2015

Guernsey's Future Ambulance Service

Guernsey's Future Ambulance Service

Steering Group

November 2015

Guernsey's Future Emergency Ambulance Service
Final Report - Proposals & Implications

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1. Summary

Purpose & Background

Purpose

1.1 This document proposes the nature and organisation of Guernsey's Future Ambulance Service ("GFAS") to be implemented in a phased manner over the 5 year period 2016-2021.

1.2 It summarises the work of a team drawn from the project's sponsor, the Health & Social Services Department (HSSD), the Home Department (Home), who oversee Fire and Police 'blue light services', St John, the established, long-term supplier of ambulance services in Guernsey and the Treasury & Resources Department (T&R).

1.3 Working under the oversight of the HSSD Board and Corporate Management Team, the GFAS Project Steering Group has shared widely its interim reports and scripted presentations in the spirit of open, consultative government:

1.4 This report, addressing Proposals and Implications, is an attachment to the HSSD Policy Letter for the States of Deliberation of February 2016. It seeks to capture the key messages from the other supporting documents listed in the appendices but not to duplicate them. Therefore, those seeking additional information are encouraged to read the supporting materials contained or referred to in those documents.

Background

1.5 In 2013, HSSD commissioned Lightfoot Solutions UK Ltd to undertake an efficiency review of the St. John Ambulance & Rescue Service (SJARS) who since 1938, had been the sole provider of the Island's only professional Ambulance Service.. The outcome of that review was an influencing factor the following year during negotiations between HSSD and SJARS for the renewal of the ambulance service contract, effective from January 2015. By September 2014, negotiations had failed to reach agreement in relation to the terms and cost of delivering the renewed contract, which resulted in a move by HSSD to take over the operation of the ambulance service. This move did not receive the support of T&R which led to the intervention of the Civil Contingencies Authority (CCA) who are a group comprising of Guernsey's most senior politicians and civil servants, mandated by Law to respond to potential or actual civil emergencies. As a consequence, the CCA negotiated the terms of a four year contract with St John, effective from 1 January 2015, including a break point at two years with six months' notice. Within the terms of that contract was an agreement that initiated the formation of this project.

1.6 During 2015, a project team worked to define the best sustainable future ambulance service for Guernsey. Their terms of reference were set by a Planning Group comprising of the following four individuals and were subsequently agreed by the Corporate Management Team and Political Board of HSSD.

1. Paul Whitfield - Chief Executive Officer, States of Guernsey

2. Dr. Carol Tozer - Chief Officer, Health & Social Services Department

3. Steve Le Page - Chairman, St John Ambulance and Rescue Service LBG

4. John Hollis - Non States Member, Treasury & Resources Department

1.7 The agreed Terms of Reference were:

1. Consider the Lightfoot Review of SJARS, subsequent contractual events and performance being achieved.

2. Identify the general strategic direction for emergency services elsewhere.

3. Identify 'Best Practice' opportunities for Guernsey.

4. Determine Ambition, Risk, Cost and related Guernsey-specific issues.

5. Evaluate options and priorities for Guernsey, with consultation input.

6. Develop the future 'Target Operating Model' for emergency ambulance and related services (dovetailing into Acute & Urgent Care) and Patient Transfer Services.

7. Propose the future organisation, relationship and governance structures.

8. Propose the summary performance management regime (metrics, outline SLAs & MOUs).

9. Develop an outline phased Implementation Plan for change.

10. Support the resolution of any significant unresolved contract performance issues and exceptions.

Summary Conclusions & Recommendations

Conclusions

1.8 Three factors have made it necessary for our conclusions and recommendations to be broader in scope than some might expect for an exercise focussed on ambulance services:

1. Our Terms of Reference (point 6) required us to "dovetail our future operating model for ambulance services into Acute and Urgent Care" services. Thus we needed to be mindful of potential developments and interfaces in all related areas.

2. Our early research into relevant international best practice confirmed that 'collaboration and interoperability' across the blue light services - Ambulance, Fire and Police - is an increasingly important factor for improved outcomes and cost-effective service provision.

3. We are very aware that the emergency ambulance service forms part of a critical wider network of emergency services, with aspects spanning health, social and civil care. It is unwise to design a single part of a network without considering the shape of the whole network, because apparently desirable changes to one part of the network can have offsetting undesirable implications for other parts of the network.

Recommendations

1.9 We recommend the following for progressive implementation over the 5 years 2016-21:

1. Prepare the emergency services to support HSSD's planned transformation and integrated health & social care intentions (ageing, home etc).

2. Redesign emergency medical services with a focus on patient outcomes, including new 'clinical pathways' and processes.

3. Retain and extend St John's role as a strategic partner for emergency ambulance and medical services.

4. Invest in better skills for paramedics and clinical technicians and deploy them flexibly, network-wide (on ambulances, fast-response vehicles, within A&E and into the home).

5. Fully evaluate co-locating the emergency ambulance base from St John's Rohais location to a shared base with the Fire Service.

6. Transfer the budgetary and non-clinical oversight role for the Emergency Ambulance Service (EAS) from HSSD to Home, enabling Home to have a combined oversight role for all 'blue light' emergency services (Police, Fire and Ambulance) as they work increasingly jointly to their 'best practice interoperability' agenda.

7. Pursue better States asset sharing and procurement across the emergency services (including property, vehicles, mobile technology and other support services).

8. Properly resource the HSSD ICT effort, e.g. to make possible the future sharing of core patient record data in emergencies.

9. Operate a Non-Emergency Patient Transfer System (NEPTS) as a distinct service, separate from the EAS contract, with a number of transport providers offering a 'pooled service' accessible to islanders requiring patient/special transport services for various reasons.

10. Give notice to agree a more flexible contract with St John with effect from 1 January 2017, providing greater scope for a 'win-win' arrangement than is possible with an essentially 'fixed scope - fixed cost' arrangement with St John over a phased 5 year period of change.

1.10 Detailed proposals covering the above will be submitted, together with supporting business cases, to the next States for approval from May 2016. The Policy Letter for the current States is limited number to one proposition, so that preparatory work can proceed during 2016 to reduce the risk of future benefits being delayed unnecessarily.

Next Steps

1.11 There are two main next steps:

1. After the GFAS Steering Group completes the agreed scope of its remaining work in 2015, any resulting activities should be defined and managed within two

overarching programmes within the two key Departments: the HSSD Transformation Programme and the Home's HOST Programme for emergency services interoperability. This will best manage interdependencies.

2. A Policy Letter is to be submitted to the States of Deliberation for debate before the General Election in April 2016, so that experienced politicians in the current States can provide further political input.

1.12 The current States is requested to:

1. Agree the transfer of the budgetary and non-clinical oversight role for the EAS from HSSD to Home. This will provide Home with the combined oversight role for all 'blue light' emergency services (Police, Fire and Ambulance) as they work increasingly towards to their 'best practice interoperability' agenda.

Financial Implications

1.13 There are no financial implications for the 2016 States Budget arising from the proposed transfer of the budgetary and non-clinical oversight for the EAS from HSSD to Home. The timing of this transfer should be determined in agreement with T&R, with preparations made in advance of the 2017 Budget, or the 2018 Budget (if the transfer is made closer to the intended period of co-location of Fire and Emergency Ambulance Services).

1.14 During 2016, after the April General Election, the appropriate Senior Responsible Officers and Boards will bring forward separate business cases for:

1. Capital investment requirements for any co-location and shared use of property, in the SCIP process.

2. The HSSD Transformation components of the Future Ambulance Service proposals. These will include future proposals relating to Non-emergency Patient Transfer Services (NEPTS), within which value-for-money gains can be secured by operating a system spanning multiple States Departments (HSSD, Social Security Department (SSD) and Education Department) and multiple providers (non-emergency ambulances, specialist taxis and others).

3. Other Home capital and revenue components of the Future Ambulance Service proposals.

4. Other ICT-related investments in conjunction with the States of Guernsey ICT function."

1.15 The detailed business cases associated with the proposals:

1. Migrate to efficient 'best practice' operations over a phased period, whilst improving services.

2. Improve value-for-money, outcomes and resilience via flexible deployment of paramedic skills.

3. Improve value-for-money via 'a pooled' NEPTS.

4. Save costs via better use of States property, by exploring co-location of Ambulance

and Fire.

5. Save costs or capital via improved sharing or financing of vehicles and equipment.

6. Simplify contractual arrangements with St John, to facilitate greater flexible deployment.

7. Consolidate 'blue light' emergency service operations & budgeting within Home.

2. Scope, Approach and Team

Approach Adopted

2.1 It quickly became clear to the Project Steering Group that a diverse range of pressures and emerging innovations across healthcare, emergency services, technology, island demographics and funding warranted a fundamental exercise to define Guernsey's best possible Future Ambulance Service. A short-term 'quick fix' approach would neither endure nor best serve islanders in what can truly be a 'life or death' set of circumstances.

2.2 The approach adopted, therefore, comprised the following six phases of work:

1. International research to understand 'best practices' elsewhere relative to operational approaches adopted in Guernsey.

2. The definition of the extent of 'local ambition' in making Guernsey's ambulance services as good as they can conceivably be. This included workshops on best practices elsewhere, public and professional consultation in Guernsey and challenges with members of local professions.

3. The evaluation of options and priorities.

4. The selection of a preferred 'Target Operating Model' (TOM) for EAS and NEPTS in Guernsey, having identified relative benefits and implications.

5. The design of the nature of 'performance metrics (i.e. key performance indicators) to assess future performance.

6. The definition of steps to be taken to migrate to the new TOM, via a phased implementation plan.

2.3 This was an approach based on an established Operations Design Methodology tailored to Guernsey and the specific project. We also incorporated the standard Emergency Call Process Workflow diagram (**Figure 1**) into our analysis of options.

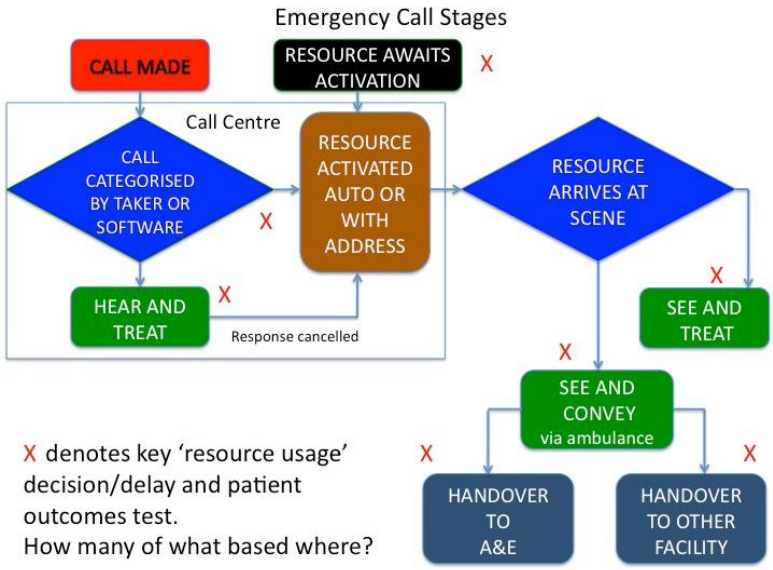


Figure 1

2.4 Oversight responsibility for the project was exercised by a newly-appointed HSSD Board with a new Minister, Deputy Paul Luxon, supported by a new HSSD Chief Officer (Dr. Carol Tozer, appointed September 2014). All previous HSSD Board members resigned en bloc in November 2014, following a major non-ambulance public service crisis and related investigations during 2014. St John also made significant leadership changes during 2014 and early 2015, involving a new Chairman and Board of the emergency ambulance service and a re-emphasis of the boundaries between the state-subsidised ambulance service and other charitable St John activities.

2.5 The Lightfoot Review of SJARS in 2013 was an important attitude-changing exercise. Prior to then, the relationship between HSSD and SJARS might be described as 'informal, benign neglect' - the ambulance service worked well in delivering the expected level of services to the public and retained high public confidence. However, the SJARS found itself in an unsustainable financial position, which threatened its continued operation. The two main contributors to this were a continuing annual operating deficit and a substantial pension fund deficit. The annual operating deficit was growing, as costs continued to exceed agreed States grant funding, one factor being that the funding of paramedics was borne entirely by SJARS and not the States. Difficult financial challenges across funded and charitable activities followed. The substantial pension fund deficit exacerbated financial and operational challenges, following cuts to pensions associated with the defined benefit pension scheme, which had been transferred to St John Guernsey from St John UK, with the service itself, some years earlier.

2.6 The 2013 Lightfoot Review was an operational efficiency snapshot at a specific point in time. The 2015 project addressed by this report has a significantly different scope: it seeks to define Guernsey's Future Ambulance Service within the context of radical future pressures and changes to healthcare services, social care, emergency services, technology and funding models. In doing so, it also sought wider input from local and international experts, openly shared intelligence reports, conducted interim workshops involving alternative operating models, and received significant public input from an Island survey that achieved one of the highest response rates in recent years. This openness does not automatically result in the final recommendations being any more appropriate but it did maximise the opportunity for others to help us to arrive at our conclusions. We are very grateful for all such input received.

Project Team & Wider Input

2.7 Membership of the Project Steering Group comprised those of those persons listed in Appendix 6. In addition to extensive international research into emerging 'best practices' in other jurisdictions (Appendix 1), we sought and received valuable input from others, including:

1. The general public and health/emergency professionals in an Island wide on-line survey conducted during June and July 2015 (Appendix 2).

2. Local and international healthcare and emergency ambulance service experts.

3. The Chief Officers of other local emergency services (Fire and Law Enforcement).

4. The Primary Care Committee of GP practices in Guernsey.

5. Current and past members of relevant political boards (HSSD, Home and SSD) and civil servants in those departments.

We are very grateful for the professional advice received.

3. Fundamentals & Future Direction of Emergency Services

Strategic Direction within Emergency Services

3.1 Our research highlighted the following international trends;

- An increasing focus on patient outcomes/quality.
- New clinical pathways (innovation in best clinical practices).
- Greater efforts to measure 'full system' performance across the healthcare network.
- Emerging valuable uses of mobile technology.
- Access to mobile patient data by emergency services.
- Joint Emergency Services Control Centre.
- Shared support services for Ambulance, Fire and Law Enforcement.
- Greater shared equipment & training.
- Increased "collaboration & interoperability" across emergency services.
- A trend to shared operational bases for emergency services.

Best Practice Opportunities

3.2 The EAS can be part of an enhanced collaborative effort. Alternative clinical pathways, mobile technologies and the use of core patient data will present opportunities and challenges. Other jurisdictions are showing that sharing practices and resources across emergency services - "collaboration & interoperability" - offers further opportunities.

3.3 We have documented and shared our summary research intelligence with key stakeholders throughout the project, including making reference to such developments as part of the public and professional consultation exercise conducted during June and July 2015.

3.4 We have assessed the potential benefits of such trends and practices for Guernsey and factored them where appropriate into our proposed future 'Operating Model' for Guernsey.

4. The Changing Nature of Primary Care

Fundamental Forces

4.1 Guernsey and much of the world is experiencing a combination of the following factors which are requiring governments and healthcare professionals to make difficult judgements and priorities:

1. Changes in patients' health needs and preferences, including long-term conditions.

2. Changes in treatments, technologies and care delivery.

3. Changes in affordability and funding models in an era of global financial austerity.

4. Increases in 'specialisms' to achieve better results and patient outcomes, located in a smaller number of specialist centres.

5. New practices in delivering care by multiple specialist providers, combining clinical care and social care more effectively, resulting in an increasing need to 'treat the whole patient (body and mind)' in a patient-centred care model.

6. Greater deployment of 'care in the community', recognising that a general hospital solution is undesirable and more costly for many requiring care and social support.

4.2 Further information on these factors can be found in our report *Considerations & Best Practice Research* (Appendix 1) and reference documents referred to therein e.g. the NHS *Five Year Forward View, 201*5.

Guernsey's Vision

4.3 At a joint meeting of political boards (Home, HSSD & SSD), plus SJARS & St John Commandery boards, the following brief statement was deemed to capture the essence of the vision in moving towards a 'patient centered care' model:

'Treat the 'whole person', in their environment, physically & mentally, with a range of skills from diverse teams, with good information and outcomes tracked'.

4.4 Much can and has been written in other documents about Guernsey's vision and aspirations for healthcare for islanders. We will not duplicate them here. However, noting them, the HSSD Chief Officer provided the following principles to guide the Steering Group when evaluating options for the future:

1. Economies of scale should be pursued wherever possible and appropriate.

2. There should be the maximum sensible integration of practices between the emergency/urgent response services (Fire, Ambulance & Police).

3. There should be transparency in any hybrid funding formula, e.g. public understanding of States support relative to private subscriptions.

4. Emergency/urgent response ambulance services should be distinct from NEPTS.

5. In undertaking a clearer 'commissioning role' with service suppliers, there needs to be a strengthening within HSSD of contract management capabilities/staff.

6. Clear timelines should be provided as early as possible, to aid related forward planning, recognising that a range of interdependencies are likely to exist with other initiatives underway within HSSD.

5. Specific Requirements & Opportunities for Guernsey

Guernsey-specific Factors

5.1 Guernsey must take account of the added impact of an ageing population. The Island is set to move to one of the worst 'age-related dependency ratios' of all islands globally (from a 1.52 to potentially a 1.83 dependency ratio by 2050, per Island Global Research, i.e. approx. 60% worse than in 2015: 100 workers to support 83 dependents, not 52).
Therefore, public, private and 'third sector' home-based initiatives will be key.

5.2 In its favour, Guernsey's inherent characteristics present opportunities:

1. Unlike some larger jurisdictions, the geographical management boundaries of all its services (medical, social and emergency) are aligned. We are aware from international experts (who have 'pressure-tested' the Steering Group's thinking) that a lack of geographical alignment elsewhere between various emergency services has impeded their progress towards increased 'interoperability'.

2. A small, compact community can sometimes take decisions and make faster progress than larger jurisdictions.

Guernsey's Ambition & Risk Perspective

5.3 HSSD's Transformation Programme and the associated funding within the Budget approved by the States of Guernsey in October 2015, envisages Guernsey moving to a 'Full Health & Social Care Model.'

5.4 Over the next 5 years from 2016, changes in different segments of the 'Full Health and Social Care Model' (listed below) will have consequential effects upon the levels of demand for the EAS and NEPTS. Careful co-ordination of phased changes will be required across all segments:

1. GP-led community medical health care.

2. Social care and support.

3. Special care (e.g. in the community and specialist centres for dementia, cancer and mental health etc.).

4. Prevention & public health improvement (e.g. obesity, smoking, alcohol and drugs).

5. Acute hospital care and services.

6. Urgent & emergency care, including the use of the emergency ambulance and related

services.

5.5 All major changes involve potential risks as well as benefits. We therefore identified and agreed with the relevant professionals and political boards, the nature of Guernsey's ambition as follows:

1. Ambulance & Emergency Medical Service performance "at least as good as the UK."

2. Better performance reporting, with a stronger focus on patient outcomes (and clinical pathways).

3. More customer service options, e.g. 'hear & treat' capability and minor injuries centre.

4. Flexible use of Advanced Paramedics & Clinical Technicians to improve patient outcomes.

5. Better services to the patient's home, reducing 'hospital' as the default option.

6. Better use of technology in emergencies, with sharing of core patient record data.

7. Better integrated care across the wider A&E, health and social care network of providers.

8. Patient-centered care for comprehensive service, involving the third and private sectors.

9. Greater collaboration across emergency services for 'best practices' and value-for-money.

10. A clear NEPTS, providing best value-for-money.

5.6 The level of ambition summarised by the above 10 points was then factored into our subsequent assessments of alternative practices and our final evaluation of options.

Evaluation of Options & Priorities

5.7 Very early in the project, we defined the criteria by which we would later evaluate different 'Operating Models.' The ranked criteria shown (**Figure 2**).were arrived at by a combination of the GFAS Steering Group and the HSSD Corporate Management Team (CMT).

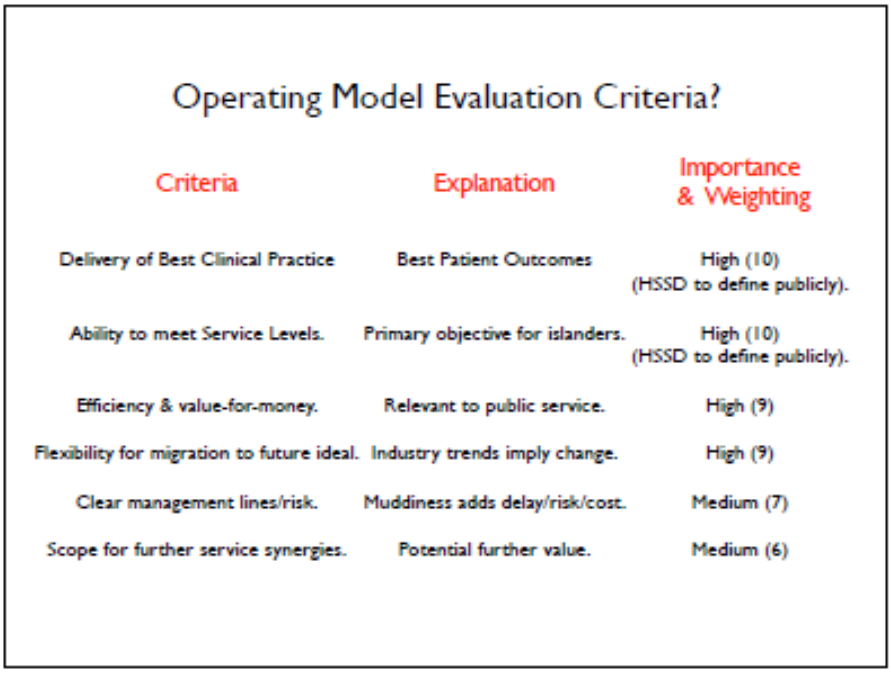


Figure 2

5.8 The criteria were 'weighted' in importance, so that the most important would be more prominent in the later scoring and assessment of alternative Operating Models

5.9 The two most important criteria (weighted 10) were 'patient related':

1. Delivery of Best Clinical Practices……..for best patient outcomes, and
2. Ability to meet defined Service Levels…….to the customer - a primary objective for islanders.

5.10 The next two criteria (weighted 9) were also important: without 'Efficiency & Value-for-money', services are unnecessarily constrained within available budgets. Without "Flexibility for migration to a future ideal', we would risk missing out on the ability to take advantage of evolving best practices in emergency medical services.

5.11 The final two criteria are relevant, but were weighted lower at 6: clear and clean management lines for operational planning, related budgets and shared practices are advantageous if slow, muddy and costly management of resources is to be avoided. Finally, some Operating Models can generate greater scope for taking advantage of potential synergies in the wider network of emergency services and care.

6. A New Operating Model for Guernsey

Target Operating Model Considerations

6.1 An 'Operating Model' is simply a coherent combination of Processes, People, Systems and Infrastructure (e.g. equipment and buildings). Understanding the performance of the Current Operating Model is important to assessing the benefits of change (**Figure 3**).

6.2 The Target Operating Model is likewise a combination of Processes, People, Systems and Infrastructure. It requires creative thinking to conceive it as good as it can be.

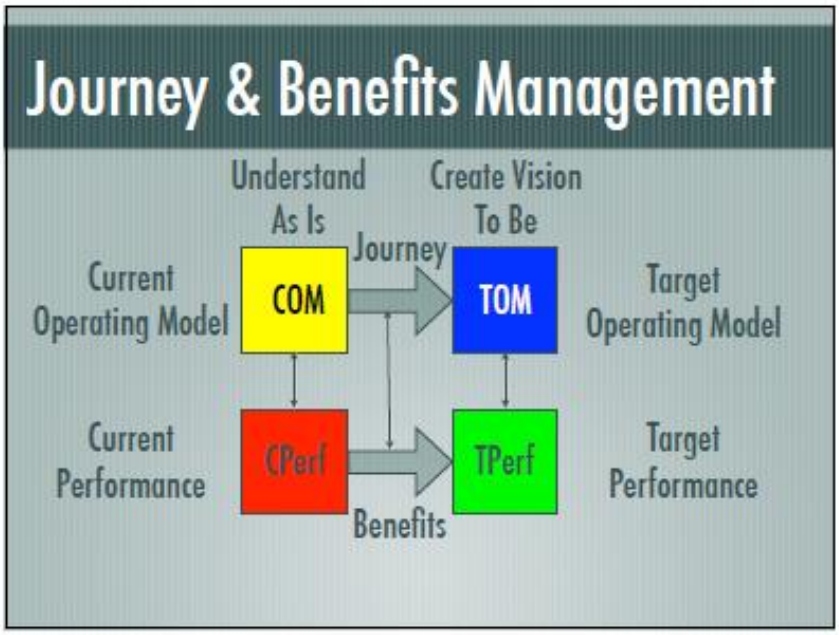


Figure 3

6.3 Conceptually, we will move on a phased 'journey' from our Current Operating Model (COM) to a better Target Operating Model (TOM). We will only do this if the Target Performance has net benefits over the Current Performance. 'Performance' can be regarded as patient outcomes (or customer service levels), financial (value-for-money), other non-financial factors or 'risk' to service levels etc. under different scenarios. We have stressed before that patients and Clinical Pathways are changing for various reasons and such changes influence the relative merits of different Operating Models.

6.4 As illustrated in our report on 'Considerations and Best Practice Research' (Appendix 1), other jurisdictions, including St John in Australia, optimise the use of new mobile technologies and communications in emergencies by linking Ambulances/Paramedics to Core Patient Health Data and to hospital A&E departments.

6.5 Using some of these mobile technologies is indeed 'child's play' and increasingly commonplace for storing medical health and fitness data on mobile phones. Nowadays young schoolchildren are known to set up their 'Medical ID' on a standard Apple app, after learning from their peers and then educating their parents on how to do it. Safeguards enable the emergency services in jurisdictions utilising such technology to electronically bypass the handset security and access that information in emergencies.

6.6 Some medical professionals and the public sector are lagging far behind children in the use of modern mobile technologies.

6.7 During our Interim Briefing (to the collective Boards of HSSD, Home, SSD and St John), we introduced the 'segments of the Orange' simile (**Figure 4**), representing the scope of integrated health and social care, and stressed that future changes elsewhere can have significant knock-on effects to the Emergency Ambulance/Medical Service and to the NEPTS. That is one reason why our research has looked widely at changes in health and care services, ambulance services and emerging technologies.

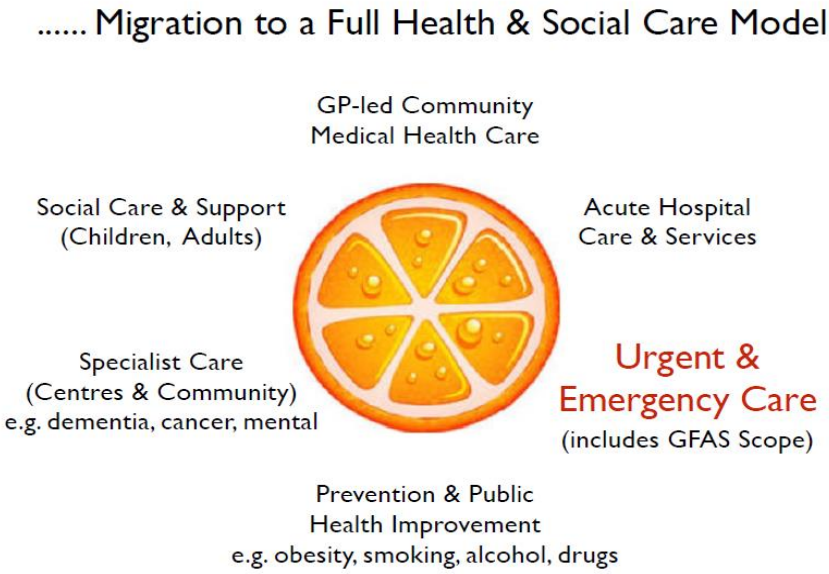


Figure 4

6.8 One example of such emerging technologies is 'Babylon', a 2015 innovation, which could have a significant impact upon how some health services are delivered in the future. Babylon and similar innovations could change the mindset of patients, GPs and other professionals. It also affects the shape of Processes, Systems, networks of People and the Infrastructure supporting health services; it can both complement and disrupt the whole shape of 'Operating Models.'

6.9 Babylon enables the public/customer/patient to do the following on their mobile phone or tablet computer:

1. Ask health-related questions and get immediate, reliable answers.

2. Book medical appointments. These may be a video-based consultation with a GP, or a specialist.

3. Monitor their health statistics and trends, similar to standalone health & fitness apps which are becoming popular.

4. Receive test results and notifications of prescriptions being delivered.

5. Operate within an integrated healthcare benefits plan. That is an interesting 'cross selling of services.'

6.10 Babylon was developed in Jersey, a product of the 'Digital Jersey' initiative and is targeted initially at the Jersey, UK and Irish markets. It is 'free' to sign up to but has 'in-app' financial purchases.

6.11 Moving on from examples of innovation and returning to wider Operating Model considerations, the key question is therefore: "Do we have the vision to conceive a better TOM and thereafter the ability to implement it?"

Influencers of Total Network & Channel Demand

6.12 Population size and demographics (ageing) are key, predictable influencers of demand upon the health and emergency care network. Innovation and new medical treatments will add further to those demands, while improved public health initiatives and education can help to suppress demand.

6.13 Our international research on alternative models and networks of care also generated some interesting performance issues and trade-offs. The simple conclusion from this was to avoid any temptation to optimise one section of the emergency care network in isolation at the expense of others and the whole network. The trade-offs listed below are illustrative of outcomes experienced elsewhere and locally.

- 'Hear & Treat' phone-based services v. Primary Care Hours
- 'Hear & Treat' caution drives 'Convey & See'
- 'Arrive & Handover to A&E' can become 'Arrive & Wait'
- Hospital bed-blocking drives 'Refuse & Wait'
- 'Refuse & Wait' drives Ambulance Costs and lower Patient Service.
- Lack of home-based Social Care also drives Hospital bed-blocking.
- Hospital bed-blocking drives up total Healthcare Costs.

6.14 As a result of such trade-offs, leading jurisdictions are seeking to use 'patient outcome measures' across the total network, so that the 'full patient experience' and outcome is measurable for performance assessment. Although this sounds logical, it has significant implications to work well in practice, posing further questions and trade-offs, which have generally contained unresolved matters in Guernsey in recent years:

- Identification of patient throughout network?
- Core records available to emergency professionals?
- Total network & channel capacity?
- Total network & channel outcome measures?
- Who decides & who 'performs'?
- Who decides & who bears which costs?
- Role of Service Level Agreements?

Evaluation of Options

6.15 Having defined our evaluation criteria and weighted scoring approach, we then defined 6 major Operating Models for evaluation, keeping an open mind for others emerging from research:

1. No Change - Continue 2014 arrangements into the Future

2. Absorb into HSSD (per 2014)

3. Agency Oversight by HSSD

4. Agency Oversight by Home

5. Operate an Emergency Services structure, overseen by Home.

6. Fully Integrated Fire & Ambulance Service

Option 1 is effectively the arrangements in place with St John in 2014. St John has moved on significantly since the Lightfoot Review.

Option 2 represents absorbing St John's EAS into HSSD, as proposed by HSSD in September 2014.

Option 3 represents continuing with St John as a separate 'commissioned partner', with improved governance and performance oversight. This is closer to what has been happening in 2015.

Option 4 represents HSSD continuing to establish the clinical pathways and standards for care as 'clinical commissioner', but Home having 'operational and budgetary oversight' of operational performance, due to the increasing collaborative overlaps between all Blue Light Emergency Services - Ambulance/Medical, Fire and Police.

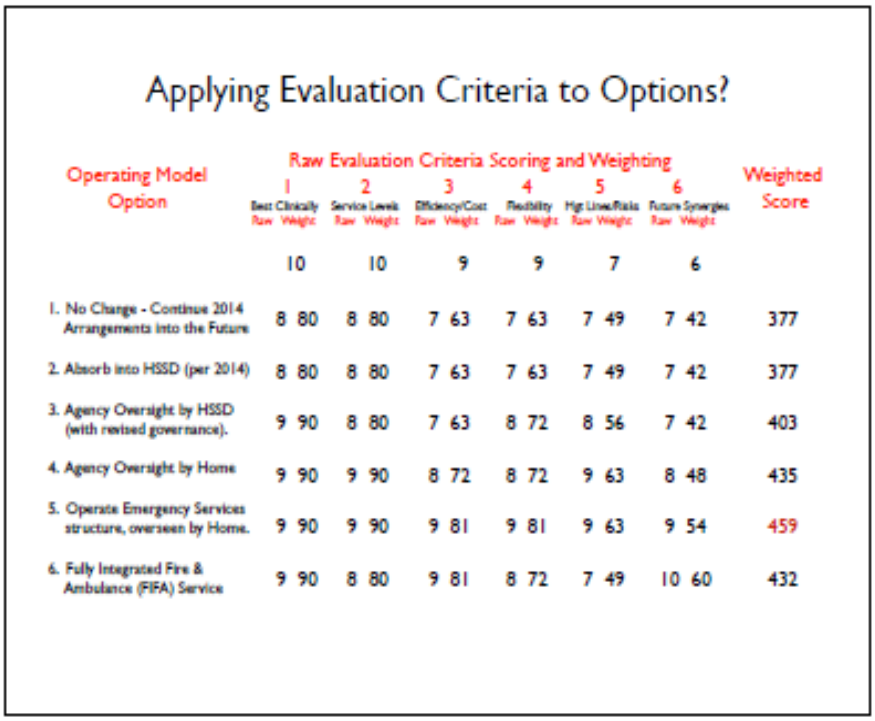
Option 5 also represents HSSD being the 'clinical commissioner', but Home pursuing opportunities for 'shared facilities and interoperability' across aspects of all emergency services, in line with evolving best practices. The JESCC, which went live during summer 2015, is one early example of this.

Option 6 represents a Fully Integrated Fire & Ambulance (FIFA) Service, operated by the States as a single service with a single multi-skilled structure. This is an approach used in some other jurisdictions, but is a radical change from practices currently used in Guernsey and the UK (from which many of Guernsey's practices are derived, due to regulatory oversight).

We also considered 'Other Customised Approaches' (not shown), e.g. partnering with others.

6.16 In our *Considerations & Best Practice Research* document (Appendix 1), you will see references to jurisdictions with varying degrees of combined Fire and Ambulance Services. The GFAS Steering Group therefore asked Guernsey's Chief Fire Officer, Jonathon Le Page, to investigate this further and report accordingly. In October 2015, he submitted a comprehensive report. The report refers to the practices of many jurisdictions, before identifying a significant range of opportunities and risks associated with adopting such an approach in our 'unique' local Guernsey. This report formed a major part of our deliberations regarding the relative merits of Option 6.

6.17 The Steering Group subsequently assessed and scored the 6 Options and used the further 6 weighted scores to arrive at a weighted score for each Option (**Figure 5**).



Applying Evaluation Criteria to Options?

Operating Model Option	Raw Evaluation Criteria Scoring and Weighting												Weighted Score
	1 Best Clinically		2 Service Levels		3 Efficiency/Cost		4 Flexibility		5 Hgt Lives/Risks		6 Future Synergies		
	Raw	Weight	Raw	Weight	Raw	Weight	Raw	Weight	Raw	Weight	Raw	Weight	
	10		10		9		9		7		6		
1. No Change - Continue 2014 Arrangements into the Future	8	80	8	80	7	63	7	63	7	49	7	42	377
2. Absorb into HSSD (per 2014)	8	80	8	80	7	63	7	63	7	49	7	42	377
3. Agency Oversight by HSSD (with revised governance).	9	90	8	80	7	63	8	72	8	56	7	42	403
4. Agency Oversight by Home	9	90	9	90	8	72	8	72	9	63	8	48	435
5. Operate Emergency Services structure, overseen by Home.	9	90	9	90	9	81	9	81	9	63	9	54	459
6. Fully Integrated Fire & Ambulance (FIFA) Service	9	90	8	80	9	81	8	72	7	49	10	60	432

Figure 5

6.18 Option 1, the 'No Change' option at 2014, scored a total of 377, (far right). The absolute number is not important, because we are comparing the relative attractiveness of different options.

6.19 Option 2, 'Absorb into HSSD' as proposed in September 2014, might have scored marginally higher for two main reasons. Firstly, a greater control over Clinical Oversight (Criteria 1) might have been thought capable of being applied directly and secondly, some greater Efficiency of operations might have been possible via direct management. Interestingly, we did not see 'direct absorption by HSSD' as being the best route to achieve 'Efficiency, Cost Savings or Value-for-money.' Neither did the T&R assessment in September 2014, nor the CCA at that time; both cited significant risks, which also extended to potential service level and financial risks. This was also happening in parallel with some very turbulent events in HSSD, as regulatory investigations were commencing and the resignation of the full HSSD Board shortly afterwards. Hence Options 1 and 2 scored similarly overall.

6.20 Option 3, 'Agency Oversight by HSSD', is closer to the 2015 Operating Model. It incorporates numerous changes recommended by the earlier Lightfoot Review, accompanied by a better governance regime and reporting of Key Performance Indicators. The improvements have been achieved by replacing a loose or non-existent monitoring role and applying a more professional partnership and contractual relationship between the two key parties: commissioner/customer and supplier. (There is still further to go with commissioning practices at HSSD). As most industries in the modern world have demonstrated (and also communist Russia and China since the 1950s), state ownership of all the resources in the chain or network is neither the only, nor best way to secure enduring performance and efficiencies. Professional partnerships, involving parties deploying their best expertise, can achieve more in a changing world. Thus Option 3 scores marginally higher in strengthened Clinical

Oversight and Better Management Lines/Risks via a clearer contractual arrangement, stronger clinical oversight bodies being established and shared KPI monitoring being implemented. Option 3 could continue to evolve and develop in future.

6.21 Option 4, however, scores higher still. It retains the benefits of Option 3, but has the ability to add three things, due to common oversight by Home of all Blue Light Services in an era when Ambulance, Fire and Police are driving their processes, systems, infrastructure and people towards greater 'interoperability.' Efficiencies, cleaner operational management lines and future synergies (including greater operational back-up and lower service risks) are possible.

6.22 Option 5, implementing a clear 'Emergency Services Structure' with common oversight and maximum teaming, sets about securing additional resilience and value-for-money opportunities from the 'interoperability' mindset being pursued in other jurisdictions, starting to emerge in the UK, and having been achieved in Europe, North America and Asia. Although Option 5 scores the highest, it does not imply that Home absorbs St John. It implies an enduring, evolving partnership.

6.23 Option 6 involves some complex trade-offs between synergies/efficiency/costs on the one hand, and risks or critical 'care culture' changes impacting service levels on the other. Even within each area of scoring, there are further complex trade-offs, of which some relate to professional 'hearts and minds issues' of the respective workforces delivering care, e.g. there may be greater 'clean management reporting lines' in an integrated workforce and improved resilience in logistical back-up services, but this might be offset by a lower, true 'care' delivery to the public if the 'care culture' is felt to be diminished in any way, or 'traded away for efficiency gains.' (This is something which the NHS feels may have happened with aspects of nursing in the UK). Furthermore, it is undesirable for Guernsey to take the risk in pioneering implementation of this prior to the UK, given that currently-accepted regulatory working practice standards (governed by separate Fire and Ambulance Service regulatory bodies in the UK) would need to be redesigned in Guernsey first, probably at disproportionate effort and cost.

6.24 Neither the Steering Group, nor the public, nor professionals in the Guernsey consultation, saw any non-Guernsey agencies as having a stronger proposition as a quality supplier in preference to St John. We also saw less potential in other Operating Models than those we propose elsewhere in our GFAS report.

Target Operating Model & Implications

6.25 Moving on from the detailed numerical scoring (**Figure 5**), the summary below seeks to capture the essence of the choice of Option 5 by the GFAS Steering Group.

Recap of Evaluation of Options			
	Options	**Weighted Score**	**Conclusions**
1	No Change or 'Fine Tune'	377	Unable to fund age-related services
2	Absorb into States - HSSD	377	Loses some shared Blue Light benefits. HSSD Transformation overload
3	St. John Overseen by HSSD	403	Some shared services benefits
4	St. John Overseen by Home	435	Greater shared services benefits
5	St. John Partners with Home - Emergency Services Structure.	459	'Best of breed' teaming benefits. Increases 'interoperability' gains
6	Fully-integrated Fire & Ambulance (FIFA) Service	432	Scope for marginal gains. Substantial culture/care/other risk

6.26 Of course, the relative scores of the options listed above are driven by an understanding of the more detailed combinations of Processes, Systems, People and Infrastructure associated with each option. We list below some of the features associated with the Target Operating Model:

Target Operating Model - Processes:

1. New HSSD Clinical Pathways and Outcomes for accident/emergency responses and outcome KPIs.

2. Aligned 'Blue Light' processes and equipment across all services, including related training.

3. HSSD commissioning role fully established for integrated patient care (medical and social).

4. Home operational oversight role - all Blue Light operations, with greater 'interoperability.'

5. Shared processes (and support systems) between Ambulance and Fire Services at common base.

6. Segregated contracts for Emergency Ambulance Services and other St John services.

7. Greater deployment of services to the home; Hospital no longer the automatic 'default.'

8. Greater assessment of patient social care needs (at home), rather than segregating medical needs.

Target Operating Model - Systems:

1. Expanded scope of JESCC - mental & social. Additional medical modules, plus A&E linkages.

2. Shared Core Patient Records (& opt out) system re-established and successfully implemented.

3. Good interfacing to patient mobile (phone) medical data and 'apps' for personal medical data.

4. Shared emergency network systems for tracking end-to-end patient outcomes.

5. Mobile Blue Light technology/comms upgrades: mobile technology, video, access comms. etc.

6. Pooled Patient Transfer System for non-emergencies, with simpler booking & billing.

Target Operating Model - People:

1. St John confirmed as trusted provider; longer, flexible contract for skills investment.

2. Skills spectrum widened and increased for Paramedics, Technicians & Nurses to match demands.

3. Flexible deployment of Paramedics; rostered across network (A&E and JESCC) for experience.

4. All 'people' (professionals & third sector) feel part of a 'virtual hub' of skilled providers.

5. Pan-island teamwork for integrated patient care - medical and social.

6. Strong ICT systems encourage wider team communication - central and dispersed specialists.

7. Greater common rostering of Ambulance and Fire personnel, dictated by requirements.

Target Operating Model - Infrastructure:

1. Shared Emergency Ambulance Service base with Fire Service.

2. Purchase of next generation of multiple use emergency Ambulance and Fire vehicles.

3. Better use of capital assets (shared property, vehicles etc); better States financing options.

4. A&E expanded with Minor Injuries Centre at PEH; pooled triage and paramedic support.

5. Shared 'open' Non-emergency Patient Transfer System (NEPTS) - booking, scheduling & billing.

6. St John non-EAS property opportunity at Rohais - let, lease, capital sale?

6.27 The general benefits of the Target Operating Model, as we migrate from past practices to future practices, are summarised below. The respective values of these will form part of the detailed business cases to be approved before individual investment initiatives are launched.

	From	To
1.	Limited HSSD service spec	Better defined clinical pathways
2.	Patchy outcome reporting	Known/better patient outcomes
3.	Limited patient choice	Greater patient service choice
4.	Patient Record constraints	Network-wide access to core
5.	Service/cost muddiness	Greater patient cost clarity.
6.	A&E resource constraints	Greater A&E resource flexing
7.	Muddy paramedic funding	Enhanced roles for paramedics
8.	Poor technology support	Common mobile technology
9.	Limited care to home	Greater range of home care
10.	Embryonic JESCC	Extended service JESCC
11.	Charity subsidising States (or vice versa)	Clear, segregated service costing.
12.	Costly Patient Transfers	Cost-effective patient transfers
13.	Ad hoc Services sharing	Active collaboration & sharing
14.	Separate operational bases	Shared operational bases
15.	Managing isolated units	Managing emergency network

6.28 In addition to identifying the general benefits above, we further assessed the benefits for the States and St John in moving to the proposed Target Operating Model:

Benefits for States - HSSD

1. Retains role for setting clinical standards and pathways.
2. Commissions clearer, formal clinical standards and KPIs.
3. Capitalises on JESCC extension for HSSD integrated care vision.
4. Transforms to 'best practice' integrated clinical & social care.
5. Leverages skills of Home Dept for full 'blue light' operations.
6. Leverages paramedic skills for A&E, calls, home & telemedicine.
7. Gains from better VFM shared use of property, vehicles & PTS.

Benefits for States - Home:

1. Secures more benefits from expansion of JESCC investment.
2. Progresses HOST Strategy - 'blue light' interoperability.
3. Builds on post-JESCC 'blue light' Service Chiefs' collaboration.
4. Improves mutual team understanding, back-up & resilience.
5. Gains from better VFM shared use of property, vehicles.
6. Simplifies operational planning & budgeting - one States Dept.

Benefits for St John: "an opportunity-generating change."

1. Public recognition of brand and quality of care/service.

2. Longer-term contract for certainty & investment in people.

3. Simplified contract, involving less P&L risk & finance.

4. Flexible 'strategic partner' contract - 'best practice' reference.

5. A property opportunity - space/capital asset/lease.

6. Further strategic opportunity - HSSD integrated care to home.

7. Core driver in new 'pooled' modern PTS system.

Benefits for Islanders

6.29 Perhaps most importantly, the Benefits for Islanders were also identified as follows. These are being tested in a further round of consultation via 'A Day in the Life' workshops with patient/specialist groups and related professionals.

1. More likely to receive better skilled treatment in emergencies.

2. More likely to receive emergency treatment faster.

3. More likely to receive coordinated health & social care.

4. Less likely to 'bed block' in hospital, awaiting 'other processes.'

5. More likely to be seen in comfort of own, safe home.

Flexible use of paramedics across the network

6.30 Whilst the catalyst for this Review was the difficult 2014 negotiations for the renewal of the ambulance service contract, it is the future that has shaped our findings, underpinned by demographic data, external research and the burgeoning cost of the delivery of health care. Collectively, these are the factors that should incentivise and shape the effective restructure of the delivery of services and collaborative working.

6.31 The unscheduled care system needs to change how it identifies people at increased risk of a need for urgent or emergency care treatment and to manage that risk with services, care and support at or close to home, preventing needless and avoidable emergency hospital admissions. Reducing unnecessary attendances at A&E may help to reduce unscheduled hospital admissions and bed days. Various value for money initiatives within the proposed TOM will support that aim e.g. better use of collaborative resources will increase available investment to upskill staff in other areas.

6.32 All the evidence indicates that the scale and pace of change will increase over the coming years and this Review has taken that into consideration, with a focus on placing ambulance services within a wider, whole system.

6.33 It is widely believed that many people attending Emergency Departments do not need to be there and would be better served elsewhere, whether they require minor interventions or not. One way to resolve this is to bring the hospital to the patient and this has been the primary driver behind the development of Advanced Paramedics or Emergency Care Practitioners (ECPs) within the NHS. Elsewhere in this report (1.9 & 5.5) there have been references to investment in better paramedic skills and the flexible use of Advanced Paramedics. What does that mean?

6.34 Through the development and deployment of Advanced Paramedics in England and Wales, many other benefits have emerged as their practice evolves. This is especially true where Advanced Paramedics work in a number of different environments, usually by rotation, as the skills and experience of each role and environment often directly benefits their practice in others. An Advanced Paramedic is able to provide much more care to the patient, including resolving many calls at the point of response, and referring patients onwards to different care pathways using their own transport, all of which avoids admission to hospital. This makes Advanced Paramedics more operationally effective and frees up other ambulance clinicians to respond to 999 calls. Typically, Advanced Paramedics rotate their practice through two or more of the following areas;

- Emergency response (999)
- Out of hours home responder, telephone advice and face-to-face
- Self-present environments e.g. A&E, minor injuries clinic
- Community Care in hours (GP surgery, home visits)

6.35 Remote access to core patient data or service directories via mobile technology will be key to maximising opportunities for the operational effectiveness of Advanced Paramedics and indeed other ambulance clinical technicians. Without that technology, opportunities for Advanced Paramedics to divert or prevent unnecessary hospital attendances will be reduced.

6.36 A new vision for the Island's ambulance services which is clearly defined, realistically achievable and aligned to the whole system direction of travel for unscheduled care services needs to be agreed as a first step. Everything else, including how services are planned, delivered, measured and funded should flow from this vision.

6.37 The ambulance service is an integral part of the future urgent and emergency care system, with further opportunities through the emerging new models of care. These opportunities are set against a background of recruitment challenge and the need to review current training programmes to ensure that the workforce is flexible, has the right skills to deliver out-of-hospital care and forms part of a wider multidisciplinary approach.

7. Future of Non-emergency Patient Transfer System

Current Non-emergency Patient Transfer Function

7.1 The Non-emergency Patient Transfer System (NEPTS) warrants a separate Target Operating Model to the Emergency Ambulance Service (EAS), otherwise both can operationally compromise each other in terms of scheduling and availability. This view was confirmed by our research in other jurisdictions and reinforced strongly by one of our 'expert pressure testers', Hayden Newton.

7.2 With multiple suppliers (primarily St John, but other providers too), evidence indicates that there is scope to improve on current arrangements.

7.4 Patient requirements are currently met and financed by multiple service providers and can range from complex to simple. Demographics indicate that demand for these services will grow. We therefore need to conceive a practical alternative, which will achieve net benefits and adequately handle the current complex 'cost authority' process, which is split across several States departments.

Performance & Costs; Issues & Opportunities

7.5 At an early stage of this project the SJARS Chairman suggested that we should contemplate an "Uber Taxi approach with a clinical overlay", meaning:

1. A common technology-based booking system (capable of mobile self-booking) for all users.

2. A co-ordinated system developed and funded by the States or others as a community-wide scheme.

3. Having the capability to recognise specific customers and specific assistance needs/profiles (the "clinical overlay").

4. Recognising entitlements or authorisations for charging/billing/payment purposes.

5. Starting with the high volume or commercial providers, then opening the system to other specialist charities when proven and appropriate, e.g. some specialist charities who are reported to have under-utilised vehicles/volunteers.

7.6 HSSD is one of three States Departments (**Figure 6**) funding a range of transport providers. Education provides transport for 'special educational needs' children and in certain circumstances, SSD provides funded transport for benefit claimants attending medical appointments.

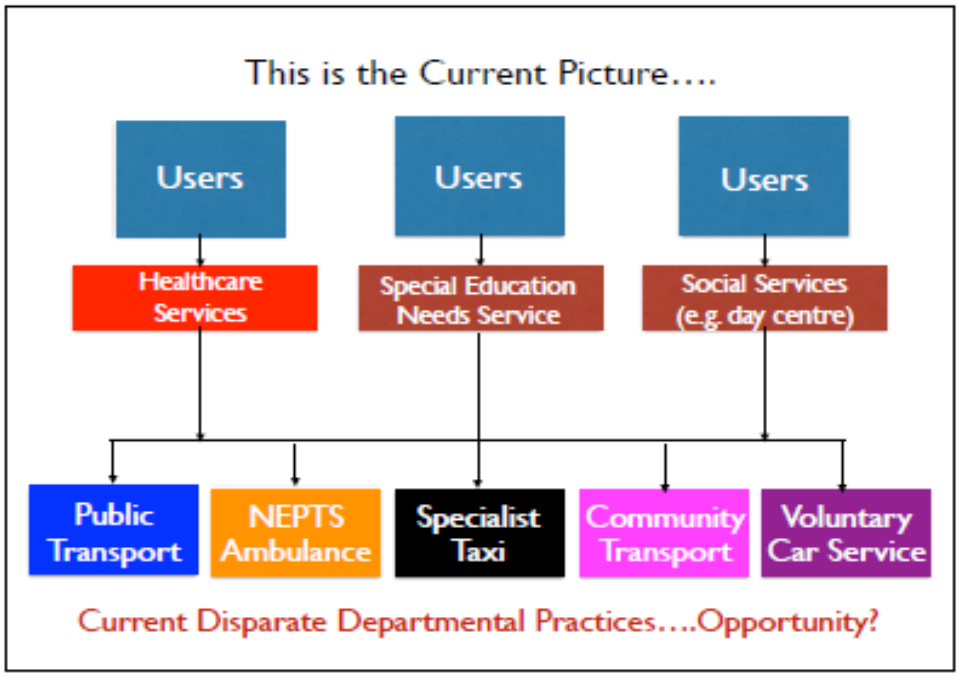


Figure 6

7.7 During a workshop with service providers and user groups, we concluded that:

1. Different arrangements would provide greater value-for-money.

2. An opportunity exists beyond solely within Healthcare Services to bring together these disparate Departmental practices.

7.8 Our conclusions are reinforced by a separate written submission made in November 2015 by Ageing Well in the Bailiwick, in response to the States Community Survey on Public Service Reform who made the following suggestions relating to services for older people:

1. Develop "a single front door" to access community services.

2. Enable gatekeepers to effectively to signpost people in the right direction.

3. Improve awareness of and access to care services

4. Resolve the considerable uncertainty of how to access transport for medical appointments.

Proposed Future of Patient Transfer Function

7.9 Phase 1 of Change can be carried out in the near term, solely within HSSD's mandate (**Figure 7**):

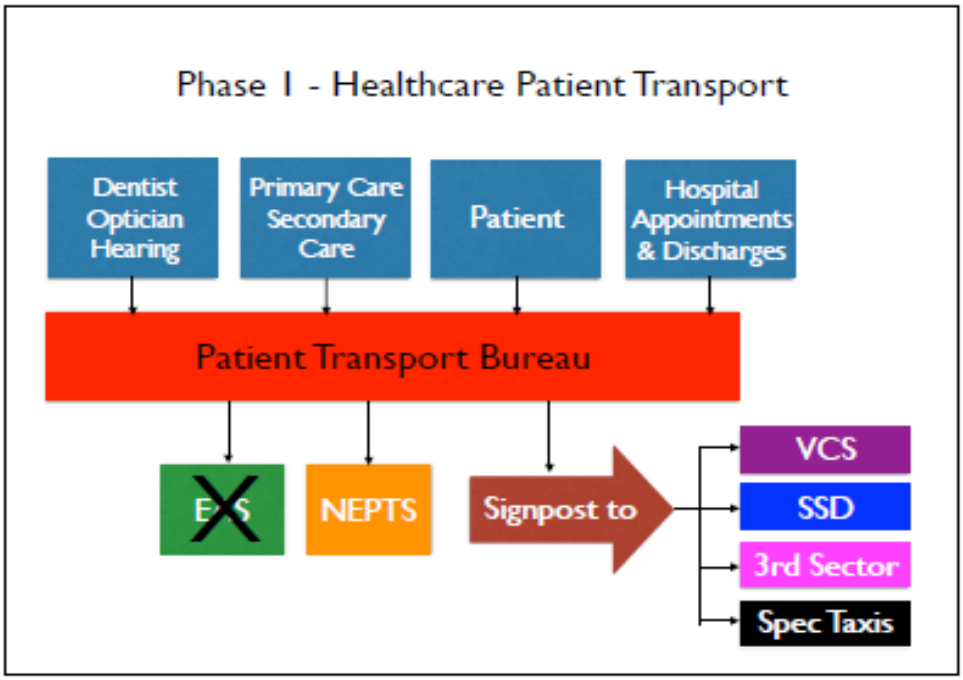


Figure 7

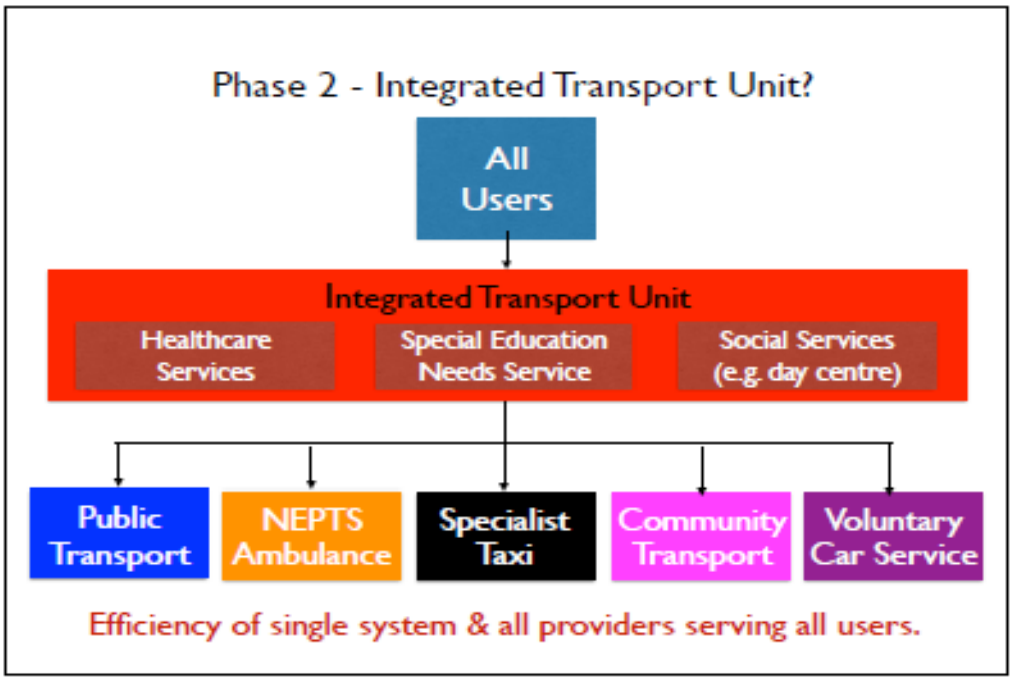
1. A Patient Transport Bureau, operated by or on behalf of HSSD, receives transport requests from multiple sources.

2. It then determines needs, entitlements and approvals for a NEPTS or 'signposts' the requestor to other potential service providers e.g. the Voluntary Car Service (VCS), currently funded by HSSD, SSD, who under certain criteria can assist with the funding of transport, usually taxis, the Third Sector or specialist taxis.

7.10 Unlike in Guernsey, users of voluntary car schemes in other jurisdictions e.g. England and Wales, pay a subsidised contribution towards the cost of journeys. Demographic data and a shift towards the delivery of more home/community based healthcare services will in future increase the pressure and demand upon these services. The planning of any future reconfigured service delivery should consider the benefits of subsidised payments by service users.

7.11 There are occasions in Guernsey when non-emergency patients require transportation on a stretcher (e.g. elderly people from care homes being admitted or discharged for a pre-booked hospital procedure). Currently this requirement can only be met in 2015 by deploying an Emergency Ambulance and crew operated by the EAS. We envisage that need being met in the future by the NEPTS provider. The use of an emergency ambulance would then be better utilised for emergency use only.

7.12 Our proposed TOM for Phase 2 (**Figure 8**), based upon a Uber Taxi approach with a clinical overlay', extends beyond merely Healthcare Services and HSSD. The model illustrates how the Integrated Transport Unit (ITU) acts as a single point of contact for all users e.g. hospital, GP, patients, who have a health/social care transport requirement. The ITU could be operated by the main transport provider or by a third party. Overall, the model provides an opportunity for the States of Guernsey to maximize efficiency and flexibility of its cash and physical assets invested in this area of transportation.



(**Figure 8**)

1. All users and States Departments access a common, comprehensive system (which may be called the 'Integrated Transport Unit' or a more appropriate final name).

2. All providers make their services available to it.

3. The ITU system and operator allocate the most appropriate and cost-effective option available to meet the specific needs of the patient/customer for each journey or sequence of journeys.

7.13 Our evaluation of options for a NEPTS was driven by an understanding of the more detailed combinations of Processes, Systems, People and Infrastructure associated with each option. We list below some of the features associated with the Target Operating Model:

Target Operating Model - Processes:

1. PTS segregated from EAS contract.

2. Single point for transport bookings.

3. Migrate to self-booking mobile systems.

4. Open to further providers & charities.

5. Share service with other States Departments.

Target Operating Model - People:

1. Overseeing pooled transport.

2. Familiar with all providers.

3. Can be a home-worker.

4. Intervene when system requires.

5. Linked by phone/system network.

Target Operating Model - Systems:

1. New self/group booking system.

2. Matches customer needs to providers.

3. System provides cost-effective matching.

4. System includes 'clinical overlay.'

5. System handles entitlements & billings.

Target Operating Model - Infrastructure:

1. States or non-States entity.

2. At provider/home-worker base.

3. Providers own transport/bases.

4. System knows vehicle availability.

8. Performance Management

Performance Management Regime

8.1 We believe that the oversight approach adopted by the States of Guernsey (T&R) during 2015 in relation to certain States Trading Entities is worthy of consideration in any future contractual arrangement with SJARS. Both types of entities are managed by their own professional Boards, with States oversight, but without undue political interference in professional operations for the long-term service and benefit of islanders.

8.2 Such arrangements incorporate clear political and strategic objectives and key performance indicators. In addition, operational management and performance are

judged at three levels:

1. Strategic Planning - sound, appropriate plans.

2. Operational Efficiency - operational benchmark comparisons and delivery of KPIs.

3. Customer Service - range and quality of service, based on periodic customer surveys.

8.3 Contract-related performance reporting arrangements required by HSSD, of St John (and others), has changed greatly since 2014, after the Lightfoot Review highlighted the loose practices previously in place and the need for a more professional commissioning approach by HSSD.

8.4 Current best practice trends elsewhere have moved towards tracking 'patient outcomes' across the full set of clinical processes or 'clinical pathways' through which a patient passes. This applies equally to patients handled by the EAS and the NEPTS.

8.5 As illustrated in our report (Appendix 1), this trend is also resulting in a gradual move to revise ambulance service KPI reporting. Greater emphasis is being placed on getting the best 'patient outcome' by deploying skilled resources to where they are needed. Correspondingly, less emphasis is being placed on the simpler forms of time-based ambulance vehicle response reporting (although response times do remain important).

8.6 Locally we need to address other factors before we can evolve much further in our KPI reporting:

1. KPI reporting has been instigated since Lightfoot and is embedded into internal management practices and reporting from SJARS to HSSD.
2. Current KPIs are agreed, based on the Lightfoot Review recommendations and are reported regularly.
3. 'Best Practice' is evolving from time-based to patient outcomes, and will continue to evolve.
4. KPI reporting cannot evolve fully to patient outcome KPIs before:

    a. Agreed clinical pathways/processes are defined (by HSSD)
    b. We can track start-to-end patient outcomes (IT reliant).
    c. We can identify patients (records) 'in the pathways.'
    d. All involved can provide information (to patient records).
    e. Investments are made in shared core patient records.
    f. Emergency services have mobile technology (as elsewhere).

Key Performance Indicators

'Not everything that can be counted counts, and not everything that counts can be counted' – Albert Einstein

8.7 It is rather timely given the scope of this project that in November 2015, the National Ambulance Commissioners Network (part of NHS Clinical Commissioners, representing ambulance commissioners working across all 11 ambulance trusts in England) embarked upon a process of consultation with all

stakeholders to review the scope, design and delivery of future ambulance services and the means by which such services should be measured.

8.8 It is recognised, as with many other parts of the NHS, that the current way in which ambulance services are delivered were not designed to meet the needs of today's population. Health and care systems cannot afford the year-on-year increases in activity and so the way the service is provided and commissioned needs to change to ensure that the system remains sustainable going forward, while providing the best care for patients.

8.9 As a consequence, the following key recommendations are being promoted by the Commissioners:

- The ambulance service should develop into a mobile health provider, working in multidisciplinary teams.
- There should be a refocus on commissioning and provider systems that support non-conveyance and provision of the right care closer to home as its principal aim for most patients, whilst continuing to provide immediate transport and treatment solutions for those patients who need a fast response.
- There should be a shift away from time-based targets for the majority of responses, to ones focused around patient and clinician experience and patient outcomes, building on the current ambulance quality indicators.
- There is a need to develop a workforce and training plan with commissioners to support the shift to new models of care which are realistic in terms of timescales for implementation.
- Collaboration is fundamental in developing new models of care through a multiplicity of collaborative forms including sub-contracting, alliance and prime providers.

8.10 It may be reassuring to readers of this report that the above recommendations of the Commissioners have been promoted and shared during various briefings by this Steering Group as our research and consultation with experts and the wider public evolved throughout the duration of this review.

8.11 The Steering Group are of the belief that future service targets should be based upon patient outcomes, building on the current quality indicators and patient experience data, with a reduced focus on time-based targets other than for the most critical patients requiring such a response. Determining those targets will be a matter for HSSD, as the commissioning body, in consultation with the providers of ambulance services. The framework and timing of the introduction of such targets will be dependent upon the scope and timing of HSSD's development of hospital and social care services and the wider supporting ICT infrastructure. It would therefore be inappropriate and premature for this Committee to seek to specify new KPI targets at this time, other than in the wider holistic sense.

Interim Performance & Costs

8.12 Following the 2013 Lightfoot Review, SJARS has evolved, moving from their previous 'Operating Model' to the current 2015 Operating Model. Examples of these organisational changes in Process, People, Systems and Infrastructure are detailed within Appendix 4.

8.13 Summarised below (correct as of 31/10/15) is the progress achieved by SJARS in relation to Lightfoot's 49 recommendations (Appendix 3). Some of the recommendations required parallel changes in areas outside of St John's sole control, e.g. in HSSD or elsewhere, such as the implementation of a JESCC, which went live in Summer 2015.

- There were 49 prioritised recommendations
- 90% were agreed by HSSD & SJARS of which:-
- 51% are complete with:-
- 34% in progress
- and 14% not commenced, comprising:-
- 5 contested (9, 13, 18, 24, 29),
- 1 for HSSD (27)
- and 1 not started (45).

There were no major contract exceptions during 2015 between HSSD and SJARS that required the GFAS Steering Group to intervene.

9. Implementation Considerations & Plan

Phased Implementation

9.1 In practice, we need to phase change over time, either to reduce the risks associated with major change or because there are external dependencies which need to be met along the way. In addition there are a number of interdependencies within HSSD and Home. Furthermore, it is sensible to incorporate flexibility and options into TOMs and phases. This is because economics or other factors can and will change during a 5 year journey.

9.2 As a result of such interdependencies, and related risks, it would be wholly unrealistic to portray now a complex 5 year bar chart showing all tasks, dependencies and deadlines. It would become rapidly out of date, wrong and be a misleading waste of effort.

9.3 Any one or more of the dependencies listed below could be disruptive, resulting in missed deadlines:

1. Investment in people/skills - paramedics/care culture extension/interoperability.

2. ICT investment success for resilient patient records/mobile systems.

3. Roll-out of HSSD Transformation and JESCC enhancement.

4. Priority-based phasing of States-wide resources.

5. Site planning permission for dual Fire & Ambulance use.

6. Site build-out prior to dual Fire & Ambulance use.

9.4 In addition to the above there are further interdependencies. Most importantly, we are trying to "dovetail" into the moving feast of a broader HSSD Transformation which is currently being defined, planned and resourced. There are many parts moving in parallel and all programmes need to fit within a broader States of Guernsey service delivery plan.

9.5 However, we know our direction of travel to three futures, based on 'best practices':

1. HSSD's Integrated Health & Social Care.
2. Home's Emergency Services Interoperability, and
3. A technology–enabled 'pool' system for providers of NEPTS

9.6 We also know the range of benefits to be targeted; other jurisdictions have already achieved some of them. Whilst we cannot know all the precise phases of our journey, the range and scale of benefits are such that we should:

1. Take the first steps on the journey.
2. Monitor progress and evolving best practices/technologies along the way.
3. Conduct major Checkpoint Reviews every 2 years.
4. Revise the journey destination and phasing to accelerate perceived net benefits.
5. Be alert to any changing economics of options.

9.7 For example, a longer term joint Fire/Ambulance/Police Base might become a more (or less) realistic option, based on Police deployment plans with mobile technologies, changing site acquisition/disposal values and numerous other factors. This will be evaluated in detail as part of the HOST States Capital Investment Prioritisation Process (SCIP) process during 2016.

Interim Checkpoints

9.8 The following table (**Figure 9**) portrays a standalone phased implementation plan, before activities are merged into the evolving HSSD Transformation Programme and Home's HOST programme (for greater interoperability of emergency services). It implies various phased implementations of increases in functionality. Some of these may be accelerated if business cases and related resources are brought forward and agreed earlier than currently anticipated.

9.9 The plan (**Figure 9**) also contains various major review checkpoints, at which the overall economics and resource plans should be re-confirmed, or the programme realigned to changing circumstances.

	Key Early Tasks	Programme Year						Dependency Risks
		2016	2017	2018	2019	2020	2021	
1.	New Contract/MOU	Design	Implmnt	Monitor	Review	Monitor	Review	Low
2.	Home 'blue light' role	Plan	Implmnt	Run	Run	Run	Run	Low
3.	Co-locate with Fire	Plan	Design	Implmnt	Run	Review	Run	Medium
4.	Flexible paramedic skills	-	Plan	Build	Impl 1	Impl 2	Review	High
5.	Share core patient data	Plan	Plan	Design	Build	Implmnt	Review	High
6.	Mobile technologies	-	Plan	Design	Impl. 1	Impl. 2	Review	High
7.	Expanded JESCC	Plan	Build	Impl. 1	Impl 2	Review	Impl 3	High
8.	Pooled NEPTS	Plan	Impl. 1	Review	Impl. 2	Review	Impl. 3	Medium

Figure 9

Delivery Responsibilities.

9.10 As already suggested the programme of work outlined above should not proceed in isolation of other HSSD, Home and States initiatives. It needs to be integrated with them, so that priorities, interdependencies and resources can be best managed.

9.11 In the remainder of this States term, the following actions should be taken:

Responsible	Near-term Actions (This States Term)
1. HSSD	Submit States Report. Strengthen 'Commissioner' role. Strengthen ICT partner/capability.
2. Home	Proceed with HOST strategy. Evaluate co-location property options in SCIP.
3. All Sponsors/SROs	Take ownership for next steps.
4. T&R	Approve timing of HSSD/Home budget transfer. Include NEPTS in States transport strategy.
5. GFAS Steering Group	Complete documentation and disband.

Other Issues

9.12 A successful and efficient future service delivered by the Ambulance & Emergency Services depends upon both a strong culture of care and much better use of available technologies than has been the case in the past. Strong patient information and core record systems are fundamental. The public consultation in Summer 2015 also

confirmed that the public wanted and expected their core medical records to be available and shared with emergency professionals in emergencies. Their lives might depend on it.

9.13 Steps therefore need to be taken to remove the barriers to sharing of key patient data information across the emergency services and healthcare network, providing sensible opt-outs for the minority of people (20%, per the consultation) who do not support the sharing of their information. These issues may be legal, technical or managerial. Overall, they are a professional healthcare and technical delivery issue.

9.14 During 2014, the States of Guernsey ICT Sub-committee had 'withering criticism' of the Electronic Health & Social Care Record (EHSCR) project, which was intended to form the basis of personal medical records. This criticism related to prolonged 'project drift', resourcing, management and political oversight.

9.15 ICT project practices have subsequently been strengthened. However, the following still apply:

1. HSSD Transformation will fail without SoG ICT Transformation.

2. A "best efforts with few departmental resources" approach is untenable.

3. Strong development and operations partners are needed for ICT developments within the States of Guernsey. This relates to technical ICT platforms, mobile apps and potentially, to shared solutions/costs with Jersey etc..

10. Future Organisation, Financial Implications & Oversight

Future Organisation & Contract Implications

10.1 As outlined at the outset of this report, this project was initiated in January 2015, as a result of the intervention of the CCA the previous September, following the unsatisfactory outcome of contract negotiations between HSSD and SJARS for the renewed delivery of an ambulance service.

10.2 The gross operating cost of the service contract between the States of Guernsey and St. John is £3.5m, which incorporates £0.9m in membership subscriptions revenue from members the St. John Supporter Scheme and net costs (to HSSD) of £2.6m. These are covered by a 'fixed scope - fixed cost' contract, which includes both the Emergency Ambulance Service (EAS) and the Non-emergency Patient Transfer Service (NEPTS).

10.3 The contract is due for renewal on 1st January 2019, but has a break clause at 1st January 2017 if 6 months' notice is given (by 30th June 2016).

10.4 Since the signing of the contract St John has not had significant financial or other exceptions. There remains a separate issue relating to unfunded pension liabilities from a historical defined benefits pension scheme (as within the States) but this is a separate non-contractual matter, outside the scope of the GFAS review. It is and needs to be, dealt with in a manner isolated from the contract.

10.5 The GFAS proposes a significantly different contract from 1st January 2017, if the States wants to pursue related HSSD Transformation and Home 'Blue Light Interoperability'/HOST-related policies and benefits before 1st January 2019. Alternatively, the States could elect to delay changes until 2019, but we believe this

would be undesirable as it would defer the wider benefits associated with those recently-approved States programmes or policies for 'Blue Light Services.

10.6 The proposed new contract (from 2017) would be more flexible, more focused and different from the current 'fixed scope - fixed cost contract', which was perhaps driven by a need for 'legal certainty' in a very fractious period in the autumn of 2014. It is the design of this that is of far greater relevance to the States and Home than the historical contract.

10.7 The new contract envisaged for the EAS separates out the NEPTS (not 'blue light') and strips out property costs (co-location in States property), strips out vehicle/equipment capital costs/maintenance (best kept States-owned and probably financed, especially future 'hybrid use' vehicles), strips out other support overheads (e.g. HR, accounting and IT etc. as being shared across all blue light services), and hence, effectively strips out most P/L management risks for both easier management by St John and reduced States exposure to volatility.

10.8 What remains in a future EAS contract? Primarily skilled employees - paramedics, technicians and management, the core competences within St John for the delivery of 'care' to islanders, plus, training/development costs and the public subscription system. The contract should therefore be driven more by an agreed level of skills and workforce numbers (paramedics, technicians etc. at 'going rates'), working to flexible rosters across locations, to match the clinical pathway standards set by HSSD and expected incident volumes. Expected incident volumes would drive flexible rostering of paramedic and other skilled individuals, located/rostered flexibility across multiple locations including A&E, on ambulances and staged for delivery of services to the home in line with HSSD's stipulated clinical pathways (for falls, diabetes, cardiac arrest etc.). As Home implements their 'blue light interoperability' policy and rostering, they have a key role to play in any future St John volumes, contract negotiations and budget-setting/oversight. Thus, the historical contract has little relevance in the future but Home Department's involvement in a future contract is key.

10.9 St John are already taking 'enabling' steps with the subscription system to segregate the two components of EAS and NEPTS in overall subscriptions being paid, including tightening group rules relating to the latter.

Financial Implications

10.10 The GFAS Steering Group has sought to define best practice future operations in the light of agreed States policies, namely the Transformation drive to Integrated Health & Social Care within HSSD (approved in the 2016 Budget passed by the States in November 2015) and the HOST-related 'blue light interoperability strategy established within Home, for which the JESCC has been the most visible concrete evidence to date (going live in Summer 2015).

10.11 GFAS therefore should not be viewed as a stand-alone 'project', but one which supports those other programmes. Accordingly, business cases will be brought forward during 2016 in conjunction with those wider programmes. This is not to avoid spelling out the financial cost/benefit business cases for GFAS, but to ensure that 'double-counting' of benefits does not arise in any business cases. For example, the co-location business case will be part of the existing States Capital Investment Prioritisation (SCIP) programme, with co-location of Ambulance and Fire Services being one such option to be justified within that SCIP proposal. A further example is the flexible use of paramedics and clinical technicians providing greater services to the home, or at home and A&E, as envisaged by GFAS; this is also envisaged by the approved HSSD

Transformation business case (2016 States Budget) and related emerging initiatives such as SLAWS (Supported Living & Ageing Well Strategy).

10.12 Existing political Boards are not being asked by this GFAS Final Report to approve extra funding or policy changes in 2016, or commit to either in 2017 or thereafter. In that sense, there are 'no financial implications' directly associated with this report's proposals, until further business cases are made from mid-2016. This report is coming to the States 'early', rather than accept a 'political void' for 6 months due to the election, so that political Boards can take the opportunity to demonstrate a collective degree of encouragement and support for the operational public service workforces involved, who have operated under much personal/family uncertainty over the past 2 years.

10.13 That said, members of the GFAS Steering Group have worked with officers from T&R to define, as far as possible at this stage, all financial cost and benefit implications associated with every proposed change in processes, people, systems and infrastructure associated with the moves to proposed new Operating Models described in this report. Although the final values of such costs and benefits will necessarily only be included within later 2016 business cases, when full interdependencies from those other emerging programmes are factored in, we can provide the necessary financial reassurance at this early stage that such business cases are sufficiently sound to accept the broad recommendations of this Report.

10.14 In summary, the financial implications of this report's proposals are to:

1. Save costs via better use of States property, by exploring co-location of Emergency Ambulance and Fire Services.

2. Save costs or capital via improved sharing or financing of vehicles and equipment.

3. Improve value-for-money outcomes and resilience via flexible deployment of paramedic skills etc.

4. Improve value-for-money via 'a pooled' NEPTS.

5. Simplify contractual arrangements with St John, to facilitate greater flexible deployment.

6. Consolidate 'Blue Light' Emergency Service operations and budgeting within Home.

7. Migrate to efficient 'best practice' operations over a phased period, whilst improving services.

10.15 Sponsors will bring forward separate business cases for:

1. Capital investment requirements for any co-location and shared use of property, in the SCIP process.

2. The HSSD Transformation components of the Future Ambulance Service proposals, including the volumes of increased paramedic skills to be deployed and a Non-emergency Patient Transfer System, segregated from the Emergency Ambulance Service.

3. Other Home capital and revenue components of the Future Ambulance Service proposals.

4. Other ICT-related investments in conjunction with the States of Guernsey ICT Function."

Future Business Case 'Sense-checks'

10.16 The following approximations illustrate that the separate business cases outlined above are sufficiently attractive to justify moving to the next stage of analysis, namely the development during 2016 of full business cases, which tie into the existing policies and transformation programmes of both HSSD and Home. For each area of potential investment, we show a potential magnitude of marginal investment cost, recurring spending and recurring savings. By applying a cost of capital of 4% (States core borrowing costs), it is possible to ascertain the annual savings required to justify upfront investment costs and then conclude on the practical feasibility of achieving those annual savings. In some instances, this has been done by reference to case studies from other jurisdictions (e.g. regarding interoperability across blue light services); in other instances, this has been done by reasonableness tests (e.g. the potential systems investment for better managing a NEPTS across multiple States departments. The comments on financial and non-financial benefits are illustrative and not exhaustive.

10.17 Some investments will be 'joint investments' from which GFAS-related activities could benefit, but for which sensible cost allocations are not yet practical. For example, the use of the next generation of mobile technologies by all blue light services would have a range of operational benefits (as shown in other jurisdictions), but ride on the back of mobile data networks required by some four or more separate States of Guernsey departments and being justified jointly within the States ICT Strategy. Attempting to disaggregate such costs at this stage is too inexact to be appropriate, especially as the related benefits to GFAS are not critical to the timing or scale of the overall total of benefits envisaged from GFAS. However, it is still feasible to apply judgement to ascertain the broad justification for preparing full business cases during 2016 with related HSSD, Home, Public Services Reform or States ICT transformation initiatives.

10.18 Finally, some investment initiatives are highly scale able, meaning that the risks are reduced, i.e. investments can be scaled upwards from earlier modest sums when benefits become proven in practice. For example, investing in greater paramedic skills across the emergency network and to home, should help to achieve the HSSD Transformation targeted benefits of fewer hospital admissions and related high costs (as described in the BDO analysis of HSSD's potential future cost savings, published with 2016 States Budget). This would be phased in gradually, as HSSD defines new 'clinical pathways' (incident-handling processes), which result in fewer unnecessary hospital visits or admissions and hence form part of concrete operational steps to help achieve the scale of the BDO HSSD Transformation savings.

10.19 Within GFAS, the operational changes (new clinical pathways) were defined for the 10 highest volume emergency ambulance calls as part of the 'A Day in the Life' exercise, illustrating changes, benefits and patient outcomes. Given HSSD's clinical oversight responsibilities, these will be further refined during 2016, using HSSD's 'Senate' processes, as part of HSSD's move to new approved clinical pathways.

10.20 Additional investments in paramedics deployed across the network:

Possible cost **p.a**.	£200,000+	Investment in people costs/skills.
Possible benefits/savings **p.a.**	£200,000+	Fewer/shorter hospital admissions. Chargeable minor injuries work.

Scaleable, in line with benefits.

10.21 Extension of Joint Emergency Services Control Centre to 'hear & treat':

Possible investment cost.	£120,00	System/software module.
Possible cost **p.a.**	£150,000+	People costs/skills (incl. paramedics).
Possible benefits/savings **p.a**.	£150,000+	Fewer ambulance trips or A&E visits. Fewer/shorter hospital admissions. New, faster services to customers.

10.22 Co-location of Emergency Ambulance with Fire Service (to be assessed as part of existing SCIP evaluation during 2016 and heavily dependent on specific properties and whether extended to Police):

Possible investment cost.	£8m	Property modifications and/or move. Ambulance & Fire, new technologies.
Possible benefits/savings **p.a**.	£300,000+	Lower rent to third parties (Rohais). Shared support services & systems. Shared composite vehicles/service. Staffing interoperability/back-up.

10.23 Separate pooled NEPTS, spanning multiple States departments, but potentially a simpler, rudimentary system initially:

Possible investment cost.	£200,000	System build, if not acquired. Booking system with clinical overlay.
Possible benefits/savings **p.a.**	£25,000+	Less use of expensive ambulances. Modified taxis and third sector cars. Target 8%+ saving in current costs.

10.24 Greater use of mobile technologies and potential subsequent extension to telemedicine:

Possible investment cost.	£600,000+	Decision for all blue light services. Higher cost if phase in telemedicine.
Possible benefits/savings **p.a.**	£100,000+	Reduction in patient/clinical visits. Extension to overseas visit reduction. Reduced, faster administration Better access to patients and records. Faster, better services.

10.25 Properly resourced ICT for key HSSD projects, e.g. Electronic Health & Social Care Record (EHSCR). This is not an additional GFAS-related investment cost, simply the completion of past systems investment delivery as part of a modern way of working. It may be appropriate that the critical 5-6 pieces of core information usually needed by emergency ambulance/medical services could be held for access separately to core medical records. e.g. with a degree of patient mobile phone maintenance. Various models for this exist in other jurisdictions.

Possible investment cost.	N/A	An existing, planned investment. Standard modern way of working. Scope for simpler core system for EAS.

10.26 As stated elsewhere, full business cases will be developed prior to investments being made. In early 2016, the States are not being asked to commit to any of the above

investments, merely that Home should have a greater oversight role in Emergency Ambulance Service operational budgets if Home is to pursue its blue light interoperability policy (HOST Strategy) to its full potential.

St. John

10.27 The future offers some exciting opportunities for St John, coupled with some challenging implications in managing change (as is indeed the case for HSSD and the States of Guernsey). In continuing to build the St John brand, and retaining strong public trust in its 'skilled people delivering quality care', St John has opted to make three major strategic choices. These choices involve three major 'Best Practice' opportunities:

1. Strategic Partner in Blue Light EMS Interoperability

2. Potential Strategic Partner in Integrated Patient Care to the home.

3. Core Partner in best practice NEPTS pooled system.

10.28 These are all consistent with the aims of a restructured and simplified "One St John - Skilled People Delivering Care" to islanders whenever and wherever needed.

10.29 Change is never easy but the scope of these proposals can help create a modern, flourishing, local St John organisation, in conjunction with St John's other complementary initiatives spanning volunteers, training, retail and fundraising activities.

Governance & Oversight

10.30 Clinical oversight currently operates at three distinct levels:

1. Regulatory Bodies

2. Guernsey/HSSD, and

3. St John's Clinical Oversight Committee.

10.31 No change is envisaged to this basic shape, however, for operational and financial oversight, past and current practice becomes increasingly less sensible the greater that desirable joint planning and asset sharing across Blue Light Services exists. This became increasingly apparent during the development of the JESCC and during early live operations. Consider the scenario whereby:

1. The three Service Chiefs (Ambulance, Fire & Police) sensibly get together (under Home's coordination) to plan 'best practice' joint operations, investments, use of assets and mutual support.

2. There follows a 'degree of negotiation' across States Departments to determine who should take what proportion of a joint cost. This generally benefits no-one but cost accountants, who enthuse about obscure unproductive allocations.

3. The Ambulance Service (and hence HSSD) might end up with a third of the cost, but they might not.

4. Worse still, when the actual costs are incurred, another bout of unproductive cost

accounting follows to allocate those joint costs, sometimes using the same method, and sometimes based on 'who has budget to spare?'

5. And yet worse still, the resulting tracking of 'actuals v. budgets' becomes even more divorced from the original joint operational plan and decision.

10.32 Clearly, as we move to make increasingly productive use of shared property, assets and technology across Blue Light Services, we should cease these unproductive accounting practices and consolidate budgets and budgetary accountability for all Blue Light Services within the Home Dept. This will affect the budgeting process for 2017, if not implemented earlier by mid-year budget transfers during 2016, as new Boards are established following the April 2016 Election.

10.33 It is proposed that HSSD has a 'clinical commissioning' role for services at defined service levels, for which the budget must be agreed in advance with Home who then decides how best to deliver those services with all resources at its disposal.

11. Management of Change

Journey Management

11.1 Journey Management' isn't about spending the cost budget on time producing pretty charts; it is about working with operational management to maintain clear focus on the achievement of maximum net benefits, and deploying resources flexibly to get there. In practice, only the lead operational departmental heads have full, flexible resource control, so only they (rather than temporary project team members) can take responsibility for delivering operational benefits. They therefore need to begin the journey with the end in mind, namely securing the net benefits. This is one reason why this report and related Briefing presentations have listed at the outset the range of benefits to be pursued.

11.2 There is always a desire to "Learn the Lessons" from past project experience and from 'problem projects', but it is surprising how quickly they can be forgotten. This is true both in the wider world and in projects carried out within the States, particularly those involving technology. When reading 'post implementation reviews' of projects which have been completed and which have, or have not, achieved their full potential in terms of net benefits secured, it is surprising how many common themes exist which drive relative success or relative failure. Therefore, it is appropriate to be reminded of those factors which encourage 'relative success', and aim to put them in place. Likewise, it is wise to be reminded of those factors which encourage 'relative failure', and aim to ensure they are avoided. Assessing such factors at the outset and throughout the journey is not merely a task to be carried out by the designated programme manager; it is something to be at the forefront of thinking of all members of Steering Groups and oversight Boards. It is remarkable how often 'project failures' can be traced back to prior basic resourcing or judgement errors, which should have been identified by multiple people much earlier in the process.

11.3 The successful management of change in areas within the scope of the GFAS recommendations will be challenging. The full breadth of transformational change challenges are involved: changes in processes across multiple departments (a regular cause of problems within the States in the recent past, e.g. SAP and FTP); changes in technology, including new mobile technologies; changes in people, spanning new working practices and deeper skills (e.g. paramedics), new working locations (new

physical bases and working flexibly across the emergency services network) and new organisation structures/responsibilities; and changes in infrastructure (e.g. new shared physical bases, vehicles and equipment). In addition, as highlighted in the Implementation Planning section of this report, there are numerous dependencies on other factors outside the immediate control of a GFAS project implementation team, primarily dependencies on related people, technology or infrastructure projects elsewhere within HSSD and Home (e.g. JESCC expansion). Hence, focused but flexible programme management will be required.

11.4 Factors which positively influence success include the following:

1. A Project Oversight Board and Steering Group comprising skilled individuals with a clearly aligned vision of the future and with sufficient time to steer the programme to a successful conclusion.

2. A project team working to a Benefits Realisation Plan, not simply a 'Work Plan' of days, dates and costs.

3. A strong Communications Plan, ensuring that the rationale for change and positive enthusiasm for it remains clear. This can be linked to awareness training in 'best practices' to be adopted. For those concerned about the effort of training, the following phrase can be relevant: "If you think Training is expensive, try Ignorance instead (and see how much more expensive that can be)."

4. Fully committed operational line management and users, capable of delivering the planned benefits in practice. (The project team's role is to support them with a benefits realisation focus through the difficult peaks of resource demands and change assimilation).

5. A project team comprising individuals sufficiently respected to redesign a Department's ways of working for everyone in future, and not comprising junior, weaker personnel just 'because they are available.' Otherwise their equally weak design input will dictate the way the best Departmental people will have to work in future. Projects and programmes similar to GFAS should not carry "passengers" - that is what buses are for.

6. Operational line management formally signing up to the planned benefits (Benefits Realisation Plan) at the start of the project, and hence being required to get to grips with how and when they will operationally deliver them. Otherwise, the benefits won't be delivered.

11.5 Factors which will negatively drive failure include the following:

1. The absence or partial absence of the positive success influencers listed above.

2. A lack of leadership drive at the Board, Steering Group or Programme Management level.

3. Unrealistic expectations arising from naive personnel (at any level) who underestimate the time it takes to achieve either changes in mindsets, workforce cultures or familiarity with new processes and technology.

4. A failure to deploy a stable, experienced project team without disruptive changes to personnel. Otherwise, the 're-learning effort' of new joiners will undermine collective knowledge and progress.

5. A focus on 'process' over targeted results, by people happy to travel without actually ever arriving at the required destination.

Arrival Times

11.6 As Guernsey's favourite airline Aurigny often demonstrates, arrival times might be published in advance, but can be upset by conditions immediately prior to take-off and natural turbulence en route. On-time arrival requires a good pilot, crew, plane, fuel and engineers - all with a very clear idea of the final destination. But these still do not guarantee on-time arrival.

11.7 Keeping with an airline analogy, the skies above the States of Guernsey are becoming increasingly crowded by proposed new Policy Letters seeking funding, which does not exist and which, if collectively agreed, would break the existing States policies of financial restraint. T&R has indicated very clearly and publicly on multiple occasions that new policy initiatives can only be funded by a process of prioritisation: either the sponsoring Department has to prioritise new policy spending above other existing initiatives and spending within its own Department, and hence stop doing lower priority things, or the States as a whole has to do likewise and remain within agreed fiscal rules by correspondingly reducing budgets for all other Departments.

11.8 The proposals arising from this report relate primarily to migrating to 'best operational practice', not establishing new policies or net new spending. In summary, the GFAS proposals involve investing in people (paramedics and skills) and funding this by making more efficient use of shared property, shared equipment, shared systems/technology and other shared resources. There would be up-front technology costs in 2017/18 associated with developing a booking system for Non-emergency Patient Transfer Services (NEPTS), but the business case for this would involve an immediate reduction in operational costs via the better matching of patient requirements/entitlements with the lowest cost suitable mode of transport. The timing of introduction of such a NEPTS system can be flexible and driven by the future business case and resource priorities at that time; it is a matter of economics and its timing is not fundamental to other wider GFAS recommendations relating to the EAS.

11.9 However, as stated elsewhere in this report, some key GFAS proposals are dependent upon other policy initiatives being pursued successfully within their agreed parameters of funding and delivery:

1. Co-location of the Emergency Ambulance and Fire Services is dependent upon the outcome of an existing Home proposal (within the 2016 SCIP capital expenditure priority-setting process).

2. The use of mobile technologies by the emergency services is a common occurrence in other jurisdictions but is dependent upon approval being granted to the States ICT function to meet the common needs of a mobile network requested, and to be used, by multiple States Departments. The States Corporate Information Systems & Services (CISS) Function are already pursuing funding from the States-wide Transformation & Transition Fund for this.

3. Access by emergency services to core patient records data in an emergency will require at least three things: a successful eventual outcome to past attempts by HSSD to complete the Electronic Health & Social Care Record (EHSCR) system; a mobile network and technologies; individual patient consent within ethical/legal guidelines. However, it may well prove possible to make progress in this area by focusing on the

very limited data set required at speed by the emergency professionals (e.g. blood type, major allergies, major conditions, current medication etc.) and making it available pragmatically.

4. HSSD's wider Transformation Programme initiatives (for which funding was set aside in the 2016 States Budget, following the BDO Report), in particular different ways of working by health and social care professionals, with the end result of treating more patients in the community rather than unnecessarily in hospital (the latter being at greater cost and disruption to the patient). This includes the definition and formal agreement by the HSSD clinical professionals of new clinical pathways (appropriate treatment processes), especially those relating to pathways/responses to specific types of emergency calls. The GFAS project (and Final Briefing Presentation) has illustrated these for the most common types of different emergency calls; however, they should be tested and confirmed by the HSSD clinical leadership via inclusive testing involving patients and clinicians during 2016. (HSSD have established procedures via their 'Senate' process for doing this).

5. The successful future extension of the core investment already made in the JESCC, which went live in Summer 2015, and which could add further services and standard software modules from 2017-19 after a period of stable operation. As with other items, this would be the subject of a separate business case from the Home Department during 2017-19.

11.10 Given the above clear dependencies outside the immediate GFAS project, 'arrival times' for individual components will be subject to change, even with strong programme management of direct GFAS tasks. However, by attempting to provide a clearer vision of the route to best future operating practices, the GFAS report will hopefully increase the likelihood of a successful future arrival.

12. Education & Other Issues

Education's Role in 'Managing the Health Network'

12.1 For the past 115 years in Guernsey, an extensive annual report has been issued publicly by the Director of Public Health to highlight general health issues for islanders and related recommendations.

12.2 Public education has never been more important and valuable in helping to manage and meet increasing demands for healthcare services, which in turn impact the emergency services. We live in an era of changing patient demands (e.g. associated with changing demographics and an ageing population), changing healthcare solutions (e.g. associated with medical and technological breakthroughs) and difficult choices: a small island of 63,000 people like Guernsey cannot by itself replicate and finance the full range of health services offered by larger jurisdictions. This is not defeatism, it is simply an inconvenient truth:

1. Statistics repeatedly demonstrate that medical success in complex treatments invariably improves with experience (patient volumes) of the medical specialists involved. This is increasing the global trend to a smaller number of larger specialist medical treatment centres, serving patients from multiple jurisdictions

2. New medical breakthroughs often involve very expensive medical technology equipment, which can only be afforded by those medical centres dealing with a sufficiently high number of patients requiring it. This therefore reinforces the

preceding point and is increasing the trend to 'health tourism', i.e. the practice of travelling to recognised specialist medical centres based in other jurisdictions. Malta is one island which pursues such inward 'health tourism', with public-private initiatives to encourage such activity. Benefits include economic diversification and improved local services to islanders.

12.3 Thus, public education is needed to serve multiple objectives:

1. Educate islanders of all ages to help them take greater responsibility for their health, via a healthy diet and lifestyle.

2. Educate islanders of the practical limits to which on-island healthcare provision can operate in an era of increasing medical specialisation globally. Referrals to specialist off-island centres will increase over time, with implications for taxpayer or personal funding of related consultation and travel costs. This directly impacts the urgent and emergency services and patient transfer services addressed in this study of Guernsey's Future Ambulance Service. It also points to the increasing needs to maintain strong linkages to off-island networks of specialist centres and embrace new telemedicine technologies to improve access to medical specialists whilst reducing travel costs and delays for islanders.

Influencing Other Network Outcomes & Cost Drivers: Working with Jersey

12.4 As is often said, "there is scope to work more closely with Jersey for our mutual benefit." Jersey's plans and aspirations for its healthcare and emergency ambulance services are evolving in parallel. Jersey:

1. Has similar aspirations for integrated clinical & social care (e.g. like the Isle of Wight Hub model), due to similar demographic challenges.

2. Is behind Guernsey on JESCC and the Emergency Services 'interoperability' agenda.

3. Is ahead of Guernsey in ICT ('Digital Jersey' etc) and intent to operate with strategic technology partners.

4. Is somewhat clouded by a large Island Budget deficit and attempted major public sector spending cuts - 'Jersey FTP+'.

12.5 We should continue with past cooperation and perhaps add three further areas, to improve value-for-money and quality, and possibly reduce risk in relation to Emergency Ambulance Services:

1. Joint procurement of vehicles & equipment.

2. Joint Clinical Peer Reviews

3. Shared ICT efforts/costs - platforms, mobile technologies & strategic development/operations partners.

12.6 Jersey also has a similar background to Guernsey regarding Electronic Health & Social Care Records (EHSCR) systems. The sharing of various working practices and technology arrangements should be pursued by Guernsey. This has already been recognised by the States of Guernsey Chief Information Officer and his team. Such co-operation could be extended operationally to the choice of mutually supportive specialisms as part of a wider healthcare network of specialist clinical or care services.

GLOSSARY

A&E	Accident & Emergency Department - Princess Elizabeth Hospital.
CCA	Civil Contingencies Authority – a small group of Guernsey's senior politicians and civil servants, which meet rarely and on demand, in the event of a potential crisis or threat to secure the well-being of the island.
CMT	The Corporate Management Team of HSSD, led by the Chief Officer.
Commandery	Established in July 2012, the Commandery of St John in the Bailiwick of Guernsey has the mission to further the works and purposes of the Order of St John, taking its lead from the Order of St John through the Priory of England. In the Bailiwick this has a wider context than in mainland UK. The Guernsey organisation works across the Bailiwick islands of Guernsey, Alderney, Sark and Herm to provide: Emergency Ambulance Service Marine Ambulance First Aid cover at local events Cliff Rescue Inshore Rescue Community First Responders First Aid training to the workplace, public, schools and colleges Health Care Shop - provision of health support equipment Youth Activities Community Library These services are provided through: The St John Ambulance & Rescue Service (SJARS), a Guernsey-based charitable company, a subsidiary of the Bailiwick of Guernsey's Commandery of St John, which operates, with the authority of the States of Guernsey as the Island's emergency ambulance service. It operates 24 hours a day, providing accident and emergency cover, paramedic response and Non-emergency Patient Transfer Services (NEPTS). St John Alderney Ambulance Service (SJAAS), an Alderney-based charitable company, a subsidiary of the Bailiwick of Guernsey's Commandery of St John, which operates, with the authority of the States of Alderney as the Island's emergency ambulance service. It operates 24 hours a day, providing accident and emergency cover and NEPTS. St John Ambulance, Guernsey (SJAG), a Guernsey based charity and subsidiary of Guernsey's Commandery of St John, which provides volunteer first aid cover for community events and youth services to teach young people first aid.

	St John Training Services Guernsey (SJATS), a company owned jointly by the St John Ambulance & Rescue Service and St John Ambulance Guernsey, provides First Aid and other Health & Safety related training for businesses, organisations and the public.
EAS	Emergency Ambulance Service.
GFAS	Guernsey's Future Ambulance Service – the 2015 project name to define this review.
Hear and Treat	Is where a clinician in a control centre speaks to patients of their carers and gives advice over the telephone, once they have assessed the patient's condition and ruled out any potentially life-threatening or urgent medical conditions.
Hear, Treat & Refer	Is where a clinician in a control centre speaks to patients or their carers over the telephone and once they have assessed the patient's condition and ruled out any potentially life-threatening or urgent medical conditions, refers them to a local service, such as their GP, that is more appropriate to help the patient.
Home	The States of Guernsey Home Department has a wide portfolio and covers a diverse range of services and activities, delivered through 7 business units or operational service areas including Guernsey Fire & Rescue Service and Guernsey Police.
HOST	Home Operational Services Transformation Programme - a transformation programme designed to fundamentally change the delivery of the Home Department's operations. The aims of HOST are to improve service to the public and to generate long-term financial savings by: 1. Introducing multi-disciplinary and coordinated joint-working; 2. Establishing the flexibility to incorporate future changes in working methods; Optimising the operational efficiency of the emergency services and the Department's operations.
HSSD	The Health & Social Services Department is responsible to the States of Guernsey, to promote, protect and improve the health and social well-being of the people of Guernsey and Alderney. The Department has a wide mandate delivering a diverse range of services including preventing, diagnosing and treating people

	with illnesses and disease and caring for them in its hospital services and supporting people in the community, including people with disabilities.
ITU	Integrated Transport Unit
JESCC	Joint Emergency Services Control Centre
NEPTS	Non-Emergency Patient Transfer Service
PTS	Patient Transport Service
SCIP	States Capital Investment Prioritisation - process, which evaluates and confirms priorities for capital/project funding.
See and Treat	Is where patients are treated at the scene by ambulance staff, rather than being taken to hospital.
Senate	An approach adopted within HSSD to involve stakeholders in process review and development.
SSD	The States of Guernsey Social Security Department is mainly responsible for the collection of Social Security contributions and the day to day running of the States' contributory Social Insurance Scheme, contributory Health Insurance Scheme, contributory Long-term Care Insurance Scheme and the States' non-contributory schemes,
SJARS	St. John Ambulance & Rescue Service
T&R	Treasury and Resources Department
Uber	An international organisation which uses technology smartly for booking and managing the demand and supply of taxi services.
VCS	Voluntary Car Service

Island Health & Wellbeing

Guernsey's Future Ambulance Service

Considerations
& Best Practice Research

Overall Project Reporting Approach

Purpose of this Report Section

This report section summarises some of the studies used as sources for issues, trends and best practices. Some of these were themselves based on extensive searches for reference papers and intelligence. The list is illustrative, not exhaustive. Virtually all documents can be sourced on-line.

Benefits of Phased Release of Report Sections

1. Can have early educational value.
2. Can encourage further useful informed feedback.
3. Illustrates very open and inclusive working.
4. Signals considerations at the earliest opportunity.
5. Spreads the workload for the readers and public.

Overall Project Reporting Approach

Report Sections

1. Main Report	Early 2016
2. Considerations & Best Practice Research	Sep 2015
3. Consultation Results within Guernsey	Sep 2015
4. Early Public Briefing Materials	Jul 2015

Broad Project Timing

1. Investigate	Jan-Jul 2015
2. Consult	Jun-Jul 2015
3. Assess	August 2015
4. Evaluate Options	Sep-Nov 2015
5. Report	Early 2016

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Patient Safety in Ambulance Services Review, May 2015.
Very wide focus - extends to "hear & treat" etc.
Extensive review of available literature and studies.
Pursues 'quality of patient outcomes' over 'response times.'
Attempts to focus on 'network-wide' patient outcomes.
Highlights numerous initiatives underway.
Constrained by 'statistically non-valid' studies.
Bang up-to-date.

South West Ambulance Service NHS Trust Pilot 2015
Expansion of Pilot supported by Assocn. of Ambulance CEOs
Extends call-handling times for non-life threatening 999 calls.
Seeks to devote more resources to 'genuinely urgent calls.'
Proportion of calls dealt with by telephone increases.
Some upgrades of responses to 'Red 1' from 'Red 2' priorities.
Pilot being adopted by other areas.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Association of Ambulance Chief Executives, Oct 2015.
"Leading the Way to Care"
Ambulance Service response to NHS 5 Year Forward View.
Highlights transformation required in Urgent & Emergency Care.
Addresses pathways in hear & treat, see & treat, and see & convey.
Illustrates trends to clinical hubs and control centres.
Focus on improving access, patient experience and outcomes.
Highlights key skills & capabilities for Ambulance professionals.

Creating the Right Culture of Care, NHS Report, Oct 2015
Reinforces that "care is our business" - the core competence.
Provides a vision for nurses, midwives and all care staff.
6Cs Values : Care, Compassion, Competence, Communication, Courage & Commitment.
Emphasis on teamwork to deliver the right Patient Experience.
Relevant across the whole health, social care & emergency network.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Emergency Services Collaboration: Current Picture, 2014.
Wide focus - Ambulance, Police & Fire Services.
Highlights numerous ‘collaboration’ initiatives underway.
Scope includes all UK area services.
Includes much of relevance to Guernsey.
Up-to-date.
Ambitious and visionary.

Strategic Review of Welsh Ambulance Service, 2013.
Narrow focus - Ambulance Service only.
“Another Review”, due to sustained implementation issues.
Includes ‘Best Practice’ document review.
Illustrative of operational problems, not achieved solutions.

Considerations & Best Practice Opportunities?

Sources


Isle of Wight

ght NHS 111 Urgent Care Hub getting it right


Shaping pharmacy for the future

ROYAL PHARMACEUTICAL SOCIETY

Improving Urgent and Emergency care through better use of pharmacists

Introduction

Recommendations

Some Key Points

Isle of Wight Urgent Care Hub Review, 2013.
Unique in integrating health & social care within NHS.
Very patient focused, with sharing of patient information.
Shared patient information key to telephone/other support.
Integrated Hub, also involving third and private sector.
High level of GP support.
Island setting relevant to Guernsey (140,000 residents).
Presented July 2015 to 40+ Guernsey interested parties.

Royal Pharmaceutical Society Report, 2015.
"Pharmacists under-utilised in delivery of urgent care."
Greater role in urgent and emergency care proposed.
Claims a substantial impact on care and A&E waits.
Potential for treating common ailments.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Isle of Wight Long Term Conditions Case Study, 2015.
"Personal records underpin integrated care."
Combined ambulance, community & mental health services.
Shared web based patient records, also with patients.
25% of population over 65; common demographics issue.
Elderly self-care, self-management & crisis response.
Island setting relevant to Guernsey (140,000 residents).
Presented July 2015 to 40+ Guernsey interested parties.

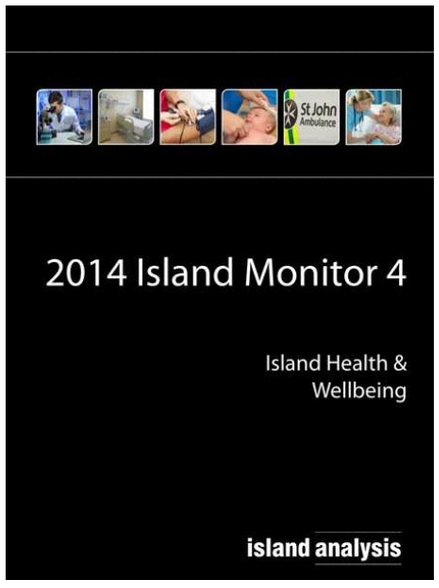
Integrated Care Value Case Tools, 2015.
Focuses on Isle of Wight Integrated Care approach.
Provides supporting information and tools for justification.
Seeks to extend tools with expanded information over time.
Performance results are high relative to much of UK NHS regions.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

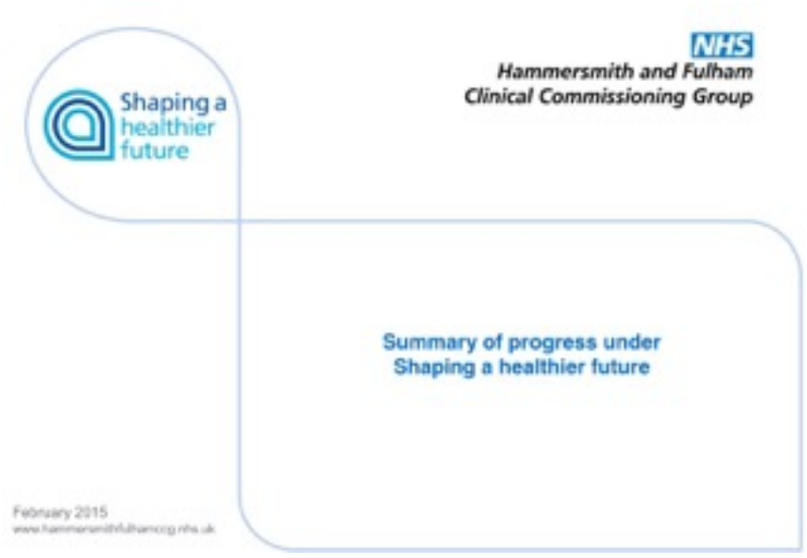
Transforming NHS Ambulance Services, 2011.
National Audit Office (NAO) Report.
Highlights shift to clinical pathway patient outcome measures.
Includes generic standard 'Operating Model.'
Highlights opportunities for performance gains.
Scope restricted to Ambulance Services.



International Island Health & Wellbeing Monitor, 2014.
Island Analysis report focusing on island benchmarks.
Includes wider Health strategic context for islands.
Summarises Health and demographic profiles.
Compares range of services and funding structures.
Provides examples of island government Health strategies.
Includes some ambulance benchmarks (e.g. Jersey cost).

Considerations & Best Practice Opportunities?

Sources



Some Key Points

NHS Hammersmith & Fulham CCG, 2015.
Summary of Progress under Shaping a Healthier Future.
Addresses some similar issues to Guernsey.
Pursuing "person-centred, whole system integrated care."
Shift in care to out-of-hospital and reconfiguring hospital.
Integrating services for mental and physical health.
A&E used too heavily due to inadequacies elsewhere in network.

Greater Manchester Health & Social Care Devolution, 2015.
Sets out process for collaborative working from April 2016.
Addresses ambition for integrated health and social care.
A large community, but interesting parallels for scope of services.
Early days - heavily focussed on 'governance & organisation.'
"Role of third and private sector providers.....to be determined."
More narrow, less inclusive and less patient-centred than IoW?

Considerations & Best Practice Opportunities?

Sources

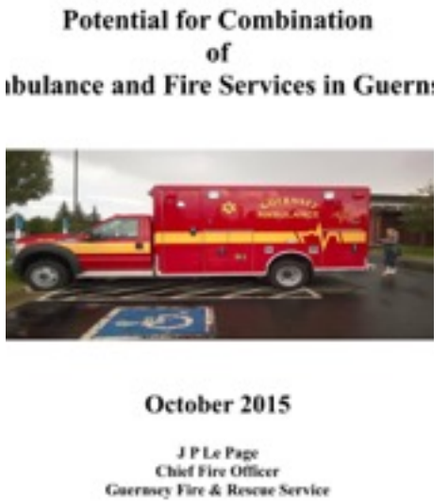
Some Key Points

Contacting Emergency Services in the Digital Age, 2015.
Briefing from Institute of Engineering and Technology.
Stresses the importance of shared information across full network.
Highlights expectations of mobile technologies.
Reinforces messages in SoG 'SMART Guernsey' initiative, 2015.

Mobile Technology Case Study, St John Australia, 2015.
Used of iPads and custom-developed apps.
Fleet of 1,000 paramedics and ambulance officers.
Paramedics send and receive time-sensitive patient data.
System receives patient information from call centre (en route).
Patient data captured before, during and after emergencies.
Benefits handover process to A&E.
Further apps provide virtual training for paramedics.

Considerations & Best Practice Opportunities?

Sources



Some Key Points

Review of Integrated Fire & Ambulance Operations, Oct 2015.
Study for GFAS produced by Guernsey's Chief Fire Officer.
Examines practices in Guernsey and overseas jurisdictions.
Addresses effectiveness of combinations and strategic fit.
Identifies range of benefits and risks, focusing on Guernsey.
Used by GFAS Steering Group in assessing 6 major options.

Babylon: Emerging 'Disruptive' Technology Example, Sep 2015.
Illustrates how technology is disrupting/improving practices.
Mobile technology originating in Jersey, targeting UK & Ireland.
Provides capability to book remote GP/specialist appointments.
Includes clinical records, health monitoring & test results delivery.
Also offers integration with healthcare plans/insurance.
Illustrates how telemedicine can become a reality, locally.
Interesting implications for local/overseas patient transport.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Transforming Urgent & Emergency Care Services, England, 2013
NHS Evidence Base from the Urgent & Emergency Care Review.
Describes current provision and patient experience.
Addresses self-care & telephone consultations (incl. NHS 111).
Includes GPs, out-of-hours services & access to primary care.
Addresses 999 services and A&E departments.
Flags fragmentation of information across Emergency Network.
Relevant to Guernsey as it builds patient service expectations.

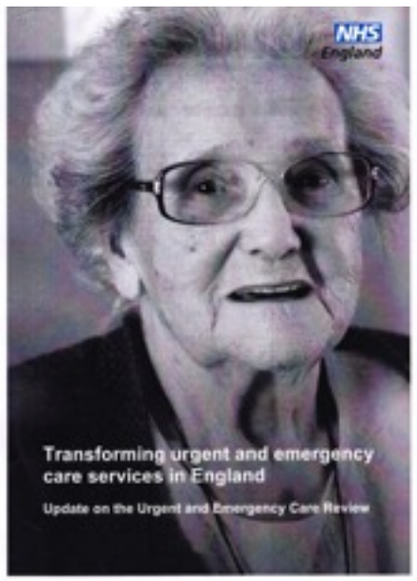
Urgent & Emergency Care Review, 2013: Emerging Principles
Lists 4 'emerging principles' for Urgent and Emergency Care.
Lists 12 overall system (network) design objectives.
Lists 'implementation options' for meeting each objective.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

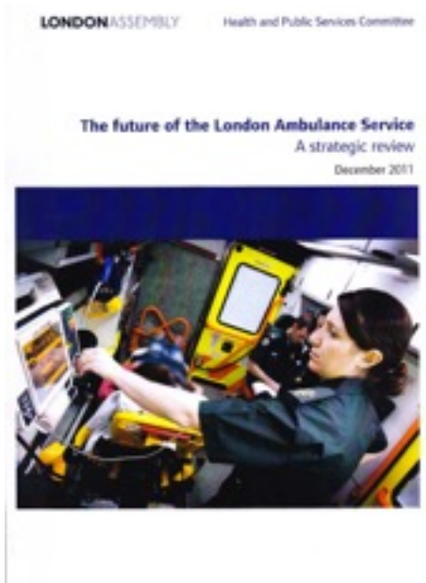
NHS Urgent and Emergency Care Review, England, 2013.
End of Phase 1 Report, Nov 2013.
Includes Vision, Case for Change & Opportunities to Improve
Proposes Improvements across the Emergency Care System
Flags future work on clinical models and outcome measures.
Spans primary care, emergency centres & ambulance services.
Flags future work on contracts and incentives.
Underlines importance of Education.



NHS Urgent and Emergency Care Review Update, Aug 2014.
End of Phase 1 Report, Nov 2013.
Briefly summarises NHS vision for urgent and emergency care.
Summarises progress with delivery.

Considerations & Best Practice Opportunities?

Sources



Some Key Points

The Future of the London Ambulance Service, Dec 2011.
Strategic Review, spanning service performance and challenges.
Addresses 'managing demand to improve patient outcomes.'
Flags the strategic challenge: 'delivering more for less.'
Addresses alternative responses to calls & ambulance despatch.
Includes the patient handover process to A&E.
Addresses shared station facilities, functions and services.
Largest ambulance service in UK: scope for learning.

Everyone Counts: Planning for Patients, 2013/14
NHS Commissioning Board Report.
Flags 24/7 working, commissioner/patient choice, and data issues.
Introduces A&E/Ambulance handover benchmarks (15mins).
Suggests ambulance turnaround times and 'contract fines.'
Includes patient outcomes measures, with rights and pledges.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

NHS Emergency Services Review, 2009.
'Office of the Strategic Health Authorities' review.
Good Practice Guide - Ambulance Services & Commissioners.
Less current, but shares intelligence & literature reviews.
Promotes improvement in patient unscheduled care pathways.
Focuses on 'whole system' and Operational Performance.

NHS Emergency Services Review, 2009.
'Office of the Strategic Health Authorities' review.
Comparative Review of International Best Practice.
Scope: Ambulance Services.
Includes response times, performance indicators & benchmarks.
International questionnaire focus; seeks areas of innovation.
Interesting Bonn medic-led comparisons.
Summarises international performance indicators in use.

Considerations & Best Practice Opportunities?

Sources

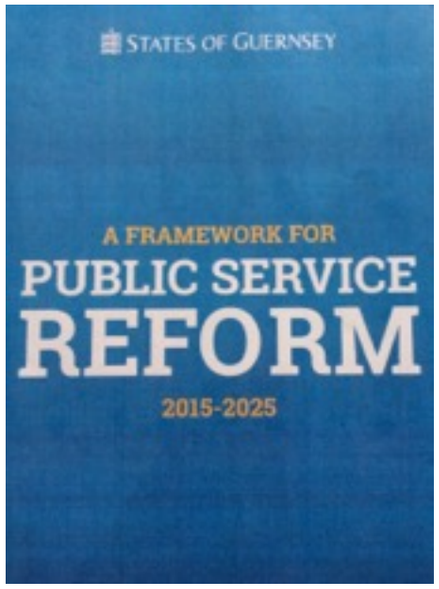
Some Key Points

NHS Five Year Forward View, 2015.
Need for better integration of health and social care networks.
Highlights examples/trials of piecemeal integration being pursued.
Relies on local organisation models, not top-down change.
Failed with past IT systems "from the centre" for patient care.
Patient information "the glue between patient-centred services."
Multiple providers (incl. ambulance personnel) serve patient at home.
Demand better managed to reduce hospital admission as the default.

London Ambulance Service NHS Trust Strategic Plan 2006-2013.
Addresses aspirations and 'Outcome Objectives.'
Extensive focus on Performance Management & Indicators.
Includes workload profiles and 'Demand Management' issues.
Addresses 'Drivers for Change' and opportunities.
Outlines 'Transformational Change' programme.
Highlights need for 'new pathways' & measures (Cat 3 patients).
Also note later 2011 Strategic Review of service.

Considerations & Best Practice Opportunities?

Sources




Current challenges in the provision of ambulance services in New Zealand

Some Key Points

States of Guernsey Public Service Reform Framework, 2015-25.
Aims to transform public services in Guernsey.
Sets 4 main priorities: customer; VFM; staff; and performance.
Highlights demographics, expectations, workforce & competition.
Relevant to Departmental culture and all SoG change initiatives.
Improved IT capabilities under 'SMART Guernsey' workstream.
Envisages 'digital by default' exchanges with customers (patients).
Stronger partnerships with charitable sector and business.

International Journal of Emergency Medicine, Research, 2010.
Challenges in Provision of Ambulance Services in New Zealand.
Parallel issues of ageing population, funding and paramedics.
Growing calls are medical-related, rather than injury-related.
Funding is part public and part private. Also part volunteer.
Flags trade-offs involving paramedics and vehicle types.
Addresses standards and performance indicators.
Explores response times and advocates 'patient outcomes.'
Highlights need for 'best clinical practice' standards.

Considerations & Best Practice Opportunities?

Sources

HEALTH AND SOCIAL SERVICES DEPARTMENT

FUTURE 2020 VISION OF THE HEALTH AND SOCIAL SERVICES SYSTEM

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

9th March 2011

Dear Sir

EXECUTIVE SUMMARY

1. The purpose of this report is to set out a framework for future development of the health and social care systems in Guernsey and Alderney. The States is requested to support the approach set out in this report. It will require all States Departments to work together. The purpose of the framework is to:

   i. describe the current health and social care systems in Guernsey and Alderney and the estimated costs;

   ii. establish the key principles within which States Departments can plan, develop and deliver health and social care services and other related activities in Guernsey and Alderney;

   iii. seek States of Guernsey approval to further develop this framework and the constituent plans to reverse the services, funding, infrastructure and organisational structure of the health and social care system; and

   iv. set out the main benefits of this approach and the high level plans which will need to be developed to deliver this vision.

2. Health and social care related issues can be currently assessed as costing the economy over £300m per annum including private and third sector provision. States funding meets approximately 60% (£180m) of this assessed cost.

HOME DEPARTMENT

Home Operational Services Transformation (HOST) Programme

Vision Statement

"To develop an appropriate, efficient and high quality Emergency Services provision to meet evolving and future needs of the Bailiwick of Guernsey"

- Enhancing service delivery to the "customer"
- Sharing accommodation, facilities and equipment etc.
- Improving communication, information sharing and use of technology
- Driving down costs

Some Key Points

HSSD 2020 Vision, Approved States Report, 2011.
Hunter Adam Minister era, prior to 2012-14 Board.
Health scope included future consideration of ambulances.
Highlighted issues, principles & priorities.
Secured approval to research options/proposals.
Not comprehensively updated 2012-14.
Resourcing to implement remained uncertain.

Home Operational Services Transformation (HOST) Vision.
Developed 2014; approved for 2015 resourcing.
Scope includes all Emergency Services.
Builds on UK Emerging Best Practices - interoperability etc.
Recognises Guernsey-specific issues.
Recognises links to Guernsey plans, e.g. mobile ICT, eGov.

Considerations & Best Practice Opportunities?

Sources

Some Key Points

Lightfoot Review, Guernsey, May 2013.
Scope included St John Ambulance & Rescue Services (SJARS).
Guernsey-specific; recognises Guernsey's volumes.
Provided best practice, operational & cost benchmarks.
Included a prioritised action plan for implementing change.
Widely accepted (with minor tuning options, e.g. paramedics).
Formed basis for HSSD-St John contract negotiations, 2014.
No patient consultation.

General online & media review, 2015.
Continuing Welsh Ambulance management & performance issues.
Continuing focus on 'interoperability' in professional press.
Illustrates drawbacks of not taking a 'network-wide view.'
Emphasises need to understand, influence & manage 'demand.'
Highlights parallel challenges across other jurisdictions.

Considerations & Best Practice Opportunities?

Emergency Services Collaboration Survey

Research Report Key findings

Research into Emergency Services Collaboration

Jon Parry, Professor Eddie Kane, Dr Denise Martin, Dr Siddhartha Bandyopadhyay

In September 2014 the cross-sector Emergency Services Collaboration Working Group was established with the remit of providing strategic leadership, guidance and an overview of collaborations across England and Wales, to act as champion for innovation and best practice and to drive forward the statement of commitment to collaboration made in February 2014 by the Chief Fire Officers Association, Association of Ambulance Chief Executives and Association of Chief Police Officers.

The research assessed existing and emerging emergency services collaboration in order to establish an evidence base for greater cooperation across the emergency services. This involved interviews with strategic and operational staff (from the three emergency services and local government) in 6 case study areas, focus groups, surveys (covering emergency services across England and Wales and a public opinion poll) and analysis of performance reports, academic literature and policy documents.

It is clear that collaboration is driven by both efficiency and effectiveness and the need to save money. This is not just related to achieving savings, it is also about delivering better services and outcomes for the public. A number of common lessons have been identified which highlight some of the pre-requisites of good collaboration. These include a clear shared vision between partners, local political (non-partisan) support, the drive of key leaders and universally agreed governance structures. However, there are a range of barriers which need to be overcome in order to strengthen attempts to collaborate. These include broadening the focus of collaboration, aligning and widening funding streams, addressing organisational differences and some reflection on current legislation.

The recommendations are focused on three key areas; *promoting enablers, removing barriers* and *increasing collaboration*. They include (but are not limited to): co-location of control rooms, creation of single back offices, better data sharing, capital resource rationalisation, shared command structures, shared operational staff, joint training programmes, intra-service rationalisation, alignment of terms and conditions and integrated local and governance structures.

Contents

Keywords

SfJ RESEARCH The University of Nottingham UWS

'Public Services Transformation' - UK, 2014

Research Report Summary

Research into Emergency Services Collaboration

Jon Parry, Professor Eddie Kane, Dr Denise Martin, Dr Siddhartha Bandyopadhyay

Background

In September 2014 the cross-sector Emergency Services Collaboration Working Group was established with funding from the Home Office, Department of Health and Department of Communities and Local Government with the remit of providing strategic leadership, guidance and an overview of collaborations across England and Wales, to act as champion for innovation and best practice and to drive forward the statement of commitment to collaboration made in February 2014 by the Chief Fire Officers Association, Association of Ambulance Chief Executives and Association of Chief Police Officers.

In November 2014 the Emergency Services Collaboration Working Group, through the Home Office, commissioned research to evaluate existing and emerging emergency services collaboration in order to establish an evidence base for greater cooperation across the emergency services. This research focused on six emergency services collaboration projects across England and Wales, covering efficient services, effective services and emerging best practice.

Aims of the Research

In evaluating these projects, the research sought to address the following questions:

- To what extent are projects operating as outlined in their project plans and business cases?
- How has collaboration been achieved?
- To what extent do these collaboration projects support wider public service change?
- How do collaboration projects ensure longevity and become sustainable?
- What lessons have been identified?
- What evidence is there of successful outcomes (including financial) of these projects?
- Which indicators should be used to monitor collaboration activity in the future?
- What evidence is there of wider sharing of the lessons and of them being learnt?

Selection of Case Studies

The case study areas[1] were selected from a list of national projects contained within an overview of collaboration produced by the Emergency Services Collaboration Working Group.[2] The following criteria were used to determine the selections:

- coverage of all three areas of project focus – *efficient services, effective services, emerging best practice.*
- geographical coverage encompassing rural and urban areas, national areas, projects within single local authorities and projects across joint authorities.

[1] The case study areas were - Hampshire, Lincolnshire, Manchester, Northamptonshire, South Wales & Gwent and Surrey & Sussex.
[2] **Emergency Services Collaboration,** The Current Picture (An overview of collaboration in England and Wales) http://publicservicetransformation.org/images/Emergency_Services_Collaboration_2014.pdf (accessed on 16/3/2014)

Considerations & Best Practice Opportunities?

Emergency Services Collaboration - France

Emergency medical services in France

Emergency medical services in France and Luxembourg are provided by a mix of organizations under public health control, with the lead taken by a central control function called **SAMU**, which stands for *Service d'Aide Médicale Urgente* or Urgent Medical Aid Service. This central hub is supported by resources including first response vehicles or ambulances provided by the fire service or private ambulance services with or without a physician-led car provision from **SMUR** (*Service Mobile d'Urgence et Reanimation* - literally translated as Mobile Emergency and Resuscitation Service) which are 'mobile intensive care units' (MICU) that have one or more physicians on board.[1]

A typical Hospital French SAMU with Helicoptered MICU on the roof and ground MICU on the basement in Dreux, France.

Organization

A law in 1986 defined SAMU missions as hospital based services providing permanent phone support, choosing and dispatching the proper response for a phone call request. The central component of SAMU is the dispatch centre where a medical regulation team of physicians and assistants has the task of:

- analysing calls to decide on the patient's need
- deciding the best solution for the patient's care
- dispatching the most appropriate mobile care resource (MICU, Ambulance, or Mobile care professional), *or*
- directing the patient to an alternative fixed resource such as primary care medical surgery or hospital service, *or*
- offering care advice over the telephone

Because of aggressive triage (called medical regulation), only about 65% of requests to SAMU actually receive an ambulance response.[2] Current performance on emergency calls

Emergency Services Collaboration - Canada

Emergency medical services in Canada

Emergency medical services in Canada are the responsibility of each Canadian province or territory. As such, the services, including both ambulance and paramedic services, may be provided directly by the province, may be contracted to a private provider, or may be delegated to the local government level, which may in turn create its own service delivery arrangements with municipal departments, hospitals, or private providers. The approach, and the standards, vary considerably between provinces and territories.

Organization

Land Ambulance

In Canada, responsibility for Emergency Medical Services, as a part of health care in general, has been allocated to the provincial/territorial level of government. With the exceptions of British Columbia and Alberta, which operates its EMS services directly, the method used for service delivery will vary to some degree between jurisdictions. Typically, the provincial/territorial government will provide enabling legislation, technical standard, accreditation or licensing,[1] and oversight to a variety of potential system operators, including municipalities, hospitals, or private companies. Municipalities or hospitals may also, in turn, elect to provide EMS service directly, as a branch of another municipal department, such as the fire department[2] or health department,[3] or may contract out this responsibility to a private company. The approaches used for service delivery are governed by what is permitted under the legislation of the individual province or territory, or under the by-laws of a local municipality, when that municipality accepts responsibility for EMS service.[4]

Ottawa Paramedic Service

Paramedic Response Vehicle in Toronto

Media Review - Illustrations

Chronic Disease Hubs & NHS

THE SUNDAY TIMES | NEWS | SCOTTISH NEWS

Private care centres 'will aid NHS'

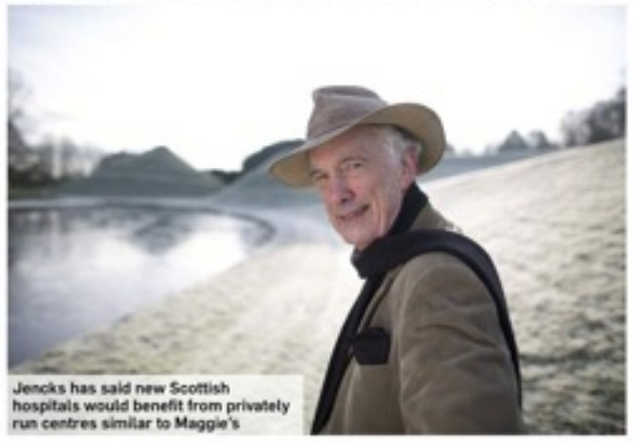
Maggie's charity boss wants network for chronic diseases, writes **Julia Horton**

EVERY hospital needs a separate, privately run centre to care for patients with chronic diseases because the "haemorrhaging" NHS cannot cope, according to the founder of cancer care charity Maggie's.

Charles Jencks said networks similar to Maggie's centres could help the health service to provide vital treatment and care for thousands of patients living longer with heart disease, strokes, diabetes, dementia and obesity.

Jencks, who will appear at the Edinburgh International Book Festival this week to talk about his vision for the future of healthcare in Britain, said: "The NHS is haemorrhaging. The world knows this. It can't do what it's supposed to do on the label, so we're picking up a lot of its workload.

"The social and emotional consequences of cancer simply can't all be handled by the NHS now. I would say it's necessary for hospitals to mutate slightly as a building type to have a cancer caring centre at every hospital which is semi-autonomous, as we are.



Jencks has said new Scottish hospitals would benefit from privately run centres similar to Maggie's

"Probably that could also work for all the five chronic diseases that people are living with now, which are debilitating, sometimes life-threatening and have all kinds of social problems that come with them. There should be a heart [disease] version of Maggie's, a dementia version and so on."

Maggie's has about 20 centres beside hospitals across Scotland and England offering secondary care for spiralling numbers of survivors who suffer a complex mix of emotional, social and financial problems, which the health service struggles to address.

Jencks, speaking 20 years after the death of his wife, Maggie Keswick Jencks, said: "Raising money is still a great challenge. Maggie's receives unbelievable support, especially from people who

Chronic Disease Hubs & PPPs

THE SUNDAY TIMES | NEWS | SCOTTISH NEWS

are not well-off. There's a working class culture of responsibility in cities like Glasgow where high numbers of people have cancer. It's more difficult for other [health] charities."

A Scottish government report this year estimated that 3% of the population of Scotland (176,000 people) had been diagnosed with cancer in the past 20 years and were still alive. Data published recently showed cancer waiting times were worsening. The number of people with dementia in Scotland is expected to double within a generation to 180,000.

Shona Robison, the health secretary, said the Scottish government was "absolutely committed" to supporting people with cancer and highlighted improvements in cancer survival rates. About 15,800 men and women diagnosed with cancer this year will survive compared with 9,500 that would have survived 30 years ago.

"The NHS in Scotland has substantial plans in place around the real challenges we will face in the coming years — for example, around dementia, stroke, heart disease and obesity," Robison said. "Those plans will also link up with the extra support provided by charities — just like Maggie's — where appropriate, to ensure patients and their families get the support they need."

The under-construction Queen Elizabeth University Hospital in Glasgow

Jean Turner, former GP and chief executive of the Scotland Patients Association, said there was a growing need for a Maggie's-style network for other chronic diseases and more clinical staff in the NHS. Demand highlighted years of mismanagement and failings in the NHS, she said.

"I would have agreed that there was a need for this when I was a GP," Turner said. "The NHS did not foresee the future or listen to staff, and money was thrown at bad ideas. We are failing an awful lot of people with chronic conditions who are living in terrible circumstances."

Jencks said: "When you have cancer, you have one big problem and a thousand little social, psychological and economic ones too, and both kinds have to be met. We do the latter, the NHS does the former, and we are both necessary."

Jencks will appear at the Edinburgh International Book Festival on Thursday. ■

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Media Review - Illustrations

Unintended Channel Loading?

THE TIMES | News

Thursday, 15 January 2015

'Absurd' NHS helpline blamed for A&E crisis

A&E waits have hit a decade high with operations cancelled as a result
DAN KITWOOD/GETTY IMAGES

Chris Smyth
Health Correspondent

Nearly all the extra patients arriving at overstretched hospital accident and emergency units have been sent there by the "absurd" NHS 111 helpline, according to the country's leading emergency doctor.

Cliff Mann, president of the College of Emergency Medicine, said that it was wrong to blame the public for overloading A&E when the health service was sending them there.

He also told MPs that much of the £700 million promised by the government to help the NHS to survive a winter crisis had not reached emergency wards. Other experts said that the money had been used to plug gaps in hospital budgets, or had not been spent because extra staff could not be found.

Waits in A&E are at their highest for a decade, and several hospitals have cancelled routine operations to cope with more

Key System-wide Trade-offs

'Hear & Treat' v. Primary Care Hours
'Hear & Treat' caution drives 'Convey & See'
'Arrive & Handover' becomes 'Arrive & Wait'
Hospital bed-blocking drives 'Refuse & Wait'
'Refuse & Wait' drives Ambulance Costs

Key is Total Network & Channel Capacity
Total Network & Channel Outcome Measures?
Who Decides & Who 'Performs'?
Who Decides & Who Bears the Costs?
Role of Service Level Agreements?
Civil Contingencies?

Don't optimise one piece in isolation.....
at the expense
of others and the whole network.....

Media Review - Illustrations

Medical Records & Technology

THE TIMES | News

Thursday September 3 2015

Medical records on your mobile 'within a year'

Patients will be able to update records with data from devices such as FitBit that monitor activity and heart rate
CORBIS

Kat Lay
Health Correspondent

Patients will be able to access their full GP records on smartphones within a year, the health secretary has pledged.

As well as seeing blood test results and appointment histories, they will be able to update their records with information from wearable devices that monitor activity and heart rates, such as a FitBit.

By 2018 the plans will be extended to cover hospital and other health records, Jeremy Hunt promised. He acknowledged that the NHS needed to earn patients' trust over digital health records as experts warned that it could be difficult to ensure that confidential details were not abused.

The announcement came hours after a London sexu-

CONTENTS | EDITION | LIVE NEWS | MY ARTICLES | AA

Key System-wide Implications

Part of the June 2015 Public Consultation.
A supportive Guernsey public.
Supportive Guernsey professionals.
UK commitments made Sep 2015.

Implications for GP systems & access.
Integration with hospital systems a challenge.
Implications for data use and security.
Recognised in HSSD 2016 Plans & Budget.
Aligns with 'SMART Guernsey' SoG Vision.
Wider mobile technology use by Emergency Services.

Recognise the full potential of personal technologies and how their future use could help assist the wider emergency, health and social care network.

Media Review - Illustrations

Managing Demand

theguardian

Paramedic: most patients we take into A&E don't need to be there

In a shift, I might see 12 patients, but roughly four will need to go to A&E. It's soul destroying

A&E crisis: major incidents risk being the new normal for the NHS

Paramedics need a universal no blame culture and the autonomy to tell patients they don't need an ambulance.
Photograph: Bethany Clarke/Getty Images

Anonymous

Monday 12 January 2015 08.30 GMT

The emergency care provision in the UK has been cracking for years, it just so happens that this winter it has collapsed. Why? I put it down to abuse of the 999 system. This can be unintentional, malicious or due to a lack of available primary care. In the ambulance service a "what if" culture prevails, causing healthcare professionals to be cautious to protect their registration - some paramedics fear repercussions if their decision to leave someone at home is questioned.

A typical 12-hour shift should, but rarely does, include a 15-minute check of the ambulance and its contents and a couple of meal breaks. I might see as many as 12 patients in a shift. How many of these actually need an ambulance? Not many. Not many actually need to go to A&E - four per shift is generous. Most should see a GP, visit a minor injuries unit or urgent care centre, call 111, or visit the pharmacy. It's soul destroying.

Why is there an A&E crisis and how can it be solved? Live discussion

You're viewing the Guardian's new website. We'd love to hear what you think.

Understanding Demand

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Emergency Medicine Journal

Emergency Medicine Journal
emj.bmj.com
Emerg Med J doi:10.1136/emermed-2012-202124

Original article

Patients who call emergency ambulances for primary care problems: a qualitative study of the decision-making process

Matthew J Booker, Rosemary L Simmonds, Sarah Purdy

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Received 1 November 2012
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Abstract

Background Telephone calls for emergency ambulances are rising annually, increasing the pressure on ambulance resources for clinical problems that could often be appropriately managed in primary care.

Objective To explore and understand patient and carer decision making around calling an ambulance for primary care-appropriate health problems.

Methods Semistructured interviews were conducted with patients and carers who had called an ambulance for a primary care-appropriate problem. Participants were identified using a purposive sampling method by a non-participating research clinician attending '999' ambulance calls. A thematic analysis of interview transcripts was undertaken.

Results A superordinate theme, patient and carer anxiety in urgent-care decision making, and four subthemes were explored: perceptions of ambulance-based urgent care; contrasting perceptions of community-based urgent care; influence of previous urgent care experiences in decision making; and interpersonal factors in lay assessment and management of medical risk and subsequent decision making.

Conclusions Many calls are based on fundamental misconceptions about the types of treatment other urgent-care avenues can provide, which may be amenable to educational intervention. This is particularly relevant for patients with chronic conditions with frequent exacerbations. Callers who have care responsibilities often default to the most immediate response available, with decision making driven by a lower tolerance of perceived risk. There may be a greater role for more detailed triage in these cases, and closer working between ambulance responses and urgent primary care, as a perceived or actual distance between these two service sectors may be influencing patient decision making on urgent care.

Media Review - Illustrations

Continuing Welsh Ambulance Issues

iPad 05:38 81%

THE TIMES
Saturday, 3 January 2015

News

Welsh have to wait longer for ambulances

Kat Lay

People in Wales face longer waits in A&E
ANDY DRYSDALE/REX FEATURES

The NHS in Wales is performing worse than its English counterpart, with patients facing longer waits for an ambulance and delays for diagnostic tests, according to a parliamentary report.

The study, produced by the House of Commons library, also found that Welsh patients had to wait longer in A&E, and that a cancer treatment target had not been met since 2008.

The Conservative party seized on the report to claim that Labour could not be trusted to run the NHS.

Andrew Davies, the leader of the Welsh Conservatives, said: "On almost every measure Welsh patients receive an inferior service when compared to patients across the border, and having run the Welsh NHS since 1999, Labour must take full responsibility for their appalling management of the health service."

The report found that 13 per cent of patients in Wales had spent more than four hours in A&E in 2013-14, "around double the percentage recorded by major departments in England".

It also found that only 55 per cent of ambulances called to patients in life-threatening situations in Wales arrived within eight minutes, well below the 65 per cent target. In England, 74.8 per cent of such calls had an ambulance on the scene within eight minutes.

It also concluded that waiting times between referral and treatment, and waiting times for diagnostic tests were longer in Wales than England, although direct comparisons were difficult because of differences in how data was recorded.

A target that 95 per cent of patients newly diagnosed with cancer by GPs should start treatment within 62 days was last met in 2008.

A Labour spokesman said: "David Cameron attacks the NHS in Wales to run away from his own dismal record in England . . . He should take respon-

'On almost every measure Welsh patients receive an inferior service'

Obesity - Vehicle Width Gets Taxing.....

iPad 05:12 84%

THE TIMES
Saturday, 3 January 2015

News

Ambulance fleets get wider to carry obese

Chris Smyth
Health Correspondent


A reinforced, wider ambulance, right, compared with a normal vehicle
ADAM HARNETT/CATERS

Hundreds of ambulances have been converted to handle obese patients, with paramedics saying it is now common for them to treat patients housebound by their weight.

Ambulance chiefs in some parts of the country are planning to upgrade their entire fleet to cope with patients weighing more than 50 stone. Others are testing special units to deal with obese patients, which have already been called out hundreds of times.

A quarter of British adults are obese. Experts said that spending up to £100,000 for specialist ambulances underlined the need for tougher measures to stop people becoming overweight.

Figures obtained through Freedom of Information requests by the Press Association show that more than 800 ambulances have been designed or adapted to deal with very heavy patients. Designated bariatric vehicles with wider doors, reinforced stretchers and specialist lifting equipment were first introduced several years ago and now appear to be becoming routine.

Tracy Nicholls of the East of England Ambulance Service, a council member of the College of Paramedics, said while some ambulance services were equipping all vehicles to deal with obese patients, others were setting up smaller specialist teams to deal with the challenge, and her trust's unit had been called out 260 times in eight months. "A lot of the time we're only finding patients when they reach crisis point, because they haven't sought the routine checks and help they need out of embarrassment or simply because they cannot get out of the house," she said.

"Two or three ambulances and a fire truck arrive in a street and we have to remove a window to get the patient out and that attracts a lot of attention and can be just awful for that person. It is really important to paramedics that they can treat patients, who are often collapsed or in an awkward situation, with dignity. Having the right equipment

CONTENTS EDITION LIVE NEWS AA

Media Review - Illustrations

Changing Welsh Ambulance Targets

Wales | Wales Politics | North West | North East | Mid | South West | More

Time targets scrapped for most ambulance calls

29 July 2015 | Wales politics

The number of code red calls subject to an eight minute target will be cut from 40% to 10% of total

Targets for ambulance response times in Wales are to be dropped for all but the most life-threatening calls.

In a one-year trial from October, performance for less urgent incidents will be assessed by clinical outcomes - the results of the treatment delivered.

The target of responding to 65% of very urgent calls within eight minutes will remain in place but be monitored.

Statistics released on Wednesday showed the service missed its target for responding to emergency calls in June.

"Shift from time-based to quality of care"

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

New Clinical Response Model National Pilot from October 1, 2015

Information for the Public

This information has been written to help you understand how we are changing and improving our services

Q: Why is the Welsh Ambulance Service NHS Trust (WAST) changing the way it responds to 999 calls?

A: Since 1974 ambulance services have been measured on the time taken to reach emergency 'blue light' calls. A lot has changed since then. Now, the ambulance service provides much better treatment and care but the way we our performance is measured hasn't changed and there is still a focus on how many ambulances arrive at calls within eight minutes, regardless of the care and treatment provided to patients.

Q: How is the Welsh Ambulance Services NHS Trust (WAST) changing?

A: Our role is to deliver a range of services – some of these are delivered over the telephone and some of these are delivered by highly-skilled clinicians coming to see patients face-to-face. We are moving away from time-based targets to look more at the quality of care provided, which may be delivered over the telephone or face-to-face.

Our new clinical response model, which will be piloted across Wales from October 1, 2015, includes up to 120 extra seconds to assess the caller's clinical needs before deciding to send an ambulance. This means patients will:

- Get better advice;
- Be more involved about decisions about their care;
- And there will be more ambulances available for those who truly need them in life-threatening situations.

Giving an extra 120 seconds for call handlers in our clinical contact centre is similar to what two ambulance services in England have done as part of a successful pilot to change the way they respond to emergency calls.

The only difference will be that we will dispatch the right vehicle and crew for the caller's need.

Media Review - Illustrations

Politics of Performance Record

Paramedic Richard Lee explains how 999 calls will be handled under the new policy

The Welsh Conservatives described the latest statistics as "another month of failed Labour-managed ambulance response times".

Welsh Conservative Shadow Minister for Health, Darren Millar, said: "Wales has amongst the worst response times in Britain and the most urgent target has now been missed for 20 consecutive months.

"It is Labour's mismanagement of our NHS that's led to this shameful failure in performance and only a change at the top will put that right."

Plaid Cymru described the trial as a "dangerous experiment" and said the service was "moving the goalposts instead of dealing with the issue".

Leader of the Welsh Liberal Democrats Kirsty Williams said targets should be about "patient outcome, not political convenience".

She added: "Of course, it is politically convenient for the Welsh Labour government to scrap targets that they've been incapable of meeting, especially with an election just around the corner."

The Welsh NHS Confederation described the changes as "innovative" and

Time-based targets for 10% of calls only

New traffic light system

The new model will introduce three categories of calls - red, amber and green.

Red

- Eight-minute response time
- About 10% of calls fall into this category
- Immediately life-threatening calls where someone is in imminent danger of death, such as a cardiac arrest

Amber

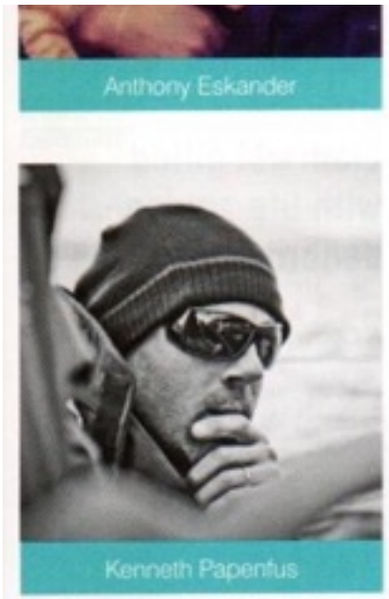
- No time-based target
- About 65% of calls fall into this category
- Patients who may need treatment at the scene and fast transport to a healthcare facility

Green

- No time-based target
- About 25% of calls fall into this category
- Non-serious calls which can often be managed by other health services

Media Review - Illustrations

Fire Teamwork & Demarcation Issues



Anthony Eskander

Kenneth Papenfus

Fire chiefs in South Yorkshire want firefighters to continue helping the ambulance service – despite union objections

The Fire Brigades Union claims lives are being put at risk by crews responding to emergencies when ambulances are not available – but fire chiefs dispute the claim and say emergency services should all pull together.

"We are clear that we are not a replacement for the ambulance service. We attend medical emergencies to help the ambulance service to gain entry, not as a primary responder, and we would expect ambulance crews to respond alongside us in a timely manner.

"Our crews have significant experience of medical intervention at road traffic collisions. Fire engines are staffed with five firefighters, at least one of whom is likely to be medically-trained. They would never make a medical situation worse and, if they can improve a casualty's prospects or make them more comfortable, we believe everyone would expect them to do so."

Deputy Chief Fire Officer John Roberts said: "The role of the fire service is to save lives.

"We are very much in favour of making the best use of firefighters for the benefit of the community.

"Historically we have always dealt with special service calls, and with fires reducing years on year it's something we should continue doing."

IoW Performance 'a piece of cake' - 2015

The ambulance service are celebrating with cakes following the news that they've met their monthly targets for every month of the year.

The Ambulance Service management team wanted to make a small gesture to their staff to say 'thank you' after another challenging year which has seen them yet again achieve all of their key performance targets.

The Island's ambulance service also came top of the league in the national staff survey.

Performance figures for the 2013 -2014 year show that the Service received over 23,000 emergency calls with ambulances reaching 80% in the life threatening calls (Red 1) and 76.40% (Red 2) of the most seriously ill and injured patients within 8 minutes and 96.75% within 19 minutes (the national response standards are 75% and 95% respectively).

The service met this target for every month of the year.

The NHS 111 which is also delivered by the Isle of Wight Ambulance Service continues to deliver some of the best care in the country in meeting or exceeding all of our performance targets.

The service has achieved this despite receiving over 55,500 calls, an increase of over 12 percent from last year and receiving national recognition for its ability to provide the service to a high quality standard.

Appendix 2

Island Global Research

Guernsey's Future Ambulance Service – Public and Professional Consultation

July/August 2015

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Guernsey, GY1 3BY
Tel | +44 (0) 1481 716227
Web | www.islandglobalresearch.com

Island Global Research is the trading name of Island Global Research Limited
Registered Address: Fourth Floor, Albert House, South Esplanade, St Peter Port, Guernsey, GY1 1AW
Guernsey Registered Company No. 60008

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1. BACKGROUND

On behalf of the States of Guernsey, Island Global Research has carried out island-wide research in support of a review of the Island's emergency and non-emergency ambulance service. The overall project is being administered by a group of senior representatives drawn from HSSD, St John Ambulance & Rescue Service, Home Department (responsible for other Police & Fire emergency services) and Treasury & Resources. The objectives are to develop, over time, the most effective ambulance service for the Island.

This particular element of the consultation process took place sufficiently early to influence future proposals which would be drawn up early in 2016. It sought the views and opinions of as wide a range of Island residents as possible including those with a direct or indirect interest in the local ambulance service.

The survey was broken down into the following sections;

- Ambulance Services
- Non-emergency Patient Transfer
- Addressing immediate Medical Needs
- Use of Medical Records by Registered Health Professionals
- Collaboration Between Emergency Services

The response to the survey was impressive. Overall, a representative sample of 1,636 Guernsey respondents took part in the research. Two out of three of these respondents had no involvement at all in the provision of health related and/or emergency services through the public, private or voluntary sectors.

The views and opinions of these respondents (defined as the 'general public' in the survey) were separately analysed to those who had some involvement in health and/or emergency services (defined in the charts as 'Emergency/Health related respondents').

NB. It should be stressed that an overall average response rate covering all respondents should not be calculated by simply adding together the percentages recorded per group response and then dividing by 2.

The overall degree of error was +/-3% for the findings generated from the general public and just over +/-4% for the responses obtained from emergency/health related respondents.

2. FINDINGS

2.1 Sample Profile

Figures 1 to 5 set out the profile of all respondents. The profile was very representative indeed of the population as a whole. Slightly more females than males responded to the survey (which tends to be the norm in all surveys).

64% or two out of three respondents (defined as the general public) indicated that they had no involvement directly or indirectly with the provision of health and or emergency services in the public, private or voluntary sectors.

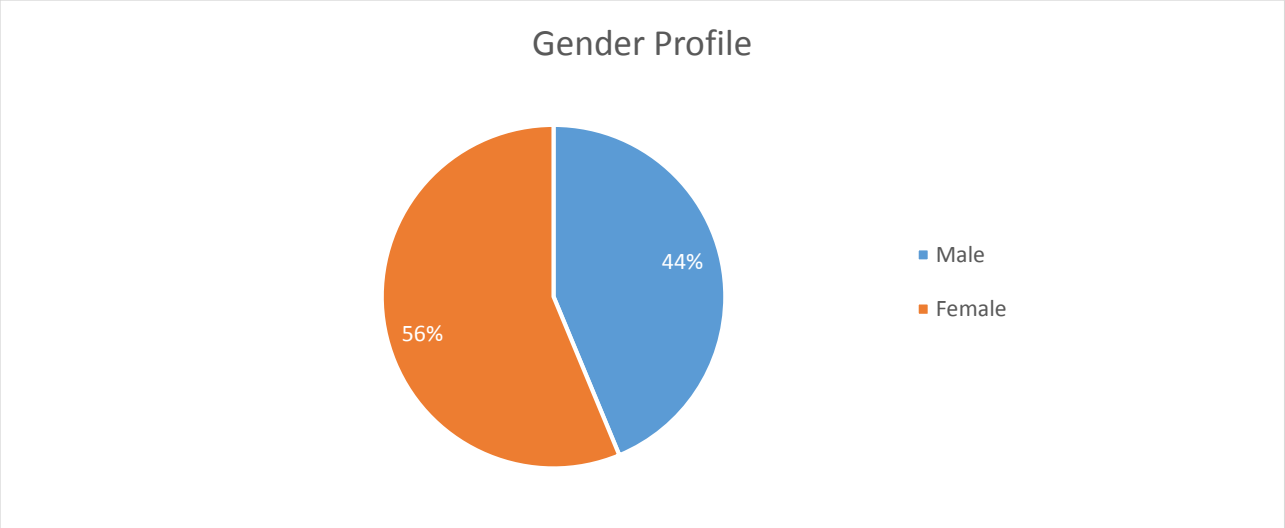

Figure 1

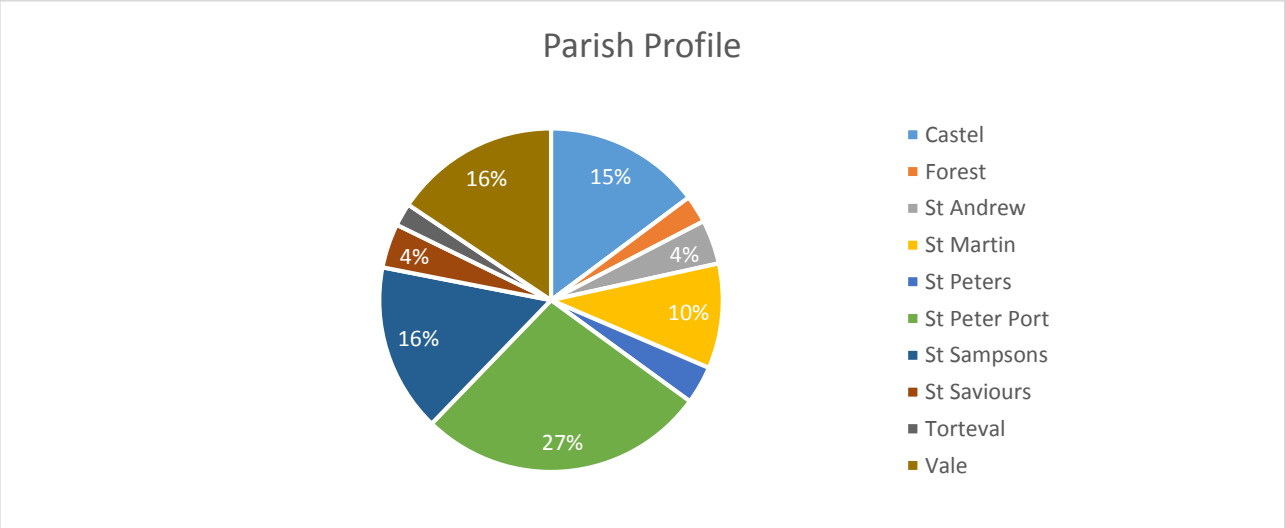

Figure 2

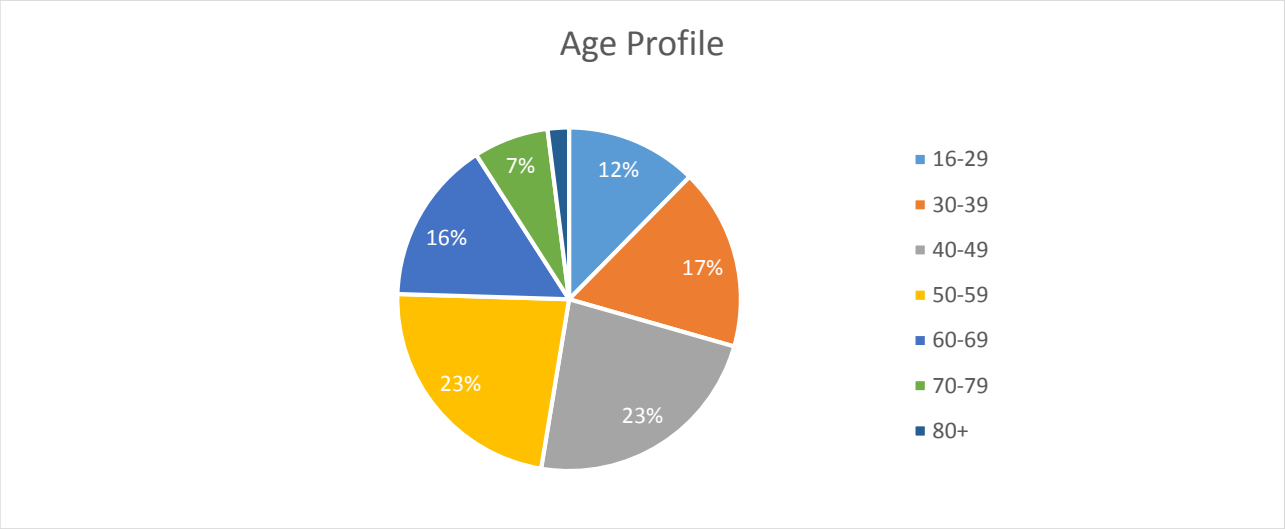

Figure 3

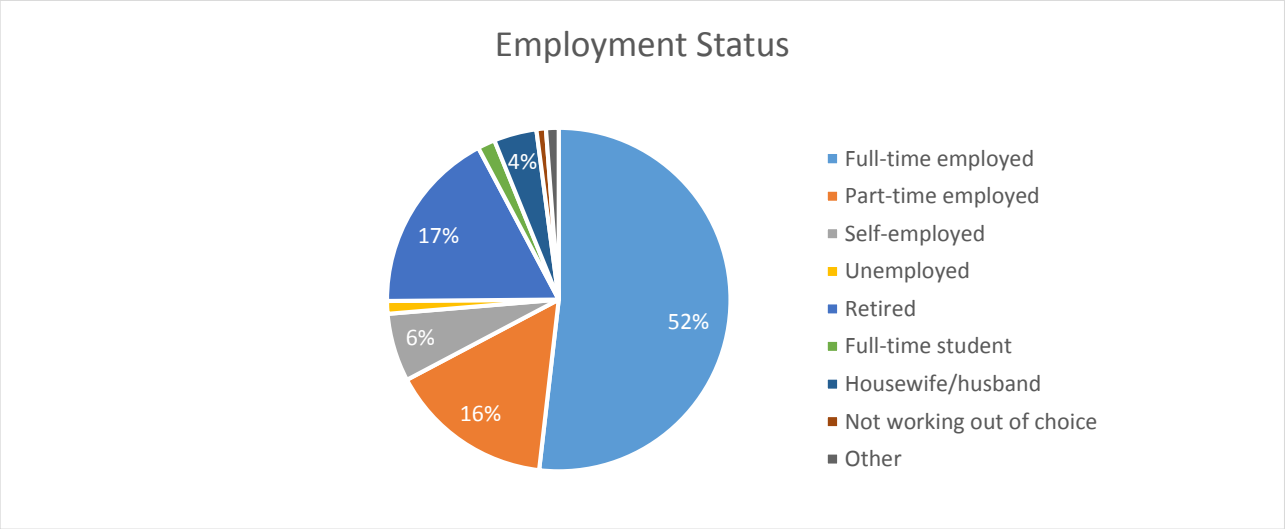

Figure 4

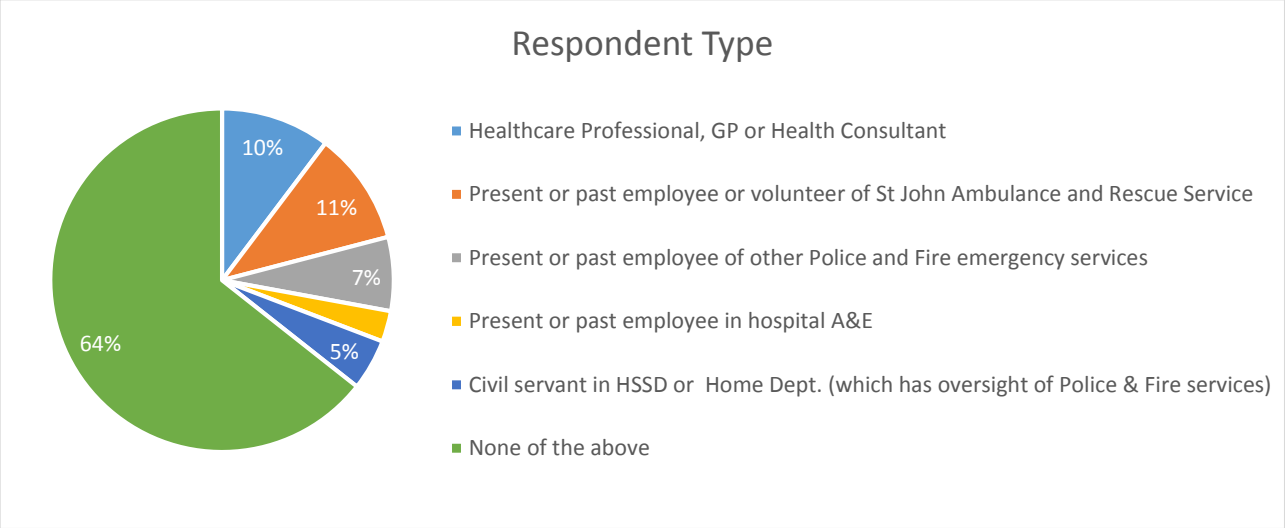

Figure 5

2.2 Ambulance Services

As far as views on which organisation should be responsible for the operation of the Island's ambulance service, two out of three members of the general public stated that this should remain with St John (as at present) while only one in three of the emergency/health related respondents were of the same view (Figures 6 and 7). Another third (33%) of this latter group were of the opinion that the Home Department should be the body responsible while 28% said that HSSD should have that role.

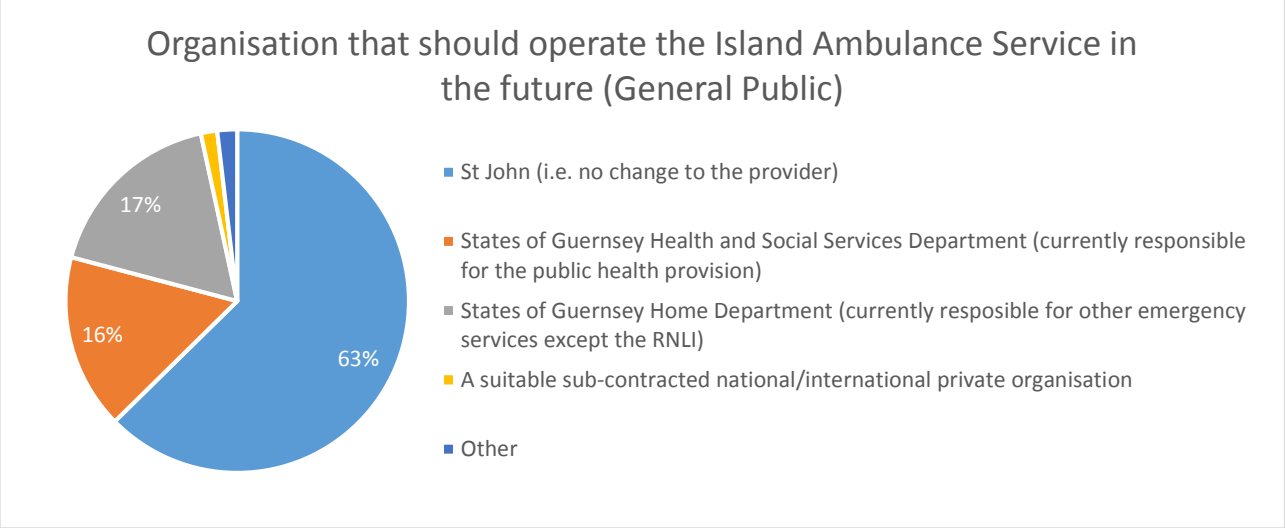

Figure 6

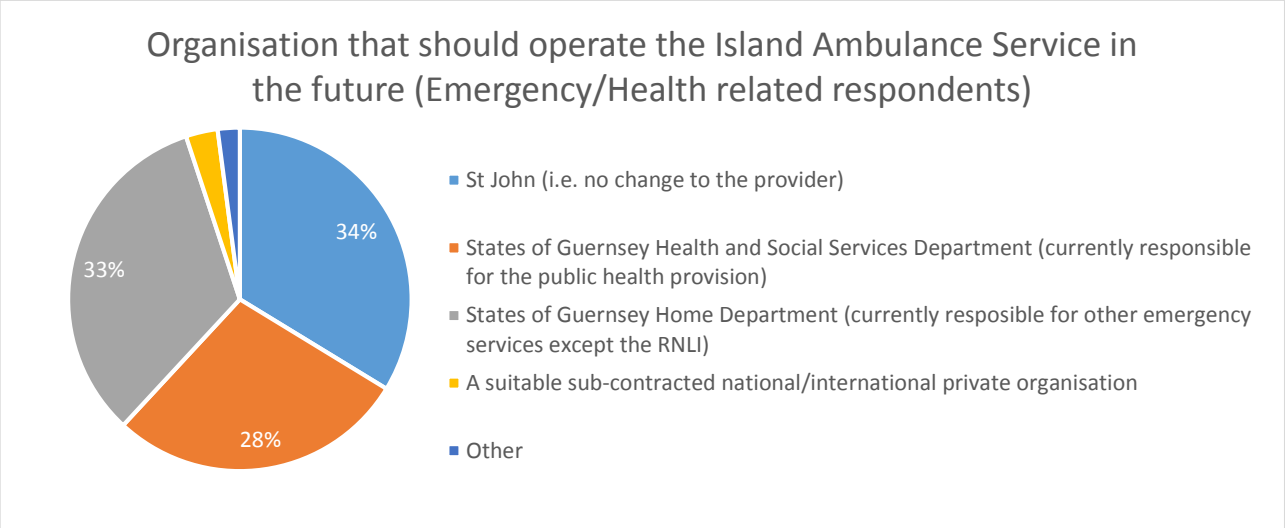

Figure 7

52% of the general public and 42% of emergency/health related respondents) considered that the cost of a call-out emergency ambulance should continue to be paid by the user. This percentage was exactly reversed in that 42% of the general public and 52% of emergency/health related respondents were of the view that the States of Guernsey should fund emergency call-outs from general taxation (Figures 8 and 9).

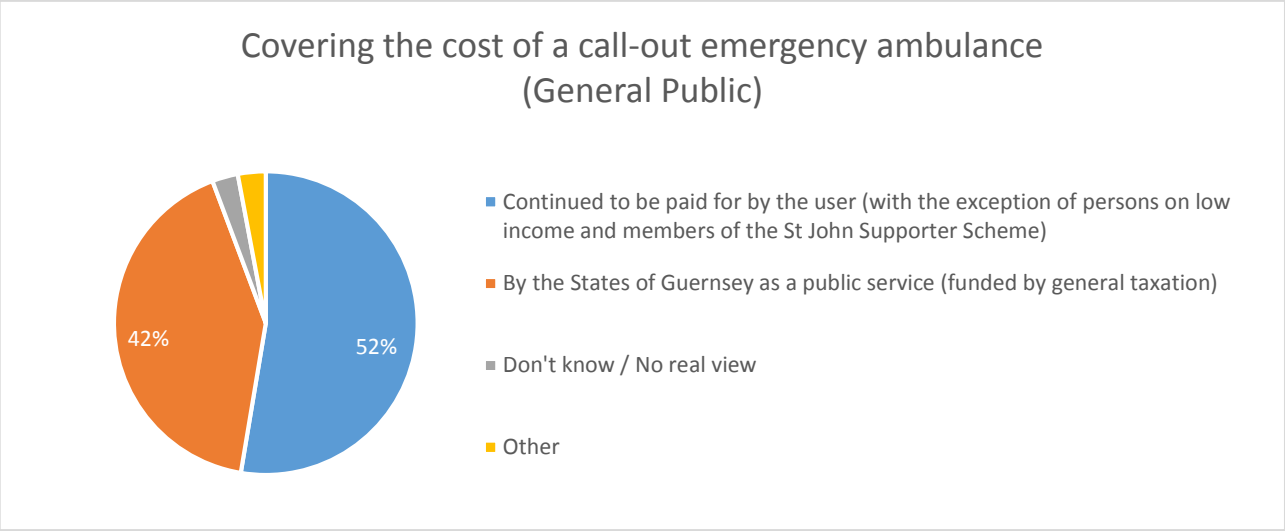

Figure 8

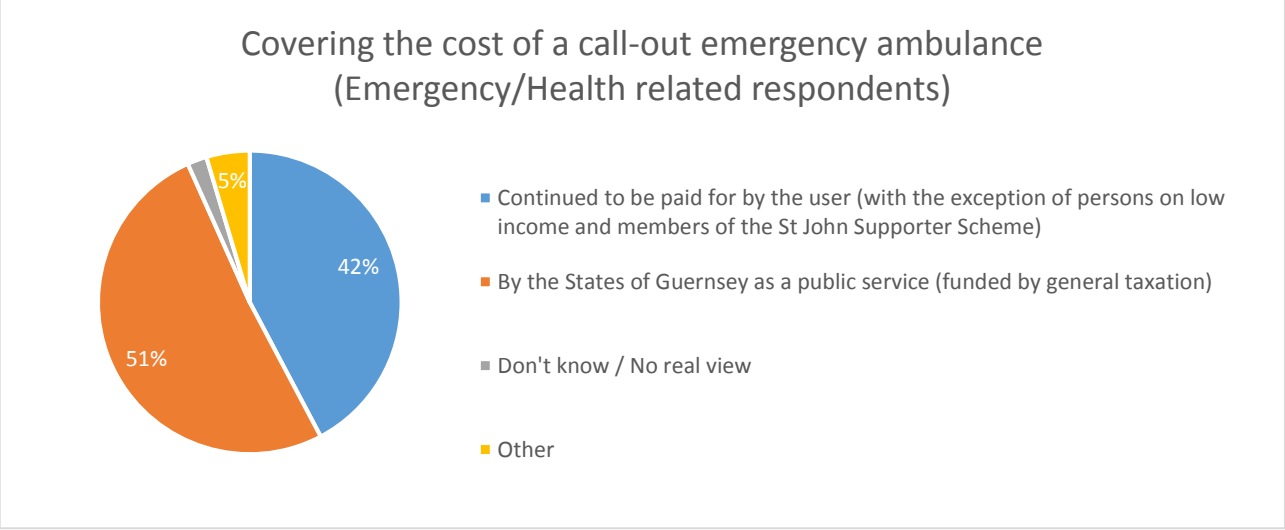

Figure 9

One in two in each respondent group considered that the standards set in Guernsey should, wherever possible, be better than those set in the UK (Figures 10 and 11). However, a further 26% of the general public (18% of emergency/health related respondents) felt that Guernsey should not compare local standards with the UK. 31% of emergency/health related respondents and 23% of the general public considered that the standards set in Guernsey should wherever possible be able to match those in the UK

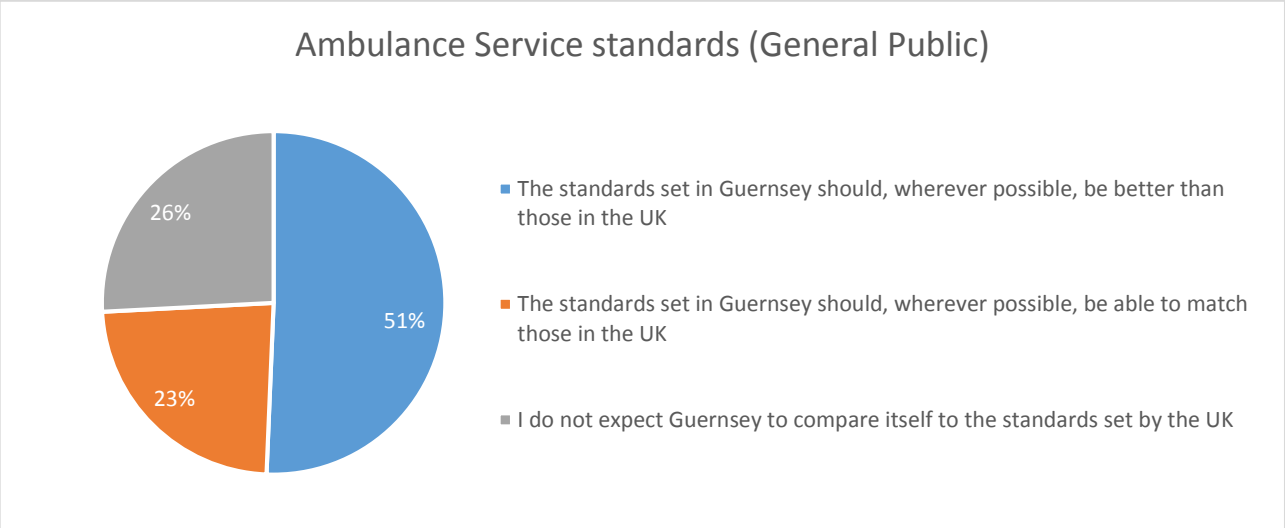

Figure 10

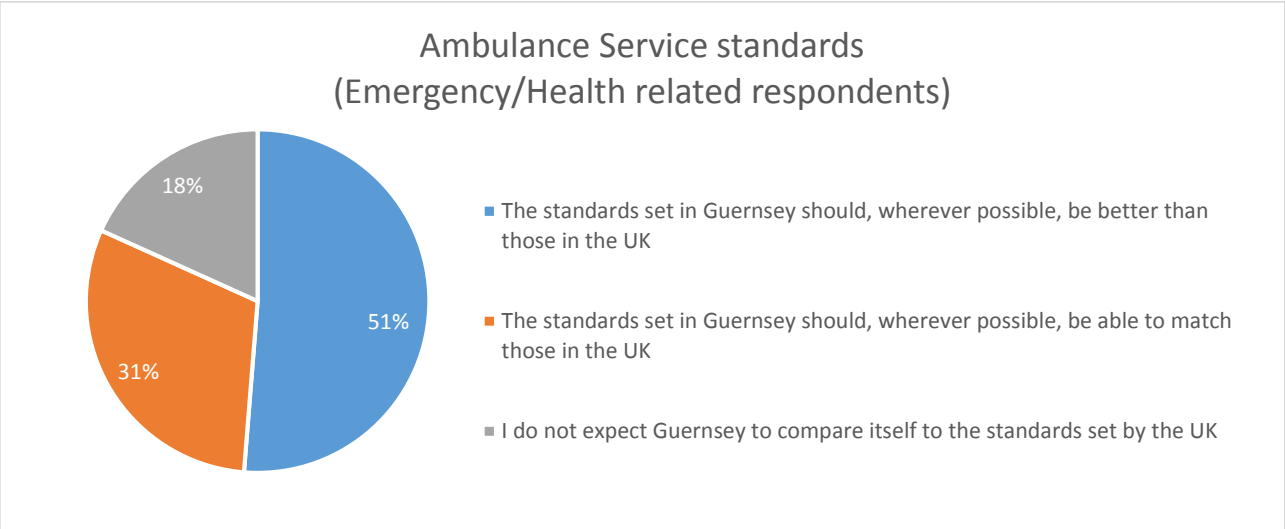

Figure 11

The overwhelming opinion of respondents in each group was supportive of the inclusion and development of the use of paramedics by having them both on ambulances and, in the future, delivering other healthcare in the community. This would help to reduce pressure on hospital attendance and the potential stay for people who were admitted (Figures 12 and 13).

A majority in each group considered that this inclusion should be undertaken regardless of cost. However, 40% of the general public and 30% of emergency/health related respondents were of the opinion that, while they were supportive of such inclusion, there needed to be a compromise between cost and service.

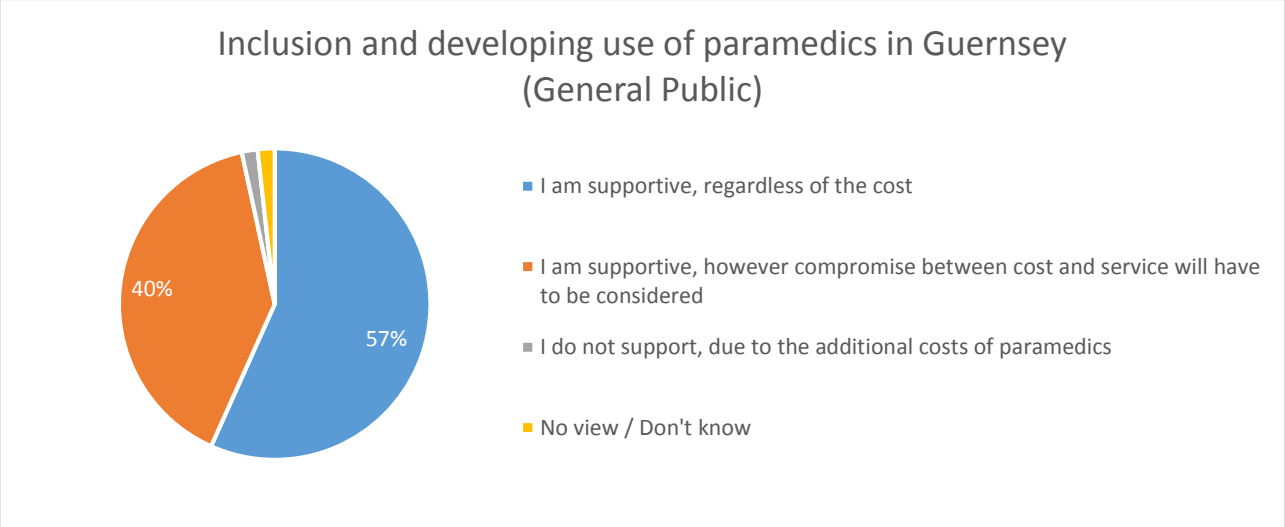

Figure 12

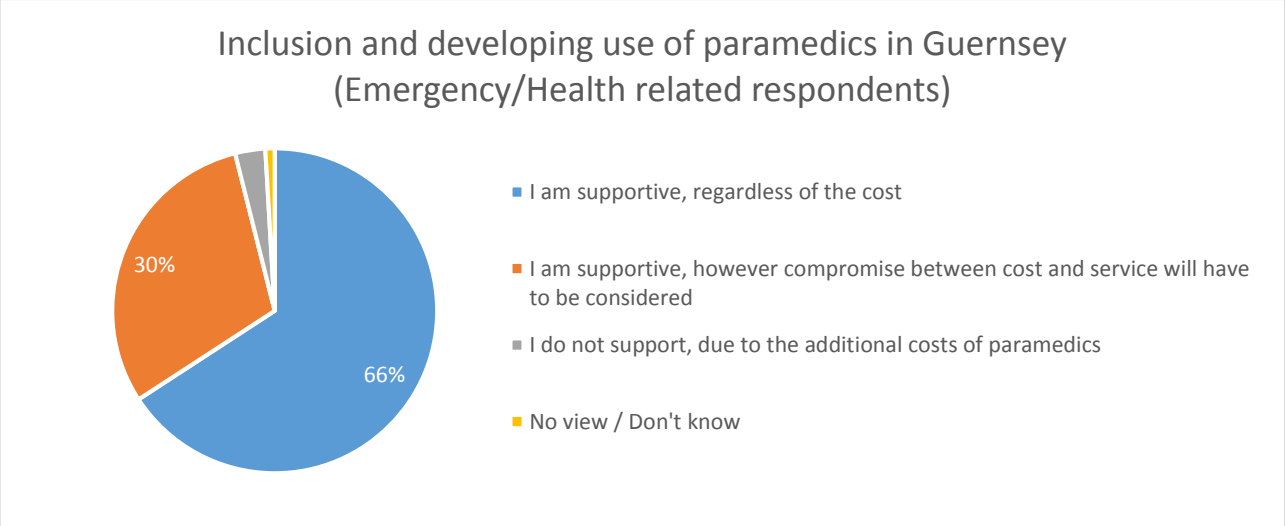

Figure 13

It should be highlighted that a significant minority in both groups had 'no view' either way on this question or answered 'don't know'.

As far as satisfaction levels were concerned with regard to the amount of information/key performance indicators that was publicly available on the performance of the Island's ambulance service, 42% of the general public and 32% of emergency/health related respondents were either 'satisfied' or 'very satisfied'. On the other hand, 29% of the general public and 46% of emergency/health related respondents were 'dissatisfied' or 'very dissatisfied' with the provision of such information (Figures 14 and 15).

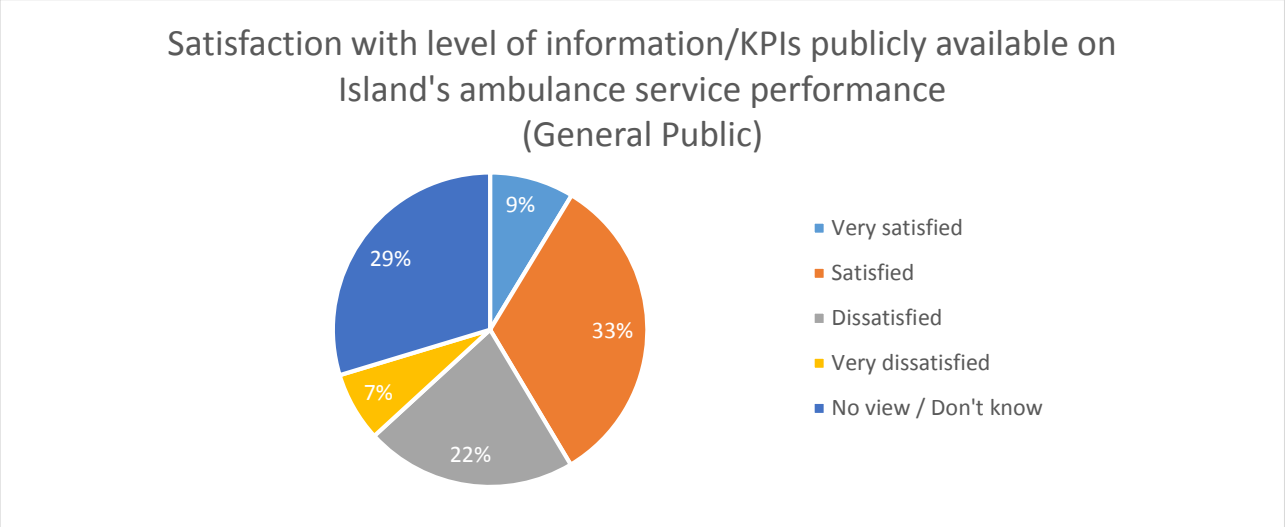

Figure 14

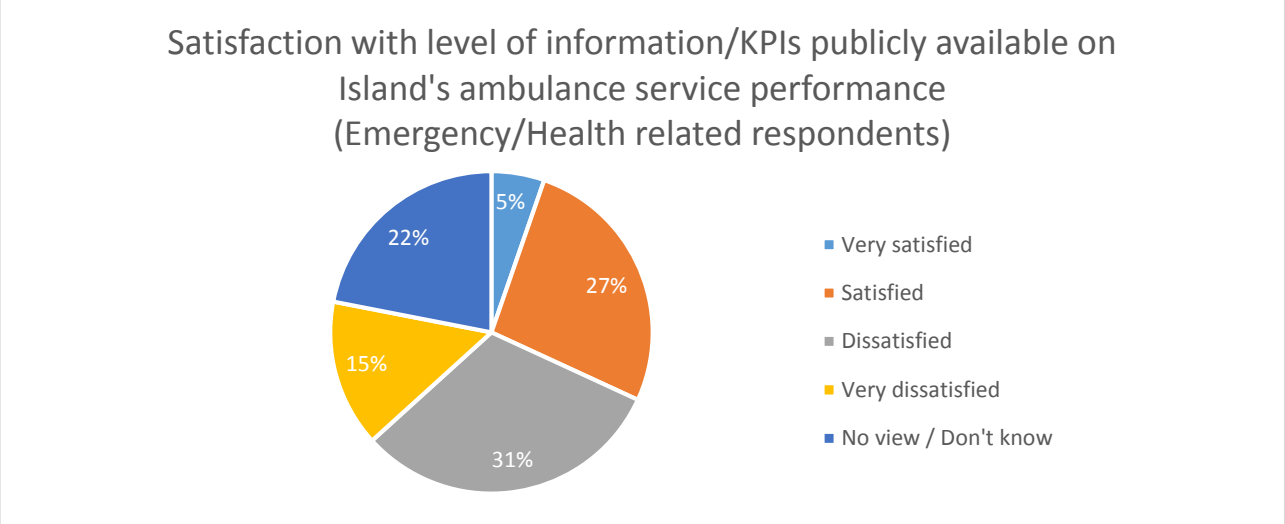

Figure 15

2.3 Non-Emergency Patient Transfers

There is a requirement in Guernsey for patient transfer services to provide pre-arranged transportation for patients to and from hospital and other specialist treatment appointments. A wide range of transport providers currently offer this service, including St John (under contract to the States Health and Social Services Department) and charities with their own vehicles and cost. Charging practices vary widely across the providers.

One in two (51%) of the general public and one in three (30%) of emergency/health related respondents answered 'don't know' to this question.

Of those that did express a view, 78% of the general public (39% of the overall sample in this group) and 60% of emergency/health related respondents (42% of the overall sample in this group) indicated that the current arrangement were adequate. However, 40% (28% of the overall sample) of this latter group did not consider that the present arrangements were adequate (Figures 16 and 17).

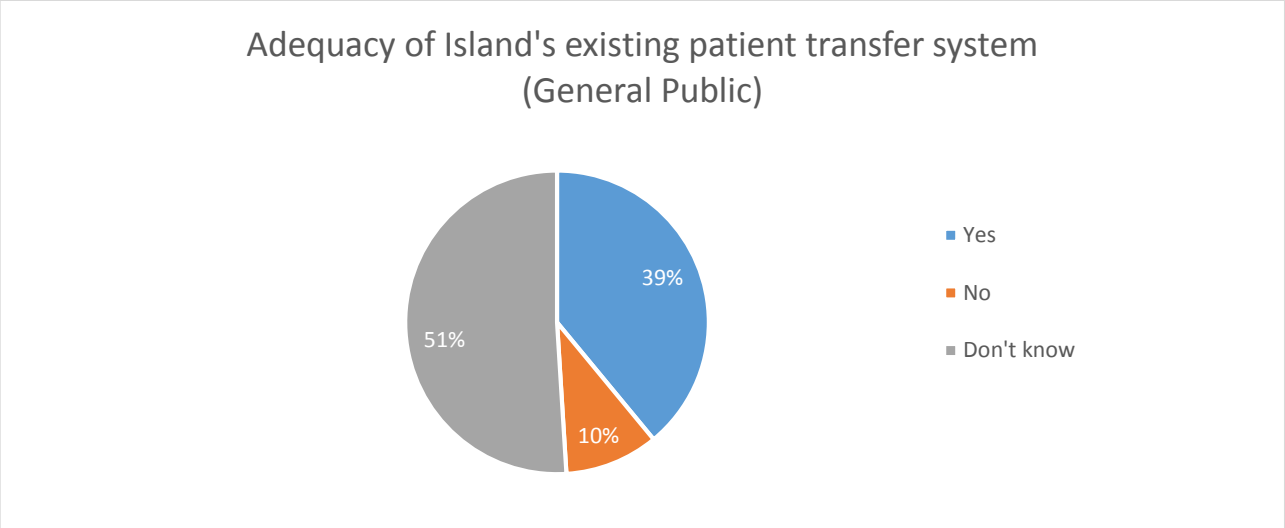

Figure 16

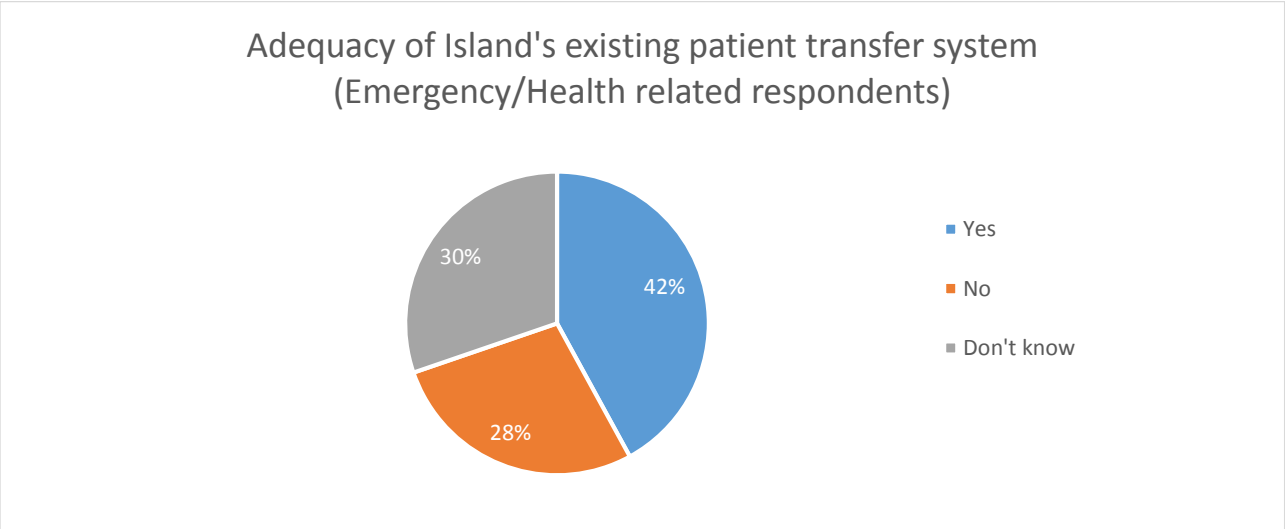

Figure 17

As far as which system respondents considered to be the best booking method for non-emergency transport services in the future, of those members of the general public that did have a firm view, 59% (47% of the overall sample in this group) considered that a central Island booking system covering all services would be most effective for co-ordination and price comparison. 51% of emergency/health related respondents (42% of the overall sample in this group) were of the same opinion (Figures 18 and 19).

41% (34% of the overall sample group) of emergency/health related respondents who had an opinion on this subject stated that charities providing patient transport services should remain independent but St John and HSSD should merge their booking systems as a single service. As far as the general public were concerned 29% (23% of the overall sample in this group) were of the same opinion.

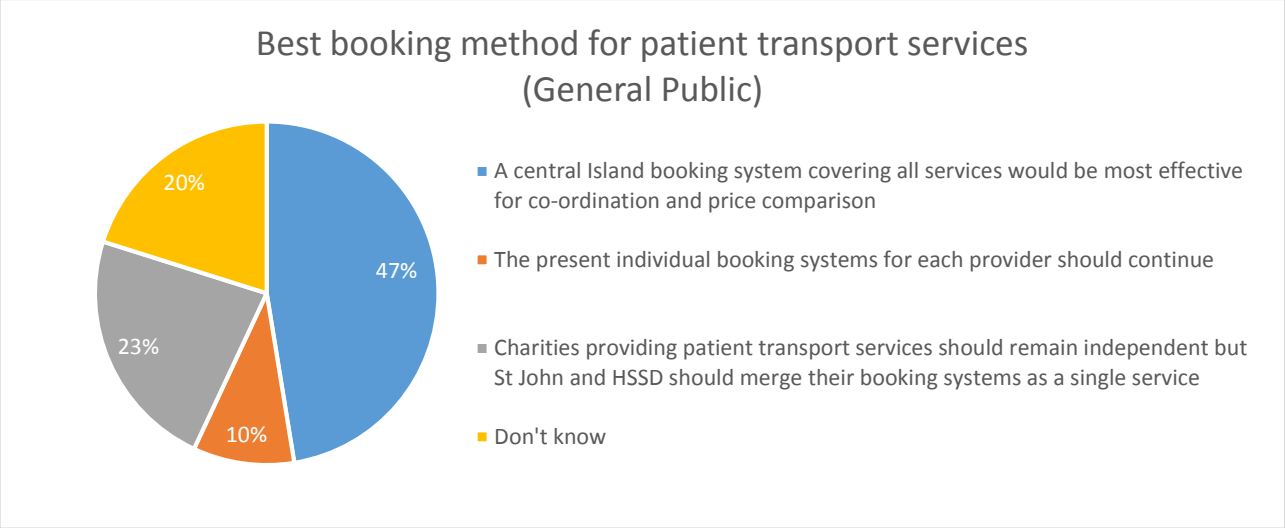

Figure 18

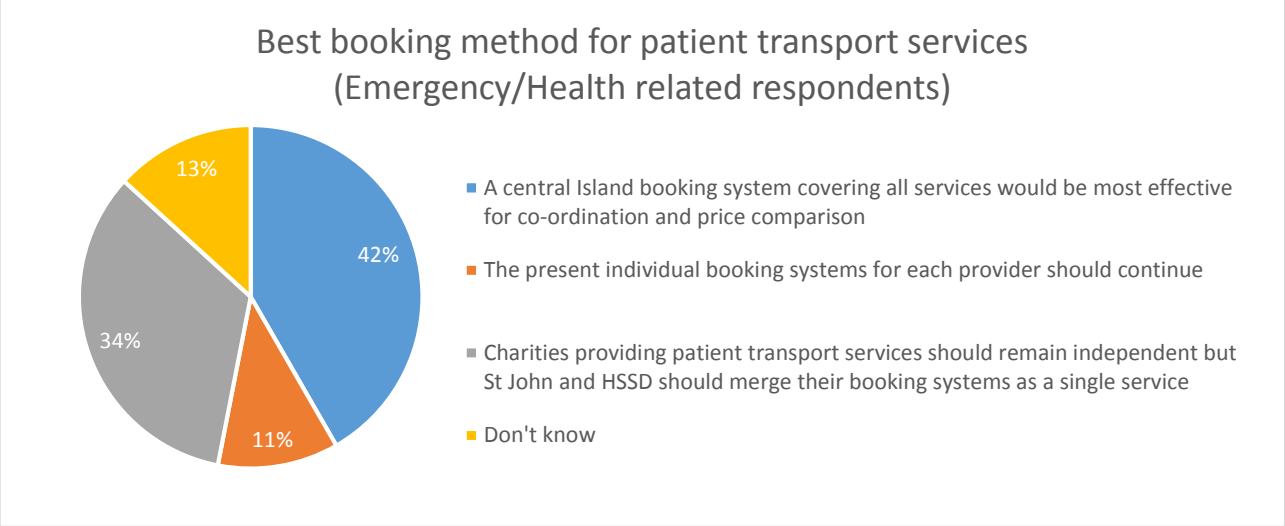

Figure 19

2.4 Addressing Immediate Medical Needs

The UK currently provides a 'Hear & Treat' service through Control Centres which are able to assess patients over the telephone and give them informed advice with regard to medical problems. In Guernsey, investment has been made in a 'Joint Emergency Services Control Centre' spanning medical, fire and police emergencies and it is possible to build such additional services into the Centre.

Only one in ten respondents in each group expressed 'no view' or answered 'don't know' to the provision of a 'hear and treat' service in the Island.

It is interesting to note that very similar percentages were recorded in the responses obtained from each group. Of those that had an opinion on the subject, 55% of the general public (49% of the overall sample in this group and 55% of emergency/health related respondents (50% of the overall sample in this group) supported a 'Hear and Treat' service (Figures 20 and 21). The majority of those that supported such a scheme considered that the cost of the service should be covered by the States of Guernsey through general taxation. 45% of those in each group who had expressed an opinion were not supportive of a 'Hear and Treat' service.

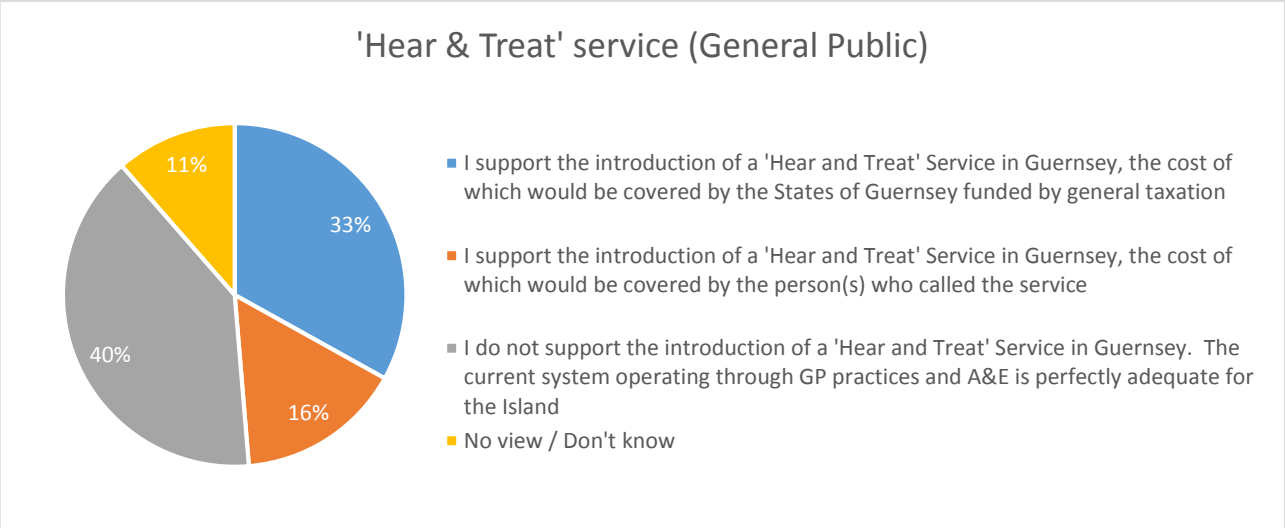

Figure 20

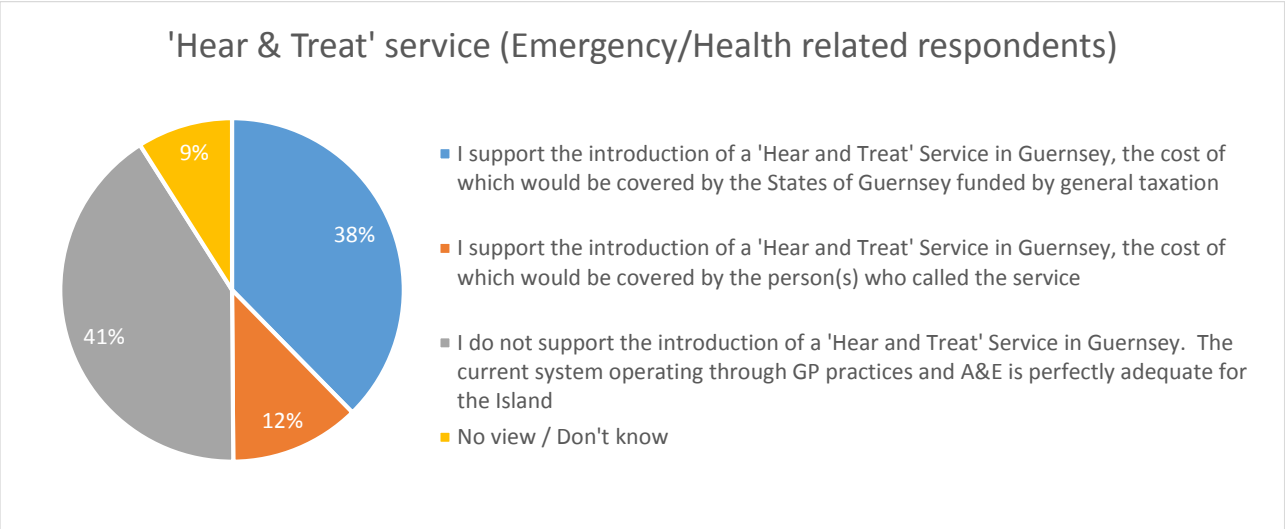

Figure 21

To improve the quality of care and potentially improve efficiency, the introduction of a 'Minor Injuries' and 'Walk-in' centre could be considered. In some jurisdictions, such centres can be based at a hospital and take 'Out of Hours' or other pressures off GP services. In some cases, staffing and resources can be shared with (but prioritised to) full A&E demands.

Respondents were invited to select a statement which best reflected their own views on the subject and the following responses were recorded (Figures 22 and 23). Very few had no view on the subject.

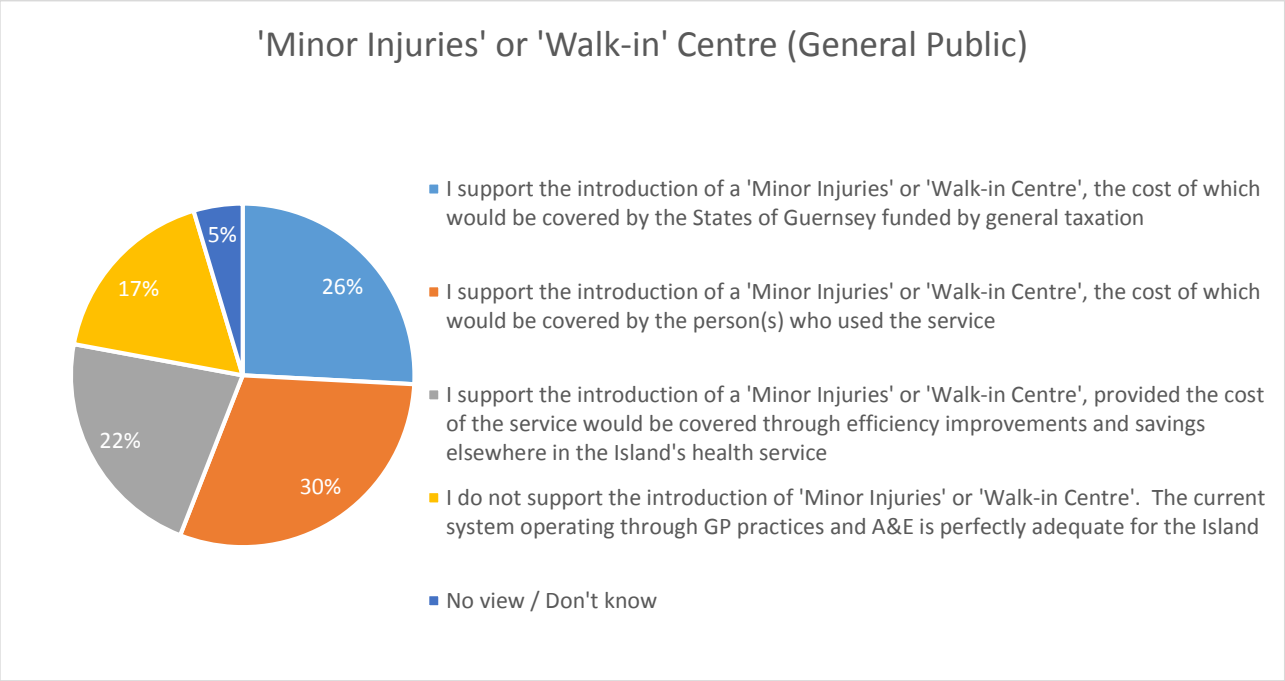

Figure 22

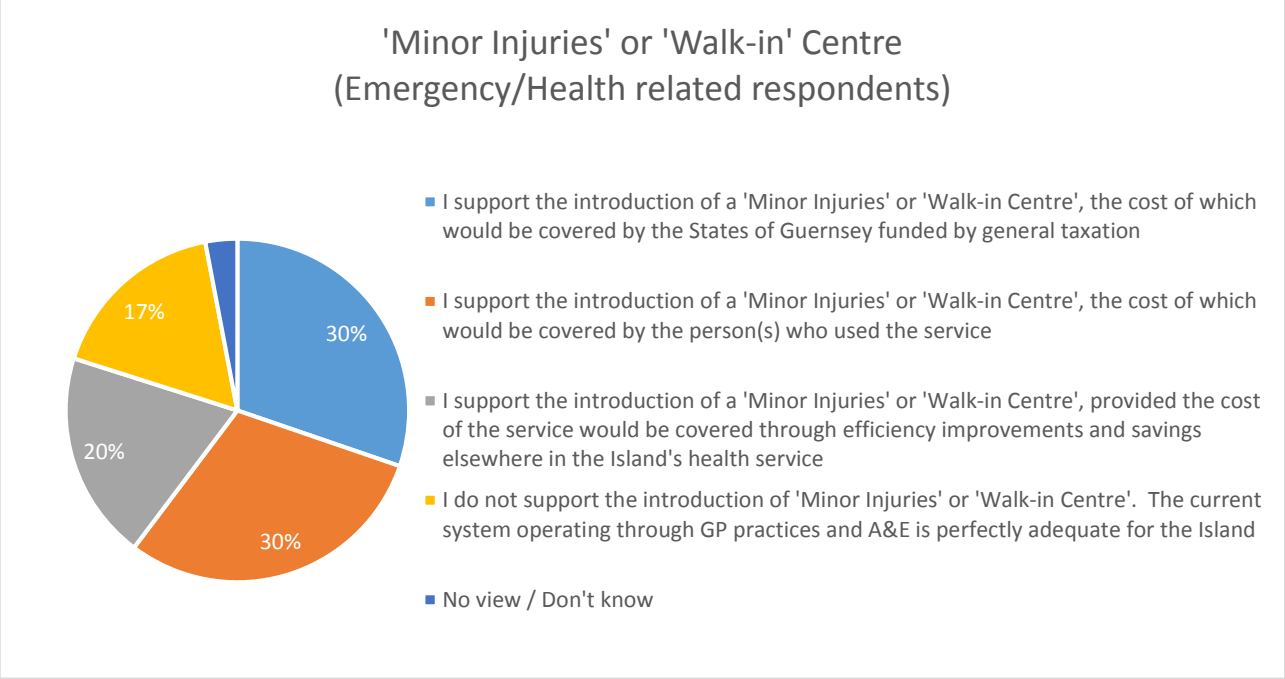

Figure 23

Technology provides further scope for 'tele-medicine', whereby mobile video links to care homes or private homes could further reduce the need for some routine medical visits and/or travel demands on patients. In this regard, respondents were asked whether or not they were in favour of a 'tele-medicine' service being trialled in the Island.

Very similar response levels were recorded in both groups. A sizable minority in both groups were 'not sure' as to how to answer. Of those that did have an opinion, a significant majority in each group were in favour of such a trial (Figures 24 and 25).

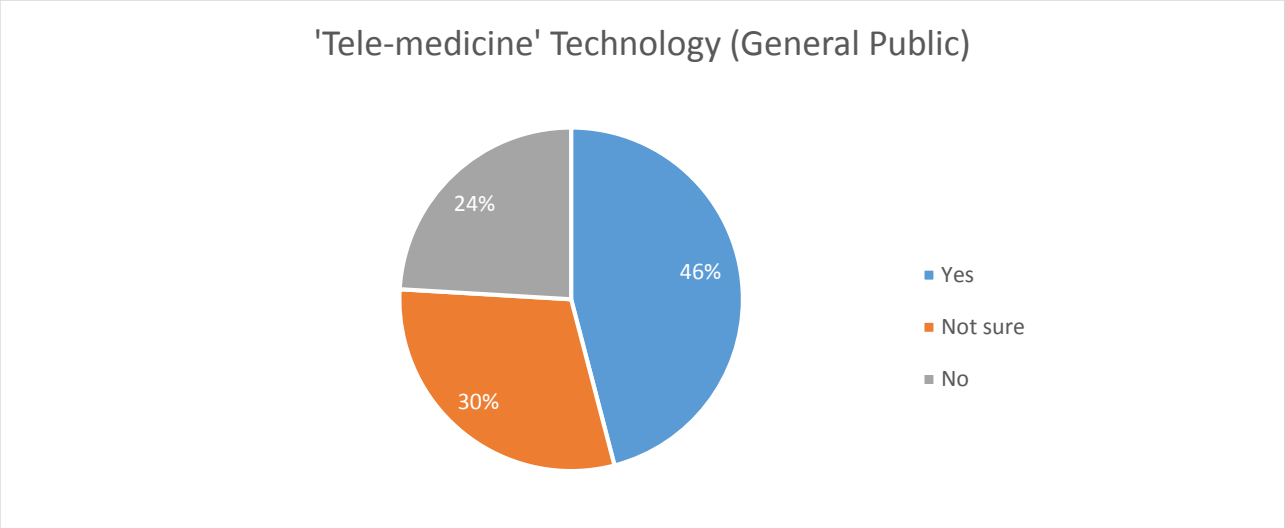

Figure 24

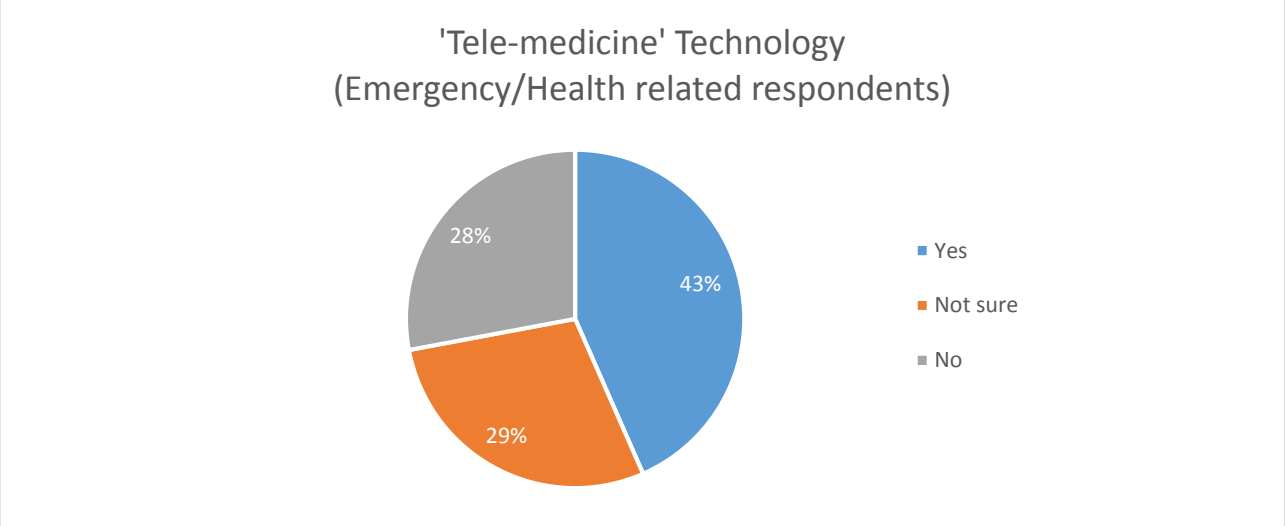

Figure 25

2.5 Use of Medical Records by Registered Health Care Professionals

To facilitate access to patient data in an emergency, the UK uses the Summary Care Record which is a secure, electronic record system that contains key medical information derived from detailed GP records.

The key medical information includes medication, allergies and any previous adverse reactions to medicines. Other information such as significant medical history, care plans, patient wishes or preferences, can be added with the consent of the patient. In addition to the Summary Care Record, all GPs across the UK now offer their patients online access to their medical records through the use of mobile technology, which can be assessed as and when required.

Three out of four respondents in each group supported the option that, subject to their authorisation and restrictions that they wished to apply, their medical records should be available on a central database accessible electronically by all registered healthcare professionals as required (Figures 26 and 27).

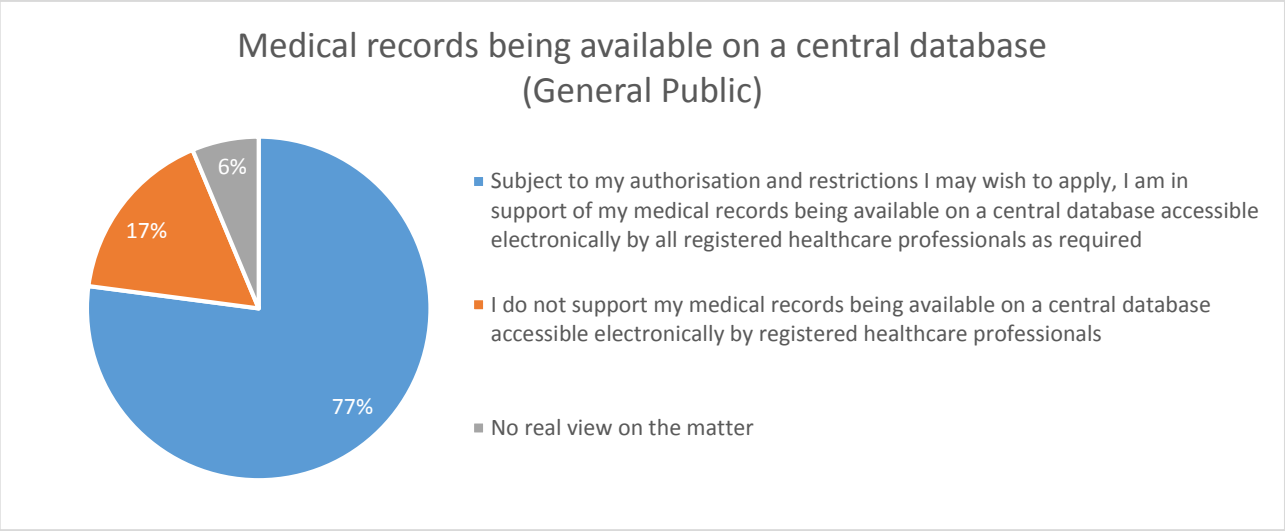

Figure 26

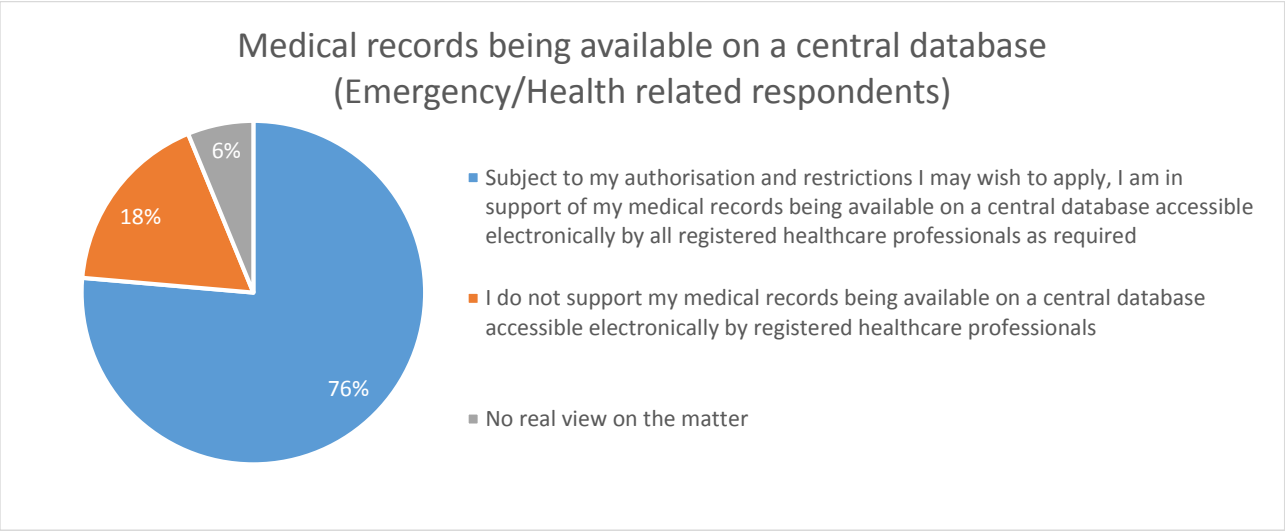

Figure 27

In some jurisdictions, technology offers patients the option of having their key medical records available via their mobile phone so that they might be readily accessible to medical professionals in an emergency.

Of those that had a view on this subject, a sizable majority in both groups were interested in such a facility being introduced in Guernsey in the future. Again, very similar results were recorded in both groups (Figures 28 and 29).

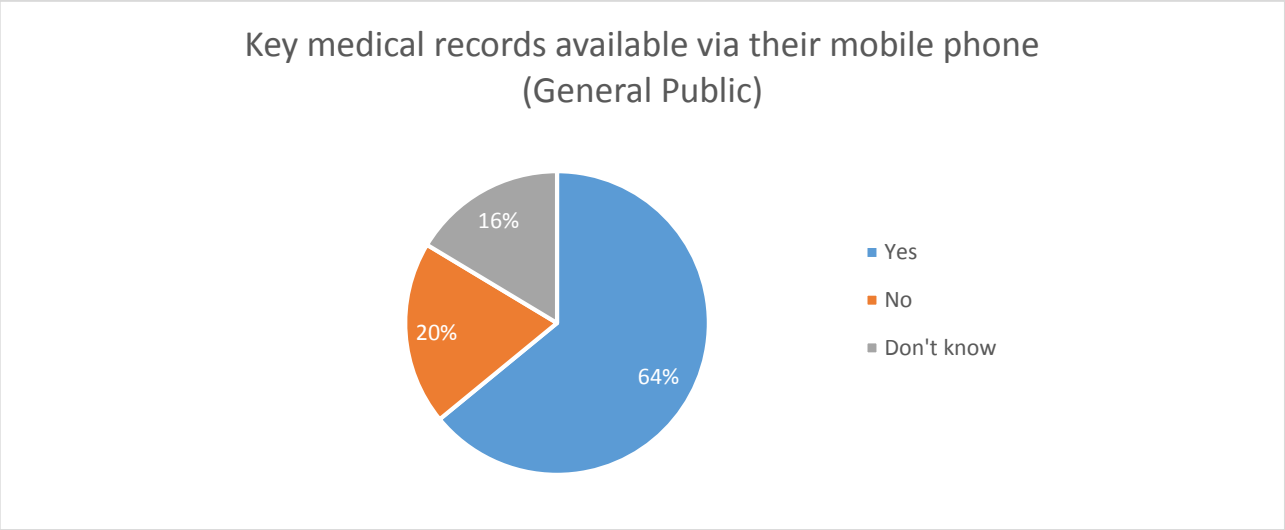

Figure 28

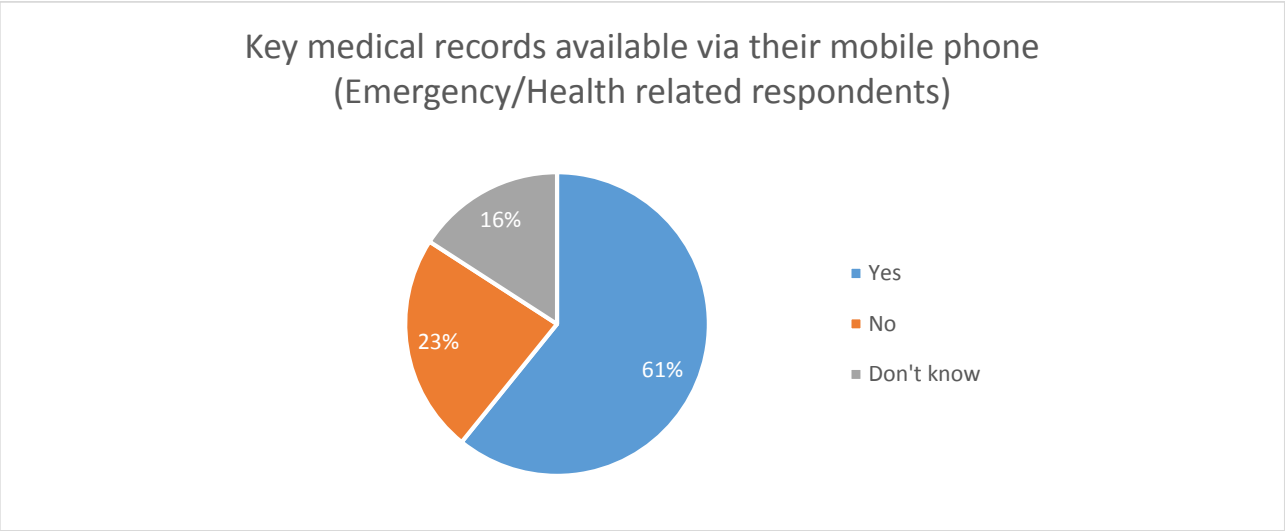

Figure 29

2.6 Collaboration between Emergency Services

Both the UK and Guernsey have seen increasing demand upon their emergency ambulance services. In response, the Guernsey Service has identified best practice off-island involving further collaboration across blue light emergency services. Examples of this include the newly formed Joint Emergency Services Control Centre which is responsible for providing a 24 hours' emergency and service call provision for each of the emergency services including, fire, police and ambulance.

There is a commonality of some skills amongst the blue light services, principally emergency driving and delivering basic life support. Police and Fire officers are trained to deliver CPR/shock which is critical in the first 5-10 minutes of a life at risk call. Whenever possible, Police and Fire personnel respond to life at risk calls in support of the ambulance service. They are not a substitute for the ambulance response, but their location within the Island could mean that they are nearer to the casualty and can administer the critical care within those first minutes of the emergency.

The overwhelming voice of opinion in both groups was supportive or very supportive of such collaboration (Figures 30 and 31) and, again, similar results were recorded in both groups.

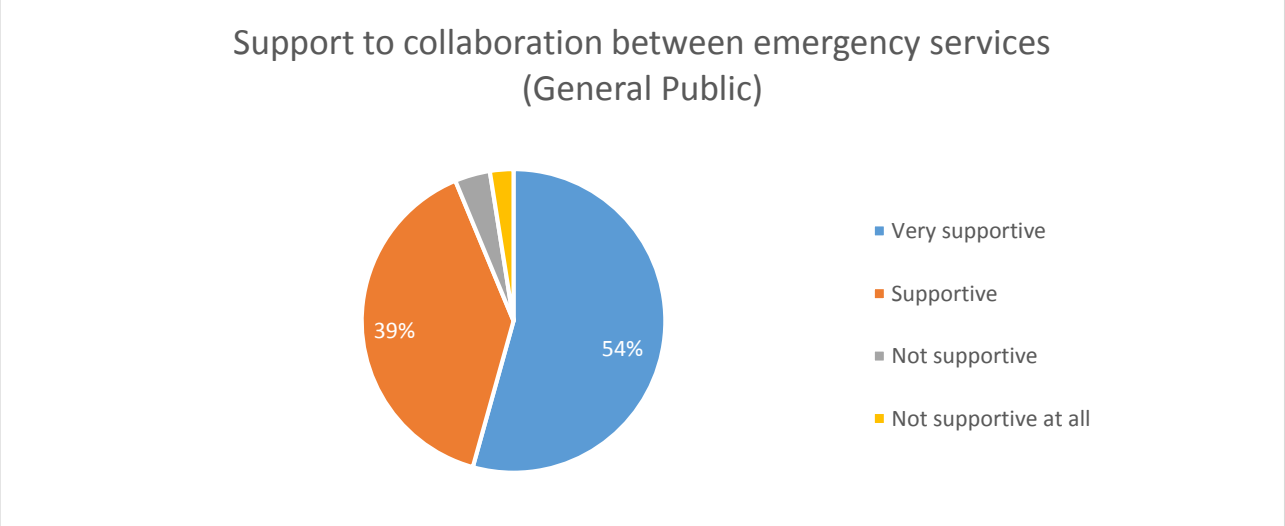

Figure 30

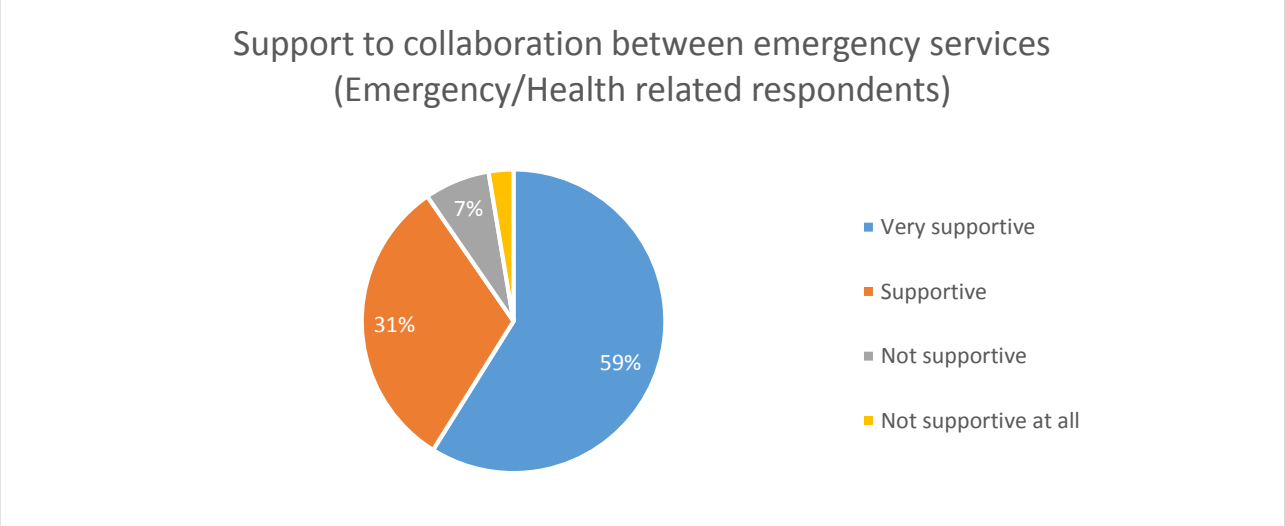

Figure 31

Lightfoot Recommendations

Service delivery

Clinical model – control room

1 There is an urgent need to equip the current SJARS control room with an appropriate prioritisation and despatch system. This should be introduced as soon as possible, regardless of any longer-term strategy, as it would be easily transferable to any future solution. It should include:

- A call-handling technology which records the time that calls are received, answered and closed, linked to voice recording of the calls and able to produce performance information by call-handler that is auditable
- A computer-based clinical record which includes caller ID and a decision-making process that is based on the needs and opportunities of the Island's services and geography and future proofed to provide for changes for 2020
- A clinical record system that is user-friendly and auditable, and provides performance and planning information
- Clinical records that can be despatched to a hand-held community device and linked to other services to include previous history and special notes that can be sent to vehicles via the Tetra system
- Clinical records that can be linked to GP records within 24 hours
- Dedicated local control staffing at Level 1 with appropriate call-handling and system training, maintaining local knowledge for advice regarding location and directions
- Up-to-date GPS navigation systems and mechanisms for tracking and recording on-scene times

2 The staffing levels in the control room need to be reviewed to ensure adequate, appropriate cover.

3 The emergency response standards should be reviewed in the light of international developments and local opportunities.

Clinical model – road service

4 If the decision is made to select the desired level of service, it is recommended that the feasibility be explored of a hybrid model of Level 4 clinicians, who are based in the hospital, work in an integrated way with the hospital staff and are despatched when needed by the ambulance service. This would help retain staff with this level of skill on-Island. These staff will have a unique opportunity to work differently, with costs being shared between SJARS and HSSD, filling vacant employment slots or providing care in the absence of a medical professional whilst updating and maintaining their skills and competencies.

5 To support both the minimum and the desired levels of service, SJARS should continue to develop and expand their Community First Responder schemes.

SJARS minor injuries treatment room

6 The SJARS minor injuries treatment room should be integrated within the hospital or A&E service with a revised charge made to patients if appropriate.

Clinical standards and effectiveness

7 SJARS should develop a Clinical Strategy, competency framework and Clinical Governance Framework. This needs to be supported by a dashboard of clinical outcome standards that are linked to the clinical pathway of care standards and outcomes required by professionals and regulating bodies and also linked to the standards of other stakeholders providing care in the pathway. These clinical outcome standards need to include stroke, cardiac, asthma and infection prevention and control (hand-washing and vehicle cleaning) along with complaints, incidents and risk. These should be linked to HSSD and other Clinical Governance processes, including joint audits and learning.

8 All clinical and operational changes and developments should be processed via a business case and be considered for the expected improvements to patient outcomes. These expected outcomes should be added to the key performance indicators (KPIs) and monitored by the Board.

9 An Island review surrounding standards, practice and joint practice should be encouraged. This should include the consistent and cost-effective provision of equipment for use across SJARS and HSSD services.

On-road rosters and relief levels

10 Rosters should be built aligning resources to demand, subject to the following conditions:

- Only emergency work is covered in the model. Either alternatives must be put in place to deal with all other non-emergency work. Or, the model week will need to be revised and the resource level adjusted accordingly.
- All other parts of SJARS' workload, i.e. cliff rescue, in-shore rescue etc, need to be covered separately from core activities, using volunteers.
- The control room needs to be fully staffed 24/7 and there has to be a robust triaging system with good governance in place. This will free up the station officer to be able to support the ambulances as required.
- There needs to be full staff engagement in developing the model and rosters so they have confidence in the outcome.

Operational efficiency

11 A target of 90 seconds from call receipt to mobilisation of vehicle should be adopted.

12 The use of cars should be reviewed in the light of the conclusions of this Review and staff should be engaged in the review process.

13 Job cycle time should be adopted as a performance indicator and an action plan to reduce it should be developed, with full staff engagement.

14 The continued use of standby points should be reviewed in the light of the other changes proposed by this Review.

Control room – longer term

15 SJARS should participate fully in the plans to develop a joint emergency control room with Police and Fire and Rescue on Guernsey.

Other services

16 A review of the provision of non-emergency transport across the Island should be undertaken, with a view to integrating the different providers either under SJARS or an alternative provider, improving efficiency and service provision.

17 SJARS should ensure clear lines of operational responsibility and finance between core and non-core services.

18 A review of the provision of equipment services across the Island should be undertaken, with a view to integrating the different providers either under SJARS or an alternative provider, improving efficiency and service provision.

Governance

19 SJARS should take the opportunity afforded by this Review to revisit their strategic direction and supporting plans, fully engaging patients, external stakeholders and staff in the process.

20 SJARS should formulate and implement a comprehensive Governance Framework which links workforce planning and training to competencies, risk and business priorities and the performance and quality dashboard reporting on key performance indicators to the Board.

21 HSSD and SJARS should agree key performance indicators and contractual monitoring measures and implement regular reporting as a matter of urgency. (See Appendix 6 for a suggested model.)

22 SJARS and HSSD should consider the opportunities for a single governance resource with the expertise in HSSD to be available on a day-to-day basis to support SJARS.

23 SJARS should review and revise the Clinical Steering Group terms of reference to include the provision of business cases to the Board for clinical developments, audit programme and workforce and training.

24 SJARS should implement Board development to include governance linked to strategy, business planning and developments, and risk.

25 The SJARS Board should review the Organisational Risk Register in the light of the revised Strategic Plan and adopt a new format which assesses the impact of the mitigating actions more clearly and regularly reviews the organisational risks SJARS face.

Management structure

26 SJARS should continue to pursue opportunities to reduce management costs, including collaborating with partner organisations.

Relationship with HSSD

27 HSSD should ensure that SJARS is a formal member of any strategic planning groups for 2020 Vision work.

28 SJARS should include HSSD as a formal member of the Board.

29 A joint annual Board meeting between HSSD and SJARS should be held to review the common objectives and progress and to agree the plans for the future years.

Service Level Agreement (SLA)

30 HSSD and SJARS should develop an SLA, including a service description/ definition, roles and responsibilities, information requirements, key performance indicators covering finance, activity, quality and governance and a range of incentives and penalties as appropriate to support the strategic direction of both SJARS and HSSD.

People

31 SJARS executive management team should take steps to ensure greater engagement of staff, for example, engaging staff fully in the development of the new Strategic Plan.

32 A formal workforce development plan should be formulated and implemented, linking with the Clinical Strategies of partners. This should incorporate mandatory and other training requirements and methods of delivery, and be fully costed.

33 Formal mechanisms for clinical supervision should be put in place.

34 SJARS should use the opportunities afforded by the Review to develop the senior management team, in particular around the areas of strategic planning, governance, organisational development, performance review and staff and stakeholder engagement.

35 An annual appraisal system for all staff should be implemented, supplemented by regular individual and team performance feedback.

Finance

See also recommendation 30 on Service Level Agreement (SLA).

36 SJARS should develop a system of service line reporting which provides the Board with assurance that services are provided within agreed parameters and which allows remedial action to be managed, communicated and timely.

37 SJARS should explore the potential for redesigning the subscription scheme charges.

38 SJARS should engage with HSSD in understanding the opportunities to support other health provision across both secondary and primary care.

39 SJARS should ensure a clear separation between the financial arrangements for core and non-core services.

40 SJARS should introduce a business case system which will clearly identify quality outcomes and financial benefit (or both).

Electronic health care records

41 SJARS should include the benefits for electronic patient records within the Clinical Strategy that is being developed to support the 2020 Vision, to ensure all providers' data can be accessed and used.

Alderney

42 A regular liaison meeting should be established to ensure that cooperation with Alderney continues and gets even stronger.

Emergency preparedness

43 The Major Incident Plan should be restructured as an overarching strategic plan with referenced action sections, possibly in the form of action cards.

44 The SJARS Business Continuity Plan should be populated as envisaged in the strategy with the detail that will make it an effective document.

45 Further regular internal training and exercising should be carried out to support both the Business Continuity Plan and the Major Incident Plan when the revised versions have been agreed.

46 SJARS and the Home Department should reopen talks to resolve the issue of who should pay for replacement of Major Incident equipment including a review of what equipment is now required, developed on the basis of a risk assessment based on the Island Risk Register.

Links with other emergency services

47 SJARS should continue to play a full part in all future joint emergency services exercises with the Fire and Rescue and Police services.

48 Discussions between SJARS and Fire and Rescue should aim to identify all possible areas of mutual aid including, for example, fire staff acting as co-responders and as drivers of emergency ambulances in times of severe pressure.

States of Jersey Ambulance Service

49 A formal liaison should be established with the States of Jersey Ambulance Service, starting with a summit to identify scope.

Appendix 4

RECOMMENDATIONS – ACTION PLAN

Key:

Green – Completed
Amber – In progress
Red – No progress

Lightfoot Reference Number	Recommendation	Progress	SJARS View on Recommendation A - Agree C - Contest
20	SJARS should formulate and implement a comprehensive **Governance Framework** which links workforce planning and training to competencies, risk and business priorities and the performance and quality dashboard reporting on key performance indicators to the Board.	In progress Workforce plan being drafted according to SJARS bid; A training needs analysis of competencies required for each clinical level has been introduced and training is being provided on a need basis; Updated KPI's introduced, reviewed and approved by the SoG Steering Committee and SJARS Board.	A
1	There is an urgent need to equip the current SJARS **control room** with an appropriate prioritisation and despatch system. This should be introduced as soon as possible, regardless of any longer-term strategy, as it would be easily transferable to any future solution.	Complete – under recommendation 15	A
2	The **staffing levels in the control room** need to be reviewed to ensure adequate, appropriate cover.	Complete – under recommendation 15	A
15	SJARS should participate fully in the plans to develop a **joint emergency control room** with Police and Fire & Rescue on Guernsey.	Complete.	A

Lightfoot Reference Number	Recommendation	Progress		SJARS View on Recommendation A - Agree C - Contest
7	SJARS should develop a **Clinical Strategy, competency framework and Clinical Governance Framework.** This needs to be supported by a dashboard of clinical outcome standards that are linked to the clinical pathway of care standards and outcomes required by professionals and regulating bodies and also linked to the standards of other stakeholders providing care in the pathway. These clinical outcome standards need to include stroke, cardiac, asthma and infection prevention and control (hand-washing and vehicle cleaning) along with complaints, incidents and risk. These should be linked to HSSD and other Clinical Governance processes, including joint audits and learning.	In progress This forms part of the KPI report which has been introduced and recently updated (see 20 above). The SJARS are a member of the new HSSD Joint Emergency Care and A&E Governance meeting which provides the link to HSSD's Clinical Governance processes. The Chief Officer is also a member of HSSD's Professional Guidance Committee (PGC) who are responsible under the SoG Contract for the SJARS medical supervision (under review.)		A
26	SJARS should continue to pursue opportunities to **reduce management costs,** including collaborating with partner organisations.	Complete – SJARS	In progress – collaboration with partner organisations to reduce costs further are being progressed by the SoG Steering Committee	A
28	SJARS should include HSSD as a formal **member of the Board.**	Completed. This is no longer applicable under the new contract and the current changes by the St John Commandery.		C
30	HSSD and SJARS should **develop an SLA**, including a service description / definition, roles and responsibilities, information requirements, key performance indicators covering finance, activity, quality and governance and a range of incentives and penalties as appropriate to support the strategic direction of both SJARS and HSSD.	Completed New contract signed.		A

Lightfoot Reference Number	Recommendation	Progress	SJARS View on Recommendation A - Agree C - Contest
31	SJARS executive management team should take steps to ensure **greater engagement of staff**, for example, engaging staff fully in the development of the new Strategic Plan.	Completed Regular Staff Forums have taken place, Staff Council Meetings, the introduction of the Post Review Steering Group and Union engagement. All management staff participated in a SWOT analysis of the ERAS following the new contract being signed and a 1 year Strategic Plan has been approved by the Board and Commnadery and communicated to all staff.	A
21	HSSD and SJARS should agree key performance indicators and **contractual monitoring** measures and implement regular reporting as a matter of urgency.	Completed This was in place during 2013 and 2014,but has now become the role of the SoG Steering Committee and Professional Guidance Committee (PGC)	A
17	SJARS should ensure **clear lines of operational responsibility and finance between core and non-core services.**	Completed	A
39	SJARS should ensure a clear separation between the **financial arrangements** for core and non-core services. (In conjunction with Recommendation #17).	Completed Separation of service activity undertaken.	A
36	SJARS should **develop a system of service line reporting** which provides the Board with assurance that services are provided within agreed parameters and which allows remedial action to be managed, communicated and timely.	Completed See 21 above.	A
49	A formal liaison should be established with the States of **Jersey Ambulance Service,** starting with a summit to identify scope.	Completed	A

Lightfoot Reference Number	Recommendation	Progress	SJARS View on Recommendation A - Agree C - Contest
10	**Rosters** should be built aligning resources to demand.	Completed. New operational rosters implemented 6 April 2015.	A
12	The **use of cars** should be reviewed in the light of the conclusions of this Review and staff should be engaged in the review process.	In Progress In conjunction with the new clinical levels and the development of first responders.	A
40	SJARS should **introduce a business case system** which will clearly identify quality outcomes and financial benefit (or both). (In conjunction with Recommendation #8)	Completed. The SOG business case template was presented to the SJARS Clinical Steering Committee, however they rejected this format as they felt it was too lengthy and unnecessary, however agreed that a simple business case would suffice.	C
8	All clinical and operational changes and **developments should be processed via a business case** and be considered for the expected improvements to patient outcomes. These expected outcomes should be added to the key performance indicators (KPI's) and monitored by the Board. (Depends on #40)	Completed. Business cases for operational/clinical development are processed through either the SJARS Clinical Steering Committee or the SJARS Board of Directors.	A
6	The SJARS **minor injuries treatment room** should be integrated within the hospital or A&E service with a revised charge made to patients if appropriate.	Completed SJARS Treatment Room closed in January 2015	A
4	If the decision is made to select the desired level of service, it is recommended that the feasibility be explored of a **hybrid model of Level 4 clinicians, who are based in the hospital,** work in an integrated way with the hospital staff and are despatched when needed by the ambulance service. This would help retain staff with this level of skill on island. These staff will have a unique opportunity to work differently, with costs being shared between SJARS and HSSD, filling vacant employment slots or providing care in the absence of a medical professional whilst updating and maintain their skills and competencies.	In Progress. This is being considered as part of the long-term options for the ERAS by the SoG Steering Committee.	A
Lightfoot Reference	**Recommendation**	**Progress**	**SJARS View on Recommendation**

Number			A - Agree C - Contest
9	An **Island review surrounding standards, practice and joint practice** should be encouraged. This should include the consistent and cost-effective provision of equipment for use across SJARS and HSSD services.	No Progress HSSD Recommendation	C
16	A review of the provision of **non-emergency transport** across the island should be undertaken, with a view to integrating the different providers either under SJARS or an alternative provider, improving efficiency and service provision.	In Progress This is being considered by the SoG Steering Committee.	A
18	A review of the **provision of equipment services** across the island should be undertaken, with a view to integrating the different providers either under SJARS or an alternative provider, improving efficiency and service provision.	No Progress HSSD Recommendation See 9 above.	C
19	SJARS should take the opportunity afforded by this Review to revisit their **strategic direction** and supporting plans, fully engaging patients, external stakeholders and staff in the process.	Completed An interim strategic direction was implemented for 2015 whilst the SoG Steering Committee considers the future of the ERAS.	A
22	SJARS and HSSD should consider the opportunities for a **single governance resource** with the expertise in HSSD to be available on a day-to-day basis to support SJARS.	Completed HSSD Governance support is in place.	A
23	SJARS should review and **revise the Clinical Steering Group** terms of reference to include the provision of business cases to the Board for clinical developments, audit programme and workforce and training.	Completed Terms of Reference have been updated, may have to be revised with SoG Steering Committee/PGC	A

Lightfoot Reference Number	Recommendation	Progress	SJARS View on Recommendation A - Agree C - Contest
25	The SJARS Board should **review the Organisational Risk Register** in the light of the revised Strategic Plan and adopt a new format which assesses the impact of the mitigating actions more clearly and regularly reviews the organisational risks SJARS face.	Completed Updated 2nd quarter of 2015.	A
27	HSSD should ensure that SJARS is a **formal member of any strategic planning groups for 2020 Vision** work.	No progress HSSD recommendation, however the 2020 vision is referred to in the CCA & SJARS "A Way Forward" document.	A
32	A formal **workforce development plan** should be formulated and implemented, linking with the Clinical Strategies of partners. This should incorporate mandatory and other training requirements and methods of delivery, and be fully costed.	In progress SJARS Workforce plan and training plan is currently being drafted following the signing of the new contract.	A
33	Formal mechanisms for **clinical supervision** should be put in place.	In progress Built into 2015-2018 structure working with the Isle of Wight Ambulance Service on utilising their framework.	A
34	SJARS should use the opportunities afforded by the Review to **develop the senior management team,** in particular around the areas of strategic planning, governance, organisational development, performance review and staff and stakeholder engagement.	In progress All supervisors and managers are will commence CMI training in 2015 – Level's 2, 3, 5 and 7.	A
46	SJARS and the Home Department should reopen talks to resolve the issue of who should pay for **replacement of Major Incident equipment** including a review of what equipment is now required, developed on the basis of a risk assessment based on the Island Risk Register.	In progress This was put on hold pending the contract negotiations but is being considered by the Project Manager of the SoG Steering Committee.	A
Lightfoot Reference	**Recommendation**	**Progress**	**SJARS View on Recommendation**

Number			A - Agree C - Contest
47	SJARS should continue to play a full part in all future joint emergency services exercises with the Fire & Rescue and Police Services.	Completed	A
3	The emergency response standards should be reviewed in the light of international developments and local opportunities.	Completed Addressed by the introduction of the computerised Medical Priority Despatch System (MPDS) within JESCC.	A
5	To support both the minimum and the desired levels of service, SJARS should continue to develop and expand their Community First Responder Scheme.	In progress Ongoing expansion.	A
11	A target of 90 seconds from call receipt to mobilisation of vehicle should be adopted.	In progress In place, however unable to monitor this as we are awaiting the implementation of C.A.D within JESCC later this year.	A
13	Job cycle time should be adopted as a performance indicator and an action plan to reduce it should be developed, with full staff engagement.	No progress	C
14	The continued use of standby points should be reviewed in the light of the other changes proposed by this Review.	In progress Awaiting the full expansion of the CFR and co-responder schemes.	A
24	SJARS should implement Board development to include governance linked to strategy, business planning and developments, and risk.	No progress This recommendation will need to be defined.	C
29	A joint annual Board Meeting between HSSD and SJARS should be held to review the common objectives and progress and to agree the plans for future years.	No progress May now be superseded as part of the new contract with the SoG Policy Council.	C
35	An annual appraisal system for all staff should be implemented, supplemented by regular individual and team performance feedback.	Completed.	A
Lightfoot Reference Number	**Recommendation**	**Progress**	**SJARS View on Recommendation** A - Agree C - Contest
37	SJARS should explore the potential for redesigning	Completed	A

	the Subscription Scheme charges.	2013/14 – will require further review.	
38	SJARS should engage with HSSD in understanding the opportunities to support other health provision across both secondary and primary care	In Progress This is being considered by the SoG Steering Committee.	A
41	SJARS should include the benefits for electronic patient records within the Clinical Strategy that is being developed to support the 2020 Vision, to ensure all providers' data can be accessed and used.	In Progress This is being considered by the SoG Steering Committee.	A
42	A regular liaison meeting should be established to ensure that co-operation with Alderney continues and gets even stronger.	Completed The Chief Officer of the SJARS is the Professional Ambulance Service Advisor to the SJAAS Board of Directors.	A
43	The Major Incident Plan should be restructured as an overarching strategic plan with referenced action sections, possibly in the form of action cards.	In progress NARU guidance and Action Cards in place	A
44	The SJARS Business Continuity Plan should be populated as envisaged in the strategy with the details that will make it an effective document.	In progress	A
45	Further regular internal training and exercising should be carried out to support both the Business Continuity Plan and the Major Incident Plan when the revised versions have been agreed.	No progress Waiting for BC plan and MI plan to be updated	A
48	Discussions between SJARS and Fire & Rescue should aim to identify all possible areas of mutual aid including, for example, fire staff acting as co-responders and as drivers of emergency ambulances in times of severe pressure	In progress Co-responding is now in place and this will be considered further by the SoG Steering Committee. A working group is also looking at more collaboration, reporting back to the Chief Officers of the SJARS and GF&RS by the end of September.	A

Appendix 5

Benefits for Islanders?

Testing via 'A Day in the Life' Workshops/'Senates'

1. More likely to receive better skilled treatment in emergencies.
2. More likely to receive emergency treatment faster.
3. More likely to receive coordinated health & social care.
4. Less likely to 'bed block' in hospital, awaiting 'other processes.'
5. More likely to be seen in comfort of own, safe home.

Benefits for Islanders?

Testing via 'A Day in the Life' Workshops/'Senates'

1. Second round of 'customer'/professional consultation.
2. Based on 'Past v Future Scenario' workshops and outcomes.
3. Segmented, based upon volume of ambulance call types.
4. 'A Day in the Life' - emergency events and responses.
5. Akin to HSSD 'Senate' workshops adopted elsewhere.
6. Can/should be extended to more 'event pathways' over time.

Benefits for Islanders

Testing by 'A Day in the Life' Workshops/'Senates'

1. Alcohol
2. COPD and Fall
3. Diabetes
4. Child Minor Injury
5. Elderly Infection
6. Falls
7. Maternity (third trimester)
8. Life-threatening 999 Calls
9. Frequent Caller

Past v. Future?

Alcohol

"My neighbour drinks a lot and I've found him in a right mess. He seems to have fallen."

PAST

1. Dispatch double crewed Emergency Ambulance
2. On scene assessment of patient undertaken and treatment rendered when appropriate.
3. Level of intoxication and/or injury determines whether patient is conveyed to A&E.
4. No consideration given to the relevance of alcohol as the possible underlying problem.

PATIENT OUTCOME

The possibility of alcohol abuse is not addressed.

Cycle continues/escalates resulting in further unnecessary demand upon ambulance and health resources.

FUTURE

1. JESCC activates single paramedic.
2. On scene assessment of patient and online review of medical records to determine whether alcohol abuse is a pre-existing impact factor.
3. If it is, referral is made by the paramedic to menu of social care interventions e.g. home support, community alcohol intervention team.

PATIENT OUTCOME

Early opportunity for lifestyle changes within a supporting package of care.

Reduction in emergency ambulance dispatches.

Avoidance of unnecessary conveyance.

Signposting to most appropriate care pathway.

"Upstreaming" to identify cause of demand at the outset provides the best opportunity to reduce repeated future demand on the more expensive ambulance and hospital resources.

COPD and Fall

"My neighbour has an oxygen machine, but they are panicking and can't get off the floor."

PAST

1. Dispatch double crewed Emergency Ambulance and Paramedic.
2. On scene assessment of patient and appropriate treatment rendered.
3. Stabilise and convey to A&E.

PATIENT OUTCOME

Conveyance of patient to hospital resulting in;

- Needless anxiety and infection risks to patient
- Unnecessary use of hospital resources.

FUTURE

1. JESCC activates Specialist/Advanced paramedic/ Emergency Care Practitioner (ECP).
2. Assesses patient and reviews their Electronic Patient Record (EPR) from scene.
3. If required, video call from scene between ECP & Primary Care/A&E doctor.
4. No conveyance following treatment and review of EPR.
5. ECP makes referral to Community Respiratory Team.

PATIENT OUTCOME

Patient receives the right treatment at right time in right place.

Care in the home.

Avoidance of unnecessary conveyance to A&E enhances patient satisfaction and reduces risk of infection.

Patient Record updated via mobile technology at the scene.

Access and use of EPR (Electronic Patient Record) enables all parts of the health system to apply effective treatment.

Diabetes

"My friend is behaving strangely - he takes insulin…."

PAST

1. Dispatch double/single crewed Emergency Ambulance.
2. On scene assessment of patient and appropriate treatment rendered.
3. Conveyance to A&E is dependent upon patient's response to treatment.
4. Diabetic Nurse Specialist notified of attendance.

PATIENT OUTCOME

Conveyance of patient to hospital resulting in;

- Needless anxiety and infection risks to patient.
- Unnecessary use of hospital resources.

FUTURE

1. JESCC activates Specialist/Advanced paramedic (ECP) in RRV
2. Paramedic sees, assesses patient, reviews their Electronic Patient Record from scene and treats.
3. No conveyance, paramedic makes referral to Diabetes Team.

PATIENT OUTCOME

Patient receives the right treatment at the right time in the right place – care in the home.

Avoidance of unnecessary conveyance to A&E enhances patient satisfaction and reduces risk of infection.

EPR updated via mobile technology at the scene.

Access and use of EPR enables all parts of the health system to assess effectiveness of treatment.

Child Minor Injury

"My 9 year old has shut his finger in the car door."

PAST

1. Dispatch double Emergency Ambulance.
2. Assessment & treatment of patient.
3. Conveyance to A&E is dependent upon clinical findings.

PATIENT OUTCOME

Inappropriate use of ambulance service

Unnecessary use of hospital resources

Needless anxiety and infection risks to patient

FUTURE

1. Assessed by nurse in the Clinical Hub linked to JESCC and, if appropriate, advised to take the child to the Minor Injuries Centre (A&E) – See & Treat

PATIENT OUTCOME

Appropriate and immediate resolution.

Patient receives the right treatment at the right time in the right place.

More coordinated patient service.

Reduction in number of ambulance dispatches.

Incidents are dealt with more promptly.

Elderly Infection

"My 85 year old dad seems confused and unwell, and is wobbly on his feet……"

PAST

1. Dispatch double/single crewed Emergency Ambulance.
2. Assessment & treatment of patient.
3. Conveyance to A&E is dependent upon clinical findings.

PATIENT OUTCOME

Inappropriate use of ambulance service.

Unnecessary use of hospital resources.

Needless anxiety and infection risks to patient.

FUTURE

1. JESCC activates Specialist/Advanced paramedic (ECP).
2. See, treat & supply antibiotics for infection e.g. UTI.
3. Update GP via completion of Electronic Patient Record.
4. Where necessary, arrange for follow up appointment by other pathway of care of ECP.

PATIENT OUTCOME

Appropriate & immediate resolution – the patient receives right treatment at right time in right place - care in home.

Avoidance of unnecessary conveyance to A&E enhances patient satisfaction and reduces risk of infection.

EPR updated via mobile technology at the scene; also enables all parts of the health system to assess effectiveness of treatment.

Better use of ECP's clinical skills. Shorter treatment times.

Resolution at the scene negates need to convey elsewhere.

Reduction in hospital admissions and treatment costs.

Reduction in dispatch of double crewed ambulances.

Falls - (1 of 2)

"My 90 year old mother has fallen out of bed and is complaining of pain in her shoulder."

PAST

1. Dispatch double/single crewed Emergency Ambulance.
2. Assessment & treatment of patient.
3. Conveyance to A&E is dependent upon clinical findings.

FUTURE

1. JESCC activates Specialist/Advanced paramedic (ECP) in RRV.
2. See and Treat - initiate assessment of patient's gait balance & cognitive impairment to identify the cause of falling, not just the consequences.
3. Examine their EPR on scene – do they have a history of falls?
4. If required, support available with manual handling from Fire Fighters.
5. If no need to convey, consider referral to other services.

Falls - (2 of 2)

"My 90 year old mother has fallen out of bed and is complaining of pain in her shoulder."

PAST

PATIENT OUTCOME

Conveyance of patient to hospital resulting in;

- Needless anxiety and infection risks to patient
- Unnecessary use of hospital resources.

No upstreaming as to cause of fall will give rise to further avoidable ambulance dispatches.

Increased emergency attendances and hospital admissions.

Increase in risk to patient of more serious injury e.g. fractured hip.

Longer hospital treatment times and higher treatment costs.

FUTURE

PATIENT OUTCOME

A more coordinated patient service.

Reduction in call cycle.

Reduction in emergency attendances.

More immediate access to clinical treatment.

Signposting to the most appropriate setting e.g. Social Care Services, Falls Prevention Services.

Care in the home.

Reduction in hospital admissions and treatment costs.

Joining up all sources of patient data into a singular, accessible EPR, will provide a better measurement of outcomes and drive up clinical quality and service.

Maternity (third trimester)

"I am 7 months pregnant and having stabbing pains in my tummy today."

PAST

1. Dispatch double crewed Emergency Ambulance with Paramedic.
2. Maternity ward notified of call, consideration given to deployment of midwife to scene.
3. Assessment & treatment of patient(s).
4. Convey to maternity ward is dependent upon clinical findings.

PATIENT OUTCOME

Unnecessary use of ambulance services.

FUTURE

1. Call routed for assessment by midwife in the "Clinical Hub" linked to JESCC and patient advised to make own way to maternity unit.

PATIENT OUTCOME

Resolution of call using telephone clinical assessment negates the need to dispatch a vehicle.

Reduction in number of ambulance dispatches.

Appropriate and immediate resolution.

Patient receives the right treatment at the right time in the right place.

More coordinated patient service.

Incidents are dealt with more promptly.

Life-threatening 999 Calls - (1of 2)

e.g. "My husband has collapsed in the bedroom. He is not breathing.'

PAST

1. Activate Community First Responder (CFR) – early CPR/defibrillation
2. Dispatch Emergency Ambulance/Paramedic
3. Ambulance arrives in target time.
4. Advanced Life Support (ALS) administered.
5. Patient stabilised and conveyed to A&E.

FUTURE

1. JESCC locates and activates the closest CFR or Co-responder.
2. JESCC dispatched emergency ambulance and paramedic.
3. Where relevant, JESCC advises caller of location of nearest public defibrillator.
4. Within 90 seconds, JESCC supports caller with advice on delivery of CPR.
5. JESCC activates Fire Service "pit-crew" to support ambulance staff in management of cardiac arrest – equivalent to A&E resuscitation team.
6. Ambulance/paramedic arrives within 8 minute target time and commences ALS.
7. On scene mobile technology enables paramedic to consult with A&E staff to agree actions and/or recognition of life extinct.
8. Patient stabilised and conveyed to A&E.

Life-threatening 999 Calls - (2 of 2)

e.g. "My husband has collapsed in the bedroom. He is not breathing.'

PAST

PATIENT OUTCOME

Best patient outcome is achieved through early 999 and delivery of CPR, defibrillation, ALS.

FUTURE

PATIENT OUTCOME

Fast and appropriate medical response, augmented by utilisation of fixed and mobile technologies.

Increased survival opportunities for cardiac arrest.

Earlier recognition of life extinct.

More effective use of CFRs and personnel across the emergency services network.

Joining up all sources of patient data into a singular, accessible EPR, will provide a better measurement of outcomes and drive up clinical quality and service.

Frequent Caller

Patient who has placed at least 10 emergency calls in a month.

PAST

1. Dispatch double/single crewed Emergency Ambulance.
2. Assessment & treatment of patient.
3. In the absence of any clinical need, patient's GP notified to give consideration to establishing a care plan.
4. Where a clinical/social issue is identified, patient's GP notified to give consideration to establishing a care plan.

PATIENT OUTCOME

Inappropriate use of ambulance resources.

FUTURE

1. Assessed over the phone by paramedic or nurse in the "Clinical Hub" linked to JESCC.
2. Reviews callers EPR
3. Any immediate healthcare needs met and referred to Frequent Caller Team

PATIENT OUTCOME

Resolution of call using telephone clinical assessment negates the need to dispatch a vehicle.

Reduction in number of dispatches.

Calls/incidents are dealt with more promptly.

Most appropriate pathway chosen.

System capacity is better utilised.

Reduction in emergency attendances.

Appropriate and immediate resolution.

GUERNSEY'S FUTURE AMBULANCE SERVICE – STEERING GROUP

1. John Hollis – Chair
2. Mark Lempriere – Deputy Chief Officer, Home Department
3. Steve Le Page – Chair, Board of St. John Ambulance & Rescue Service LBG
4. Jon Beausire – Chief Officer, St. John Ambulance & Rescue Service
5. Alison Marquis – Deputy Chief Officer, St. John Ambulance & Rescue Service
6. Vanessa Spiller – CEO to Commandery, St. John Ambulance Guernsey
7. Jan Coleman – Director of Corporate Services, HSSD
8. Mark Salmon – Senior Finance Manager, HSSD
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The GFAS Steering Group is grateful to the following individuals and groups who at various stages have provided professional input to this review.

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HSSD Corporate Management Team

Home Department Senior Management Team, including Fire and Law Enforcement Chiefs

Emergency Services Senior Management Teams

HSSD A&E Department

St. John Board

Bob Lanning, Unite Union

HSSD Chief Nurse

HSSD, Home and SSD political Boards and officers

ICT Sub-committee and Chief Information Officer

States of Guernsey Chief Executive

States of Jersey Chief Ambulance Officer

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The responders to Guernsey's Future Ambulance Service – Public and Professional Consultation.