Manager
- Social Care Governance Manager
- Speciality Manager Private Patient
- Associate Director Improvement and Innovation
- Associate Director Digital Health
- Head of Commissioning and Partnerships

This group of 46 'management' staff make up 1.7% of the total substantive staff working for HCS.

4. Reduction of non-clinical functions as part of JCM programme review

It should also be noted that since the review of the Jersey Care Model programme by the Minister of Health and Social Services, additional posts that had been created at the start of the programme in 2021 to support and deliver the re-design and creation of new community services have been reduced (27 posts in total). These included functions such as project and change management, communication support, data analysts, administrative support and business planning. HCS is short of change and project management capacity and capability which has been identified as part of the Finance Recovery Programme and wider Change Teamwork programmes which will hinder progress, if not addressed, with HCS's transformation.

5. Management Costs

The cost of these non-clinical leadership/management roles is 2% of the total HCS budget. This is some £5,113,000 of the total budget of £255,560,000. As mentioned in the context section of this report benchmarking is problematic as there are just too many variables. However, by comparison with the 1.7% ratio for HCS, 'managers, directors and senior officials' in the UK make up 9.5% of the workforce (Kirkpatrick, Veronesi & Altanlar 2017).

6. Approval of management posts

In addition to those posts that require States Employment Board (SEB) approval, all posts whether replacement or new are subject to the Financial Recovery Plan 'Vacancy Control Panel' scrutiny and with Tier 2 and 3 management posts requiring approval by the Chief Officer. At each stage of the process, we will look to find ways in which to reduce management and administration costs.

7. Performance Management

This report does not make any assessment on management capability in either the clinical or non-clinical group of leaders/managers. However, the low levels of recorded objectives and appraisals is a cause for concern and needs to improve. The reason for these low levels is multifactorial and can be seen in other healthcare settings including cultural, logistical i.e., in some areas high staff to manager ratios which makes the process time consuming and in Jersey's case the operation and understanding of the Connect system. With the latter corporate HR will be providing during 2023 training to help improve compliance. There is a clear senior leadership objective to improve this situation at all levels. Please see attached written response to a States question on HCS performance appraisals.

8. Conclusions

There is clearly a perception among the general public both in Jersey and other jurisdictions that managers are largely irrelevant for the delivery of healthcare. Spending money on managers is viewed as wasteful, with little attention given to the ways that managers routinely support and enable the work of clinical professionals to deliver services and in Jersey the democratic process.

In my time as Chief Officer for HCS I have met with clinical staff who believe that HCS has too many managers but also many who are looking for more management support. The truth is that we need the capacity and capability to deliver what the Government of Jersey requires of its health services.

In making this statement we need to recognise that managers vary in experience, ability and capability and the senior leadership of HCS must hold individuals to account for delivery and where required, support their training and development, to ensure that we do have the effective leadership and management of HCS that Jersey deserves. This is a significant challenge not least because attracting and retaining high quality leaders and managers is a critical issue for Jersey as it is with other staff and our recruitment and retention efforts must also take this into consideration. In parallel there must be a rigorous approach to identifying savings in management and admin costs where these do not impact on the safety, efficiency and effectiveness of services.

The departure at the end of 2023/early 2024 of the HCS Turnaround Team is a particular risk to the progress being made that the MHSS and Chief Officer needs to consider and establish appropriate mitigations. It is clear that the turnaround of HCS to a standard of the best in healthcare providers will take a number of years and require ongoing and strong leadership, investment, change capacity and political support.

The Chief Officer's review considered in this report concludes that the number of managers, recognising the context in which they undertake their responsibilities and with an employee to management ratio of 1.7%, HCS is not over managed in terms of the numbers. What the Chief Officer and senior leadership now need to focus on is ensuring that HCS staff and people of Jersey benefit from highly effective leadership and management that can support the delivery of the day-to-day services, continuous quality improvement and support the democratic processes.

Chris Bown

Interim Chief Officer

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Thank you

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