States of Jersey

Report to: Political Board

From: HSSD CSR Review Steering Group

Subject: H&SS 2012 – 2013 CSR Proposals

Date: 16th September 2010

Steering Group:	**John Mills (Chair and Independent Member)** **Paul Marett (Independent Member)** **Hugh McGarel Groves (Treasurer)** **Mike King (Peer Chief Officer)** **Julie Garbutt (CEO HSSD)**
Officer Support:	Caroline Anderson (CSR Team) Russell Pearson (Director of Finance HSSD Andrew McLaughlin (Managing Director JGH) Stuart Brook (Managing Director C&SS) Richard Jouault (Deputy CEO HSSD)

1.0 Introduction

There is a paradox at the heart of public service provision in Jersey - we are a low-tax jurisdiction, and proud of it, **but** we expect our public services to match the best available anywhere.

Health and Social Care (and particularly a hospital) is not like other public services when it comes to efficient delivery. In hospital care, efficiency is largely defined by the number of clinical staff necessary to provide a 24/7 service which provides capacity for the treatment of a population of about 250,000. This means that if we want access to health and social services in Jersey 24/7 they can never be as "efficient" as on the mainland where the number of hospitals can be adjusted to give each one a population base of at least 250,000 and social services can also serve a much larger population, thereby creating some economy of scale. That said, efficiency in the use of resources is a defining outcome for management and this therefore is a key objective for the Corporate Management Executive in the Health and Social Services Department. However, efficient and effective resource utilisation depends on both good management information systems and sufficient skilled and experienced people to manage the business. HSSD requires strengthening in both respects.

There is also a direct link between investment in modern facilities and business systems and the efficient delivery of health and social care. The current situation is clear to see for any visitor to the hospital or mental health services. There are a few parts of the estate that are as good as you will find anywhere (such as the day surgery unit or radiology, the Clarevale Road Recovery Unit or the Greenfields Unit) but most of the hospital is now very tired and in need of serious refurbishment to bring it up to modern standards and to reduce the potential risk of healthcare acquired infections. The same is true of significant parts of the mental health and social care estate. In terms of business systems, a significant investment has been made recently to replace the obsolete electronic patient administration system; however, the additional functionality that would allow changes in healthcare delivery to improve efficiency (such as the electronic ordering of tests and delivery of results) is on hold pending further investment which is now unlikely to take place.

Whatever the financial premium for local delivery, there are some emergency, maternity and social services that none of us would expect to travel to England to access and there are many others, such as care of the elderly, where the inconvenience of travel to the mainland would be most inappropriate. In fact, when the additional cost of travel is added to the cost of treatment it may well be more cost effective (as well as more convenient) to have the service here in Jersey. **There is a public debate necessary to establish where the balance lies between "pure efficiency" and what is convenient and appropriate in the delivery of local health and social care to keep Jersey the kind of place we all want to live with our families.**

This logic has been used as part of the CSR process to try and identify what are "core services", along with the "essential support" necessary for the delivery of those services, which effectively defines the only services that have not been considered as potential cuts. If the full additional savings (8%) were to be sought in the current timeframe i.e. 2012 and 2013, then significant cuts would have to be identified because efficiency savings cannot deliver anything approaching the magnitude or speed of budget reductions required by the Comprehensive Spending

Review. **Furthermore, in a department where over 70% of the budget is spent on pay for the 3,500 people employed, the requested budget reductions would inevitably result in redundancies.**

With regard to Community and Social services, there are complex choices to be made as to how best to protect the most vulnerable in our communities. As with clinical services, budget reductions at the levels envisaged in the CSR, will result in the significant reduction of frontline services to those in need and their carers. In addition, partnership between statutory services and voluntary, community and faith organisations is an essential part of the delivery of services to many of our most vulnerable residents. Therefore, there is a real potential for the protection of essential and core statutory services to result in reduced resources to the wider community of informal or voluntary carers.

There will be some who say that we are "shroud waving" to suggest that some clinical and social services that residents have come to rely on should be withdrawn. The awkward truth is that to the users of our services, and their families, everything done by Health and Social Services is essential. Therefore, it may be expected that every proposed reduction or cut will be opposed by those most affected. It is also predictable that when these proposals enter the public domain that staff morale will be badly affected and some key staff may choose to "vote with their feet". In effect the proposed reduction of H&SS will become self fulfilling. **This does not mean that the cuts could not be delivered if the political decision were to be taken to remove the funding. However, strong opposition from relevant interest groups, and no doubt others, is to be expected and so the political stance would need to be strong, and able to reflect wider public opinion.** In sum, cuts to the services offered by Health and Social Services are likely to be particularly contentious.

We are most fortunate in Jersey to have excellent people providing our health and social care services, supported by committed voluntary, faith and community based organisations - **but** the level of investment required to maintain excellent health and social care facilities has increased dramatically in the last 10 years. **Jersey has not kept up with the investment required in its health and social care services and estate. England has also narrowed the positive differential we used to enjoy in terms of pay and conditions**. So that, over the last few years, we have found it very hard to compete for hard to recruit staff essential for the continued delivery of our hospital, community, mental health and social services in Jersey. Putting this right will not be cheap and there may be some who will argue that we do not need the range of services we have come to expect here in Jersey and that it would be cheaper not to refurbish the health and social services estate but to travel to England, or other parts of Europe instead where they have made the investment to keep their buildings and services up to the latest standards.

In our Community and Social Services we have seen valued, additional resources invested to strengthen our children's social care and some other therapeutic services. The re-provision of some of our buildings serving children and people with learning disabilities is an example of service improvement. A concern, however, is that our mental health and disability services, particularly those for older people, need to be strengthened against a background of growing numbers of our community becoming physically and mentally frail.

This takes us back to the Jersey Paradox. What range and type of services must be provided on the island and how much is Jersey prepared to pay for

this range and level of health and social care services? A key question, moreover, is what service can be provided safely in a small hospital such as ours, when the trend in secondary (hospital) healthcare is now strongly towards more and more being done in large specialist centres where consultants can have a sufficient range and mix of cases to develop and maintain their skills. This is generally linked to improved outcomes for patients, including survival rates. The contrary question, equally key, is what cannot be done safely here in Jersey?

Efficiency is most important (and there are always efficiency savings to be made) but when it comes to health and social services, there is a premium for the delivery of services in Jersey due to the built-in inefficiency of providing access to a wide range of services 24/7 for a relatively small population. This may be partially offset by the premium for travelling to England both in terms of cost and the inconvenience.

This is not the end of the dilemma. People on the island are living longer and thus ill health associated with aging is a growing pressure on services. In addition, the development of new treatments and medicines creates an inexorable pressure for additional investment to ensure that the people of Jersey can continue to have access to the latest and best treatments. At the same time, in common with all other countries, we are seeing a significant increase in chronic or long term diseases that are a result of our increasingly unhealthy lifestyles. This will inevitably create ongoing and significant pressure on health and social services - unless we intervene to encourage, indeed even require, our population to stop smoking, eat healthily, take more exercise and control weight and alcohol consumption. But when, financially, "times are hard" it is often these "upstream investments", that create cost pressures now but deliver benefits in terms of better health and less demand for services in future, that are the first to be considered for cuts.

We are now at a crossroads. Health and Social Services in Jersey cannot stay as they are. The challenges of buildings that are no longer fit for purpose, a clinical staffing model in the hospital that is out dated and that can no longer be supported by the recruitment of new clinical staff because of the development of sub-specialisation and difficulties in recruiting nurses and social care staff and the current requirement to reduce the level of funding for public services means that we need to develop a **new and affordable strategic model** for the delivery of health and social services. This is urgent and needs to be undertaken, with full public consultation, by July 2011.

We need to decide what form our hospital services must take to be safe, sustainable, of an appropriate standard and affordable. We need to decide what sort of services should be provided in a primary or community care setting. We also need to decide how much we invest now to prevent ill health in the future. **Given the constraints on public finances this may well mean that we stop providing the broadest range of services on island or even stop providing some services at all.**

However, financial adversity also creates a climate where "necessity can be the mother of invention" and we need to embrace the opportunity to be radical in our thinking. We need, at the right moment, to engage the public in this debate and we need to provide the time and resources, in terms of management skills and capacity, to ensure that sound options are developed and the widest opportunity for public debate is offered. **This does not sit comfortably with the current timetable for the Comprehensive Spending Review.**

We can and must create a new way forward for the delivery of health and social services and this must be done in a way that is sustainable from a patient safety point of view and affordable. Cuts can be made to the health and social services budget over the CSR timeframe and the rest of this report indicates where these efficiencies and cuts may be found. Some represent sound and proven service re-design and management restructuring. Others however, mean the significant reduction or cessation of well regarded and much needed but non-core services and this may be extremely unpalatable even if they were to be provided by the 3rd sector in the future. However, we strongly recommend that the urge to "slash and burn" in order to deliver short term savings be resisted in favour of taking the time to develop a clear Strategic Roadmap that can provide safe, sustainable, appropriate and affordable services for the medium to longer term future.

There is a final caveat and it may well be an unpopular truth. Our public services must be well-led and efficient - experienced public sector health and certain social care professionals carry a premium because their skills are much in demand. They also need to be available in sufficient numbers and with the full range of skills required to conceptualise, plan and ensure delivery of the new model of safe, sustainable appropriate and affordable services that the people of Jersey deserve and require. This must take place at the same time as the day to day management of the current services is maintained and enhanced.

At the present time, the Health and Social Services Department is not resourced to offer the capacity and skill sets required. This has been evident during the course of this Review. Officers have been committed to the task of finding their contribution to CSR and have been able to bring forward ideas for service redesign, management restructuring and cuts. However, given the time constraint and the imperative to prioritise the operational management of the current services, there has not yet been the detailed underpinning scoping or business planning to form a robust view of the feasibility of the schemes proposed or the magnitude of any saving likely. **This must be borne in mind when others consider the viability of the financial savings that can be extracted from the Health and Social Services Department.**

This report therefore sets out proposals for £5m in savings over the 2012/13 period. It also provides proposals for £1.6m in terms of "User Pays" and, to create further context and demonstrate the need for the additional 2% year on year growth monies, sets out the "currently known" service pressures that the Health and Social Services Department is facing. It should be noted that these significantly outweigh the available growth funding so the requirement to generate additional internal savings in order to cover these pressures will raise the overall savings level to be found by HSSD.

The Health and Social Services Review Group proposes that urgent attention is given to the need to secure adequate capacity and capability to undertake day to day operations, the development and consultation on a new strategic model for Health and Social Services and the project management and delivery of the savings schemes ultimately selected. This will result in an additional cost pressure and an estimate has been added to the corporate cost pressure appendix.

2.0 Departmental Overview

As stated above Health and Social Services is a very diverse service delivery department with significant expenditure on goods and services that people often don't relate to in their everyday understanding of Health and Social Service provision.

To provide some context to the scale and volume of services provided:

- H&SS will receive about 35,000 referrals from General Practitioners in a year.
- There will be about 150,000 outpatient appointments undertaken.
- Clinicians in the department will perform 11,000 surgical procedures.
- A&E will see around 40,000 patients during 2010 and there will be 7,000 emergency admissions for patients who require urgent and immediate medical attention.
- For Mental Health services there will be about 1,000 referrals in a year for acute adult care.
- Social Workers have an average case load of 30 clients they are managing at any one time that.
- Annually Special Needs Services look after about 50 clients in H&SS managed facilities and contract to the charitable sector for the care of a further 80.
- Children's Services generally have 80 looked after children at any point in time, with 70% of those in foster care placements and the reminder in directly managed residential facilities (or the uk).

To deliver these activities;

- £121m (72%) of the total cashlimit is spent on staff salaries
- The average cost of each full time equivalent member of staff is £49k.
- Doctors and Nurses cost £63m.
- Social Workers, Paramedics and other clinical support staff cost £26m.
- Manual workers/ancillary staff cost £15m and civil servants/administration £17m (including circa £4m of posts categorised as senior or operational managers).
- £6m is spent on drugs each year for use in the hospital and outpatients.
- £7m is spent on providing specialist treatments in the UK
- £9m is spent on food provisions, utilities, rates, telephones and postage etc.
- £7.8m is spent on services provided by the Charitable sector to support H&SS core activities, primarily Family Nursing and Homecare
- £9m is spent on long term nursing and social care packages.

Whilst the amounts of some elements of this expenditure will surprise many individuals, others may be less surprised. Importantly though, all services undertaken in H&SS interconnect with each other in an attempt to provide the best level and range of care to patients, clients and their relatives.

Clinical staff do not undertake any activities that do not have some demonstrable link to providing a more favourable outcome for an episode of acute or social care, the real question when resources are being discussed or constrained is how much "value" does the population of Jersey place on the additional benefits being delivered.

3.0 Comprehensive Spending Review and Background Context

The States of Jersey has initiated a Comprehensive Spending Review (CSR) which is designed to consider all aspect of service and related expenditure for the period 2011-2013. The CSR is targeted to find total savings of £50m; (10%) by 2013 from the current business plan, initially split as:

- 2% in 2011
- 3% in 2012
- 5% in 2013

Each SoJ Department is required to first identify any efficiency savings that can be achieved and then to prioritise services that could be redesigned, reduced or stopped. The effect of these two components must total the Departmental savings target.

4.0 Target CSR Savings for the Department

The Health and Social Services Department contribution to the SoJ £50m target has been set at circa £18m, split as:

- £3.7m in 2011 (to be considered in the 2011 Business Plan debate)
- £5.5m in 2012
- £9.3m in 2013

The purpose of this report is primarily associated with identifying the tangible and robust opportunities for efficiencies, service redesign, reductions and cessation that could be undertaken to deliver this magnitude of savings in 2012 & 2013.

It is important that additional schemes over and above the base targets are identified to recognise that some schemes will ultimately be unachievable.

5.0 Potential Additional Growth Assumptions for the Department

As per current planning assumptions, the SoJ proposes increases each year over the three year period in pay and non pay of 2% and 2.5% respectively.

The SoJ draft Business Plan also currently forecasts an additional 2% increase in the department cashlimit to allow for the effect of “healthcare” inflation over and above normal inflation levels of 2.5% and to enable the department to manage some increased activity levels associated with demographic factors and clinical developments.

6.0 Overall Financial Position of the Department

The effect of the growth is that over the period from 2011 to 2013 the cashlimit for the department, before any CSR savings, would increase by circa £20m. After the reductions associated with the CSR are taken into account the Department cashlimit will have increased by circa £2m over the period. The effect of this is that the department is in a “flat cash” situation where in £ terms the savings required roughly equal the estimated level of inflationary and growth investment.

Whilst there is a recognition that the department will be under considerable pressure to deliver savings over the period of the CSR, it is important for transparency and monitoring that proposed savings, user pays and proposed growth are kept as individual, separate work streams and not combined to present a simple “net effect”.

7.0 Service Redesign to Reduce H&SS Expenditure

It is recognised that the UK and other jurisdictions have already undertaken considerable research and are now delivering real savings associated with the comprehensive redesign of Health and Social services.

Utilising this research and then applying these ideas in Jersey has to be the most effective way forward from a service delivery perspective. The difficulty is that each concept will require a significant level of project work and scoping to ascertain the likely financial impact in relation to current service provision in Jersey. The task is made even more difficult as there is limited information and benchmarking metrics to identify opportunities and a lack of management resource to investigate the schemes fully within the available timeframe.

Appendix I lists these high level ideas and concepts which form the basis of the H&SS CSR proposals. As stated above, due to the issue of lack of information availability, time and dedicated project management resource, it is recognised that instead of a hard savings figure, a range is the most appropriate way of presenting these options at this time.

Appendix I identifies the potential schemes for further investigation that could deliver significant savings in 2012 & 2013 after the appropriate level of scoping and feasibility testing has been undertaken. The savings that are potentially achievable have been identified as circa £5m within a range of £2.0m-£7.2m.

8.0 User Pays Schemes

The CSR process also requires departments to identify significant “user pays” options so the Council of Ministers can consider a combination of service reductions and/or user pays options to provide additional options for the management of the necessary cost reductions.

Appendix II identifies the department’s initial options for user pays schemes, totalling £1.6m.

9.0 Utilisation of Growth for Immediate Service Pressures

It is recognised that over the 2012 and 2013 CSR period other service demands will materialise that will require investment. Appendix III identifies where the proposed 2012 and 2013 2% additional growth funding will be utilised. The sums identified already outstrip the available funding of circa £3.5m per CSR year meaning that further prioritisation and savings schemes will need to be undertaken to remain within H&SS cashlimits.

10.0 Summary Financial Situation

The current H&SS CSR savings for 2011, 2012 and 2013 can be summarised as follows:

Savings	Year				
	2011	2012	2013	Total	Range
	£000s	£000s	£000s	£000s	£000s
H&SS CSR target	3,700	5,500	9,300	18,500	
Savings (2011 Business Plan)				3,700	
Savings (Appendix I)				5,000	2,000-7,170
User pays (Appendix II)				1,600	
Total				10,300	7,300-12,470
Growth 2011 and 2012					
Minimum growth (Appendix III)		6,653	4,403	11,056	
Growth available		3,500	3,500	7,000	

H&SS CSR Steering Group
14th September 2010

Appendix I

Proposed Savings

Ref	Title	Proposal	Risk and/or Consequences	Amount £000s	Range £000s
Proposed Management Restructuring & Efficiencies					
	Purchase of care services	Reduced cost of procurement of care services	Minor risk associated with any price negotiations with private providers.	30	30
	Rationalisation of Management posts	Reduction in Management posts linked with reorganisation of accountabilities for front line staff	a) Lower levels of management supervision and wider scope of responsibilities for remaining managers b) Lower levels of coordination	240	240
	Energy Savings	Utilise the SoJ energy manager to report on how H&SS can reduce energy consumption	Discussed in previous years but limited progress to date, maybe because the savings are genuinely not available	260	50-300
	Ancillary Support Functions	Redesign domestic and catering services to deliver a set level of savings (target set at circa 3% reduction)	Target resource to deliver appropriate standards of service in priority areas automatically leading to reductions in other areas	350	30-400
	Estates Support Functions	Redesign facilities and maintenance services to deliver a set level of savings (target set at circa 3% reduction)	Target resource to deliver appropriate standards of service in priority areas automatically leading to reductions in other areas	150	10-200
	Procurement Project	Develop appropriate systems to	Project already started with	500	400-800

		manage procurement and ensure contracts that deliver value for money are utilised	initial scoping report due end of September		
	Income Generation from secure unit provision	To provide a limited secure accommodation service to external authorities, most probably Guernsey.	Additional placements required by the court in the light of legislation change allowing "the Sentencing" of young people to Greenfields could result in full capacity being required by young people from Jersey. Also Guernsey may choose not to place.	100	10-200
	Rationalisation of H&SS Estate	Seriously consider the rationalisation of H&SS Estate, generating capital receipts for the SoJ and releasing facilities related savings.	Long term proposals often requiring service redesign to facilitate the reduced physical space	220	20-500
	Work force efficiencies review	Consider areas of discretionary pay , additional duties, overtime and allowances etc. with a view to ceasing some payments	Considerable scoping work needs to be undertaken to ensure savings are achievable hence very low figure included	100	10-200
	Management Restructuring & Efficiencies Total			1,950	800-2,870
Proposals for Service Redesign					
	Partnerships for Older People	Investment in community services that promote independence reducing reliance on long term care and acute hospital admissions		200	20-800
	Chronic Disease Management	Redesign the way long term		200	20-400

		chronic disease are managed in primary care and secondary care to reduce hospital admissions			
	Back Assessment Clinic	*Provide increase support to primary care facilitating individuals back into employment. Invest to save.*	*If guidelines are not complied with the net savings will not be realised Potential investment in H&SS to deliver savings inSSD administered fund £200*		
	Redesign of Special needs residential services	Re-design and re-provision of special needs facilities provided by H&SS. This will provide a better and more efficient environment for care	The proposal requires the capital re-investment of monies released by the sale of the current sites. Planning consents for new build provision will be required	100	100
	Redesign of residential services for "looked after" children	Rationalisation of children's residential care provision to avoid dependency on "high cost" placements in a smaller residential setting	That predictions re reductions in number of young people in care system may not be delivered due to changes in demand patterns. Also court requirements regarding care plans for individual children may require retention of specific places	400	40-400

	Re-negotiate funding arrangements for voluntary sector residential care provision of Special Needs Services	Renegotiation of funding arrangements for, special needs clients	Reduction of level of payments will require a long "lead in" time in order for services to adjust	200	20-500

			their business processes in line with reduced income.		
	Review of outpatient services	Implement standard outpatient ratios	Some patients may choose not to be seen by GP for subsequent primary care related follow ups with possible adverse effects on their health.	60	60
	Appropriate attendances in A&E	Stop all non emergency primary care A&E attendances approximately 8,000 inappropriate attendances a year	Likely to get considerable patient disquiet and disputes against clinical triage decisions. May discourage genuine attendances and adversely affect patient care	100	10-100
	Lean Schemes	Using lean methodologies to redesign patient pathways across acute services to create more efficient and effective care	Some methodologies may not be applicable to Jersey due to diseconomies of scale.	350	30-400
	Joint working with Guernsey	Consider service provision across Jersey and Guernsey to provide more efficient use of resources and value for money e.g Specialist Clinical Services and emergency air transport	Whilst opportunities exist it is slow to progress when working across two governmental systems	300	30-300
	Management of Chronic Mental Health Conditions	*Redesign the way stress and depression are managed in Primary Care and secondary care to reduce certification and return people to work more quickly.*	*Potential investment in H&SS to deliver savings in SSD administered fund £200k+*		
	SLAs with UK providers	Ensure that the majority of acute referrals go to specified NHS Trusts in an attempt to secure	Project already started with initial scoping report analysing activity and providing	300	30-400

		volume discounts	recommendations is due end of September		
	Service Redesign Total			2,210	360-3,460
Proposals for Service Reductions					
	Reduction in preventative family support provision	Reduction in preventative centre-based provision linked with reinvestment of 50% cost savings in alternative community based family support services	Reduction in preventative family support provision may lead to families becoming dependent on more formal services	200	200
	Older Peoples Respite Services	Cease respite service, both Nursing & Residential	A proportion of patients will either be admitted to an acute/nursing care bed, or require additional support in the Community.	320	320
	Children's Respite services	Withdrawal of preventative respite care services linked with a re-investment of some of the savings in some outreach support to mitigate the impact of service reduction	This is a valued service popular with service users, carers, and the wider community. Impact on carers offering strong commitment to care and support of their children. Withdrawal of preventative and support services emphasised in the Williamson and merging Children's Plans.	130	130

	Withdrawal of substance misuse service	Cease funding of abstinence based residential care service	Withdrawal of substance misuse service	190	190

	Proposed Service Reductions Total			840	840
	Department Total			**5,000**	**2,000-7,170**
	2011 & 2012 CSR Target				14,800

Appendix II

Proposed "User Pays" Schemes to Consider in 2012 & 2013 CSR Savings

Ref	Title	Proposal	Risk and/or Consequences	2012 £000s	2013 £000s
Acute Services					
	A&E	Introduce a charging policy for "primary care" attendances which should really be seen by GPs or in primary care settings	Some patients may choose not to access appropriate medical services and hence may become more serious acute cases in the future.		300
	None urgent/cosmetic procedures	Introduce a policy of ceasing non essential/cosmetic procedures with the option for patients to pay for the procedure if they want it undertaken.	Some Patients may not pay and continue to have physical and mental health problems.		100
	Prescription Charges	Introduce a £5 charge for all prescriptions issued by H&SS allowing those on income support to access a benefit.	Maximum potential of £600k but allowing for exceptions etc. figure reduced to £250.		250
	RTA Charges	Introduce a policy where patients are charged for care associated with insurable events e.g. Road traffic accidents	Difficult with charging the patient as they will need to be able to recover off the other party's insurance. In the event that the insurance declines to reimburse SoJ will need to consider if it will pursue the patient directly.		100
	Acute Services Total			0	750

Community & Social Services					
	Primary Care Psychological Assessment and Counselling Service	Charge GP rates for Primary Care Psychological Assessment and Counselling Service			100
	Community & Social Services Total			0	100
Corporate Services					
	Travel benefit	Remove the subsidy for travel to the UK for elective surgery, allowing those on income support to access the benefit with all other paying their air fares.	Some patients will choose not to take up their elective procedure as they will have to pay for their travel		300
	Smoking Cessation	Smoking cessation services to be paid for by patients	Potential reduced take up of smoking cessation services which will ultimately have a detrimental effect on the individual's health. As transferred to the HIF in 2011 this will be a savings for SSD.		300
	Patient Transport	Patient transport services to be paid for by patients and clients	Difficulties in patients and clients attending their healthcare appointments		150
	Corporate Services Total			0	750
	Department Total			**0**	**1,600**

Appendix III

Proposed Utilisation of 2012 & 2013 2% "Growth" Funding

Ref	Title	Proposal	Rational	2012 £000s	2013 £000s
Acute Services					
	Orthopaedic Service	Recruit a replacement surgeon and contract out spinal service to UK provider	Increasing specialisation meaning impossible to replace on a like for like basis & demand associated with ageing demographic	330	
	Renal Service	Recruit an additional middle grade doctor, 4 nurses and increase resources for supplies	Increasing specialisation & demand associated with ageing demographic	673	223
	Urology	Replace generalist with 1 general surgeon and appoint a urologist..	Increasing specialisation & demand associated with ageing demographic	300	
	Ophthalmology	Appoint an additional consultant	Increasing demand associated with ageing demographic	290	
	Midwifery	Recruit 3 midwives	Increased RCOG/RCN regulations and demand	120	60
	Gynaecology	Recruit an additional Obstetrician/Gynaecologist	To meet Governance agenda re: reduced locum use and minimise risk	330	
	Nursing staff	Recruit 36 nurses over a 3 year period	The need to meet modern safe standards of care	600	1,000
	Drugs	Provide ongoing and increasing investment in new drug regimes	Increased cost of new drugs and increasing survival rates	500	500
	Acute Medicine Middle Grade Rota	Recruit 3 additional middle	Need to maintain safe 24/7	130	260

		grade doctors	acute medical cover and create viable rotas for clinical cover		
	Infection Control	Appoint an extra BMS and extra cost of consumables	Increased prevalence of infection in the community and increased bed provision	80	30
	In Flight Service	Appoint 1 middle grade doctor and 2 nurses	Regulatory changes affecting specialised treatment and transfers	180	60
	Path Lab Diagnostic Test	Increased cost of supplies and external services	Increasing demand caused by improved chronic disease management and ageing demographic	170	
	Oncology	Appoint additional Consultant and Specialist Nurse	Increased demand due to increased survival rates	250	
	Anaesthetic Staffing	Appoint additional Consultant (depending on service redesign)	Increasing demand associated with ageing demographic		200
	Nursing Care in the Community	Invest in increased non acute beds and care packages in the community at an approximate cost of £35K net/bed/placement	Increasing ageing demographic	210	210
	Medical Staff	Appoint a new Consultant A&E/EAU	Need to meet cover requirements in A&E/EAU		170
	Diabetes Service	Appoint additional specialist staff and provide funding for consumables	Increased demand due to rising obesity levels.	60	60
	UK providers	Increased costs associated with patient and clients requiring specialist treatments in the UK	Increased demand and requirement for specialist treatments that cannot be provided on island	250	250
	Acute Services Total			4,473	3023

Community & Social Services					
	UK providers	Increased costs associated with patient and clients requiring specialist treatments in the UK (2 per year)	Funding for specialist mental health and/or Children's placements due to increases in activity and client/relative awareness	250	250
	Care Packages	Increased costs associated with patient and clients requiring specialist social care packages	Funding for specialist health placements due to increases in activity	200	200
	Special Needs	Investment in Special Needs placements in H&SS and or third sector providers (2 per year)	Funding for additional Special Needs clients due to increase in activity	200	200
	Specialist Social Work and Mental Health Teams	Investment in specialist social and Mental Health support roles	Funding for additional Social Services and Mental health staff due to increasing service expectations and increases in activity	150	150
	Community & Social Services Total			800	800
Corporate Services					
	Additional Healthcare Inflation	Increase non pay budgets where services and contracts are increasing above SoJ approved inflation (exc. Drugs).	Healthcare inflation generally is in excess of standard RPI type inflation calculations e.g. Medical Defence Union contributions, clinical supplies	400	400

			etc.		

	Increased maintenance contracts associated with more advanced medical equipment etc.	Increase non pay budgets associated with more advanced medical equipment etc. and other capital purchases.	Continued advancements in technology make medical equipment more complex and hence require more specialist maintenance contracts	80	80
	Increased management support	Increase in management support capacity to enable H&SS to develop appropriate capacity to deliver strategic initiatives and service redesign	Essential management support capacity (information analytical capacity, programme management, commissioning skills etc.)	800	
	Other Corporate Investments	Public Health, Nurse Training, Ambulance Services, recruitment and advertising etc.	Expected annual investment in all other service and support areas	100	100
	Corporate Services Total			1,380	580
	Department Total			**6,653**	**4,403**