ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Government of JERSEY

Independent Review: **The States of Jersey Ambulance Service**

APRIL 2022

info@aace.org.uk

www.aace.org.uk

Contents

Date of review on location	20-22 September 2021
Draft report shared for accuracy checking	17 December 2021
Feedback received	7 January 2022
Final Version 2	06 April 2022

Background

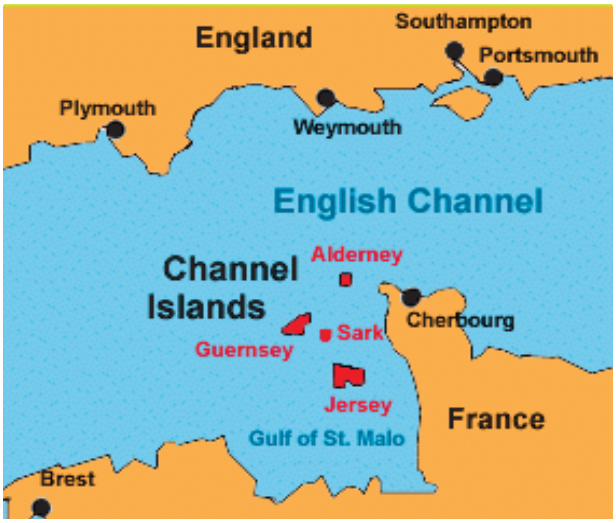
The operational management of the States of Jersey Ambulance Service (SoJAS) moved from the Health and Community Services (HCS) department in the Jersey Government, to the Justice and Home Affairs (JHA) department on 1 January 2019, with clinical governance matters being coordinated with HCS since then. Following this move, Julian Blazeby, the then JHA Director General (DG), approached the Association of Ambulance Chief Executives (AACE) with a request to conduct an independent review of SoJAS.

In order to align with inspections of the UK ambulance sector, AACE agreed to follow a similar, but not exact, process and key lines of enquiry for this review to those used by the Care Quality Commission (CQC) in England, and healthcare inspectorates for Wales and Scotland. The approach was scaled appropriately with respect to the size, structure, and scope of practice for the SoJAS.

There was a specific request made by the JHA DG that the review should also concentrate within the "Safe Staffing" component on whether the service has sufficient capacity to meet existing and future demand going forward over the next three to five years.

Finally, whilst initially the review team were not originally asked to explore the financial arrangements for the service, we were subsequently asked to consider the high-level reasons behind current overspends and determine whether the service was adequately and sustainably funded going forward.

Context



The States of Jersey Justice and Home Affairs Directorate

This directorate encompasses the following services:

- **Police**
- **Ambulance Service**
- **Fire and Rescue Service**
- **Customs and Immigration Service**
- **Prison Service**
- **Health and Safety Inspectorate**
- **Jersey Field Squadron**

Ambulance Service

The SoJAS headquarters building and ambulance station are based on the same site in St Helier, the capital of Jersey. The service provides urgent and emergency healthcare, responding to 999 calls from the public as well as referrals from General Practitioners (GPs) and other Healthcare Professionals (HCPs), to provide pre-hospital care services 24 hours per day to a resident population of approximately 108,000 over a geographical area of 45 sq. miles.

The organisation runs the joint Ambulance and Fire & Rescue Service control services function within a Combined Control Room (CCR) within the State of Jersey Police force headquarters building, coordinating responses to 999 calls. The CCR used to have responsibility for monitoring alarm services, but this became the remit of the hospital switchboard in December 2019. The out-of-hours GP service call-taking moved from SoJAS to the HCS24 service in December 2020 (post this review).

As at 2021, SoJAS were attending over 10,000 emergency calls a year; handling and triaging 14,800 medical and fire and rescue 999 calls, and approximately 1600 routine and 1200 urgent doctors' calls in the CCR.

The Intermediary Ambulance Service (IAS) function provides care and transport for urgent doctors' calls and routine stretcher transfers including transport of medical teams and patients for air transfers and repatriation.

In addition, the service runs a separate Patient Transport Service (PTS) Control Centre which manages non-emergency scheduled transport for patients attending routine appointments and day centres. The PTS transports over 32,000 patients/clients across the community for outpatient medical appointments and day centre services.

The service is a key partner in multiagency response and provides the prehospital planning and coordination for major or large-scale medical incidents in the community.

Fleet

At the time of review, SoJAS had an ambulance fleet consisting of 7 double-crewed ambulances; 1 intermediary ambulance; 10 PTS vehicles; 2 major incident vehicles and had recently introduced an advanced/specialist paramedic response vehicle.

Locations

All of the response services are deployed from the ambulance station based at Ambulance Headquarters, Rouge Bouillon, St Helier. Two standby points are used to position ambulances strategically to improve response times. These have access to public facilities in terms of welfare needs while staff are on standby.

Volunteer services

The ambulance service is supported by its three voluntary units:

- The hospital car service provides transport to those with a medical or physical need who do not require the same level of assistance as is provided by PTS, but still require assistance not provided by public service providers.
- The Ambulance Support Unit (ASU) has been providing support and assistance to the ambulance service on a voluntary basis for major or significant incidents for many years. Initially formed to assist in major incidents the team has grown and now assists at local events providing first aid cover with service staff, officers, and our voluntary partners.
- Community First Responders (CFRs) act as an initial response to immediate life-threatening calls in the community to start basic lifesaving interventions whilst an ambulance is on route. Using community responders, the service can provide earlier interventions as they are often the closest resource in time critical emergencies.

Methodology for the review

The review of the ambulance service covered all aspects of the organisation – service delivery, infrastructure, workforce, systems, and processes - and focussed on the following framework:

Principle	Areas covered
1 Safety *How effective are measures in place to protect staff and public from abuse and avoidable harm?*	1.1 Safeguarding 1.2 Infection prevention and control 1.3 Equipment 1.4 Safe staffing 1.5 Patient records 1.6 Medicines management 1.7 Serious Incident Reporting & Learning
2 Effectiveness *What evidence is there that the care and treatment given to patients result in the best possible outcomes and promote a good quality of life?*	2.1 Evidence-based care and treatment 2.2 Patient assessment 2.3 Patient outcomes 2.4 Training 2.5 Personal development 2.6 Multi-disciplinary working
3 Care & compassion *How does the organisation demonstrate values of compassion, kindness, dignity, and respect in the behaviour of its staff?*	3.1 Compassionate care & support 3.2 Feedback – complaints and compliments
4 Responsiveness *How well is the service able to meet the needs of the population it serves?*	4.1 Operational performance 4.2 Patient needs 4.3 Mental health 4.4 Resilience
5 Leadership & governance *What assurance is there that the service is well-led, with an open and fair culture, supporting learning, development, and high-quality care?*	5.1 Leadership development 5.2 Vision and strategy 5.3 Assurance and governance arrangements 5.4 Information management 5.5 Organisational culture

The review was not conducted as a formal audit or inspection process, but in the time allocated, sought to gather evidence of, and understand practice in, the application of the above principles through:

- **consideration of key documentation and data**
- **interviews with key members of staff and other stakeholders**
- **discussion with a staff focus group**

Interviews were held with the following people:

Peter Gavey, Chief Ambulance Officer

James Inglis, Senior Ambulance Officer

Gary Vibert, Acting Head of Operations

Garreth Saunders, Advanced Paramedic Manager

Jason Hamon, Head of EPR & Operational Support

Kerrie Mauger-Dorrington, Clinical Tutor

Sarah Foot, Ambulance Audit Officer

Fiona McIntosh, Interim Control Room Manager

Dee McAvinue, Senior HR Business Partner, JHA

Rob Sainsbury, Group Director, HCS

Martin Warnette, Intermediate Care Lead, HCS

Caroline Landon, Director General, HCS

Julian Blazeby, Director General, JHA

Kate Briden, Group Director, JHA

Tracy Duncan, Head of Finance Business Partnering, JHA

Dr Vishal Patel, Medical Director

Discussions were held with ambulance personnel formally in a focus group, and informally in the mess room.

Due to time constraints, the review team were unable to meet with patients, or patient group representatives, nor partake in ride-outs to observe clinical practice.

Overall summary of findings

The overall findings from the review confirm that SoJAS is a good service, with passionate caring staff providing, generally, a good quality, safe service for patients. The majority of policies and procedures required within a modern ambulance service were found to be in place and broadly adhered to, although some examples were in need of some review and modernisation in line with current best practice.

Staff had access to appropriate vehicles and equipment that were fit for purpose and were adequately trained and in receipt of regular refresher training. Leadership development training was being provided by government initiatives such as “Team Jersey” and the "World Class Management Development Programme” and managers were able to access these modules as part of their ongoing development. Resilience planning was also generally good, although some areas of emergency preparedness and business continuity planning could be improved and are detailed later in the report.

Unusually for an ambulance service, as a healthcare provider, a recent decision by the States of Jersey Government resulted in restructuring which placed the ambulance service within the Department of Justice and Home Affairs (JHA) and removed it from being a core part of the Health and Community Services (HCS). Whilst the precise home of the service within the Island’s infrastructure is a matter for the Government, it is vital that excellent and essential inter-departmental

links with HCS are maintained, and that there is a jointly owned vision for the role of the ambulance service in the provision of urgent and emergency care on the Island. Our review found that these links, as well as ambulance service engagement within HCS governance structures, need improvement, and more work was required to agree and articulate a clear strategy for delivery of that joint vision. We were astounded that there is no mention of the role and contribution of the ambulance service within the Jersey Care Model – designed to articulate the HCS vision, despite its stating: "At the centre of the model are the core provisions included in any Health and Care System".

A review of capacity in the ambulance service has revealed that there are growing signs that the service no longer has the ability to meet its present demand, as evidenced by longer response times, a reliance on overtime and increasing instances of being unable to respond to incidents without calling on managerial and other resources as a last resort. The service has never conducted a formal, independent demand and capacity review (DCR) across all its operational functions to determine the required resourcing and skill mix needed to meet its current and future demand. This is routine practice within UK ambulance services and is now urgently required if the service is to understand its capacity and funding requirements to reliably inform planning processes. It is strongly recommended that an experienced external modelling company is appointed to carry out this work.

Preliminary discussions have begun to bring the SoJAS clinical response model in line with mainland ambulance services following the Ambulance Response Programme (ARP) implemented in 2017. This, together with a robust DCR, would enable SoJAS to contribute more innovatively to the objectives of the Jersey Care Model in the most efficient and effective ways, ensuring all patients receive the most appropriate care in the right setting, for example, being able to safely provide 'See and Treat' and 'Hear and Treat' responses.

The service is currently inadequately funded due to a combination of issues including a lack of core capacity leading to a necessity to use more agency staff and overtime and some historic transitional issues as budgets were transferred from HCS to JHA leading to a shortfall in the funding transferred. At the time of the review the anticipated overspend was quoted at circa £180k on a budget of £4.8m. As we finalise the report in December 2021 this has risen to in excess of £420k. This will require the JHA to cover the shortfall through underspends in other areas. Clearly this is an unsustainable position, and the budget should be reviewed and adjusted to provide a sustainable level of funding for 2022/23 onwards. The budget review should be informed in due course by the demand and capacity review.

Examples of good practice

The review noted a number of areas of positive development and good practice.

A number of staff told us that they like the ambulance service they work for and are proud of their jobs. Although recognising some of the challenges the service faced, many felt it was a positive place to work and that colleagues gave each other strong support. Briefings at the start of shift handovers were well received and the mess room being next to the Lead Paramedic's office was felt to be a positive improvement. Staff felt that they had wide range of appropriate equipment and good vehicles, and access to a well organised stores facility that was well stocked.

The introduction of the new clinical dashboard, although resource intensive due to paper care records, is helping to review trust and individual clinical staff performance and analyse data in important patient outcome areas, such as cardiac arrest. The clinical dashboard enables clinical performance indicators and care bundles (e.g. for chest pain, asthma, or stroke) to be measured, and the standard of care in these care bundles was high. Further development will enable staff to review their own individual clinical performance on the dashboard and will link with the new Clinical Audit Review (CAR) process that is planned to start soon.

There was good recognition of the need for accurate patient care records and bespoke education sessions had been developed and delivered to staff, supported by the medical director. Noticeable improvements in the quality of content in care records had been noted by re-audit of forms.

Staff felt that training provision and continuing professional development was good, receiving equivalent of three 12 hour shifts per year per person and that they had access to appropriate training equipment. An example given was 'boats and ropes' training, which is specific to the types of incidents at sea that the service attends.

There was a strong sense of good working relationships internally and with other emergency services and volunteer agencies. It was also particularly encouraging to see and hear tangible recognition and appreciation of ambulance colleagues from other healthcare professionals.

Priority areas for improvement

A. **Levels of staffing** are currently inadequate to meet current demand as evidenced by increased response times and longer waits for patients. This not only has a detrimental effect on patients but also impacts on the health and wellbeing of staff and managers and the overall reputation of the service. Senior managers are not able to concentrate on their managerial remits due to the frequent need to support frontline resourcing. The service needs to commission a full, independent **demand and capacity review** led by an experienced external modelling company, to cover field operations, control services and PTS. Such a review would also explore the required skill mix to meet response models, and any areas where further efficiencies may be possible.

B. The decision on whether to introduce an **advanced or specialist paramedic model** in Jersey needs very careful consideration. It should only be done as part of a long-term strategy designed in collaboration with the wider HCS. The problem it is setting out to achieve must be clearly understood by all and a detailed cost benefit analysis should be carried out to ensure value for money going forward.

C. The current **financial envelope** within which the service operates is not sustainable, as evidenced by a potential overspend of some £400k anticipated by year end. Budgets need to be reviewed going forward to provide realistic and sustainable funding, with less reliance on overtime and external providers for resourcing. This work should be informed by outputs from a full demand and capacity review.

D. Current **linkages with HCS** need to be improved both at the strategic and tactical level. The move from HCS to JHA has in many ways been seen as positive, but it remains an unusual construct for an ambulance service, leaving it fragmented from the rest of healthcare provision despite being a key provider. It is therefore even more important that these linkages are fully functioning at all levels, particularly day-to-day with respect to clinical governance, and also at the strategic level identifying how the role of the ambulance in the provision of urgent and emergency care and addressing health inequalities and ill health prevention, integrates with the rest of HCS and contributes to delivery of the Jersey Care Model. The medium and long-term strategy for the ambulance service needs to be articulated, agreed, understood, and included in planning processes by all stakeholders and partners. The review team found that this was generally not the case and is an area which requires addressing urgently.

E. There is a need to review the current **triage and despatch methodology** within the CCR to determine whether an approach in line with the Ambulance Response Programme (ARP) methodology introduced successfully across the UK in July 2017 would be of benefit in Jersey. Some work has begun to understand this in more detail, and this should be progressed to realise the benefits in terms of both operational efficiency and patient safety.

F. The service operates a **'flagging system'** whereby patients are 'flagged' on the Computer Aided Dispatch (CAD) system where there may be issues that the attending crews should be aware of in terms of managing the patients or where there may be safety issues for the crews.

In general, the policies, procedures and governance of this flagging system are inadequate and need improvement.

G. **Information governance** policies and procedures require development to ensure compliance with best practice. The way in which document control is managed, and the storage of, and access to, patient care records involving patient identifiable data, need to be improved.

H. The **role of the medical director** needs to be reviewed, including identifying remit and allocated hours within a formal contract. The current arrangement allows for just 4 hours per week which is undertaken on a relatively ad hoc basis as and when time allows. As well as providing essential clinical governance accountability, consideration should be given into how this role can be provided in a more consistent manner and provide the essential integration with the wider health system on behalf of the ambulance service.

I. A review is necessary of the access to, and use of, the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) **Clinical Guidelines** for clinical staff. SoJAS has purchased hardcopies of the guidance and the related pocketbooks for all clinical staff, and some staff have purchased access to electronic copies via the JRCALC App. With the extent of clinical development and updating of these guidelines, hard copies will quickly go out of date. Use of the JRCALC App is now universal across other UK ambulance services as the digital option makes it much easier to ensure all staff are working to the latest guidance. There is also an add on option that would enable SoJAS to provide its own relevant updates, alerts and briefings via the App – important for a dispersed workforce. Consideration should therefore be given to purchasing licenses for all SoJAS frontline staff to have access to the App, either on their own personal devices or on a device which the service ultimately provides.

J. The service is considering re-introducing **endotracheal intubation** as an advanced airway skill for its paramedics, following pressure from staff to do so. This decision would be outside the position taken by other UK ambulance services, so, if this were to go ahead it is important that the rationale and governance associated with doing so is clear and well documented. In particular, the service needs to state how it will ensure that paramedic staff remain competent in this skill, which is infrequently needed, as this has proved to be a particular challenge within mainland regional services. Re-introduction should be in line with the College of Paramedics intubation consensus statement.[1]

K. There are currently **no clinicians based within the CCR** environment nor any other form of access to a robust Clinical Assessment Service (CAS). This limits the ability of the ambulance service to provide ‘Hear and Treat’ responses and results in ambulance dispatch to patients who could potentially have been managed differently and more appropriately. This needs to be considered in terms of the overall management of demand going forward. Access to clinical advice and secondary triage by experienced ambulance clinicians is now a fundamental part of ambulance control rooms across the UK and needs to feature in the SoJAS strategic planning going forward if ambulance resources are to be used efficiently and effectively.

L. The review team had a number of specific concerns with regard to **emergency preparedness for the Island**. Firstly, the lack of a formal, risk-based and tested Mass Casualty Plan was a concern to the team. Secondly, whist senior managers were aware of their responsibilities in major incident management they expressed concern that the lack of overall capacity within the service at present

1. https://www.collegeofparamedics.co.uk/COP/Professional_development/Intubation_Consensus_Statement_/COP/ProfessionalDevelopment/Intubation_Consensus_Statement_.aspx?hkey=5c999b6b-274b-42d3-8dbc-651c367c0493

was progressively degrading their ability to effectively manage a major incident scenario. It was also felt that the time period between the requirements to participate in a command role in a live exercise was too long and would further exacerbate skill degradation. The review team also felt It would be prudent to review and refresh existing policies and procedures to ensure they remain fit for purpose and contain the learning and recommendations from recent high-profile inquests and public inquiries accepting the inevitable restrictions that exist when operating within the Island environment.

M. The review team were not assured that there were comprehensive **business continuity plans** in place across the organisation. In particular we were not assured that robust plans exist for responding to a failure of the CAD system, telephony or a partial or complete loss of the CCR. Staff were not familiar with back up procedures such as reverting to paper operations etc. These systems need to be reviewed along with staff familiarisation and training associated with enacting them in the event of failure.

N. Consideration should be given to reviewing the **estate provision** for the service as the existing HQ site is of poor quality and lacks the space for further development. It is also likely that, should additional resources be required as a result of a DCR, the existing building will not be large enough to accommodate those resources.

O. **Workforce policies and procedures** are led and coordinated by a central People and Corporate Services directorate for the Government. There were some concerns expressed both from the ambulance service and from that directorate, about how effectively this is working in some regards, in supporting a relatively small service. It is fair to say that some of the systems being set up have been hampered by the pandemic however it would be worth paying attention to how this relationship progresses. The responsiveness in relation to recruitment has caused problems, the appraisal system 'My conversation – My goals' has not seemed to go well, and there were mixed reports about support services such as Occupational Health and access to counselling. Some of this may be due to the lack of maturity of the Business Partner model, with both partners needing to be more proactive in their engagement.

P. **Workforce planning** has tended to be based more on budget available than need and the aforementioned DCR should provide the necessary rationale for planning in the future, along with more stringent monitoring of turnover, retention and absence data via the data bank being established in the People Directorate.

Q. **Other workforce issues** that need addressing through engagement with the People Directorate include the need for formalised rest break arrangements within the organisation for operational staff. The service plans to introduce an interim system in Jan/Feb 2022 with a view to formalising a permanent system once the DCR has modelled possible scenarios. Best practice from the UK in this area will be factored into the design of any final arrangements. In addition, there is a need for the introduction of a safeguarding policy and guidance with regard to working arrangements for close relatives in the organisation.

R. The service would greatly benefit from a formal **mentoring system** for selected senior managers within the service, to provide appropriate challenge and support to enhance their leadership skills through personal and professional development.

Finance

As indicated earlier, this review was not specifically asked to look at the service's finances as part of the original remit as it was not felt to be necessary at that time. A short time before the review commenced the sponsor contacted us and requested that the team review the financial position to determine, in high level terms, whether the service was currently funded in a sustainable manner.

At the time of the visit in September 2021, the service was anticipating an overspend of some £180k on a budget of £4.8m. As we complete the report in December, the actual deficit is in excess of £300k, and the anticipated year end outturn will be a deficit of £421k.

The JHA confirmed that it would have to find savings in other areas of the overall JHA budget to cover the overspend.

During the visit the team discussed the current financial position and the drivers for the current overspends with both the service's management team and finance representatives from the JHA.

During those discussions we learned that in the transfer of budgets from the HCS to the JHA, a sum of £150k had been held back by the HCS for reasons which are not entirely clear but were reported to be due to a requirement for further efficiencies within the service. This had left an initial shortfall in the budget and attempts by the JHA to secure this funding have not been successful and it was now felt that this issue would not be resolved going forward.

The current overspends anticipated at year end lay predominantly in the following areas.

Ambulance & Transport	**Circa £39K**
Frontline Services	**Circa £330k**
Control	**Circa £99k**
PTS	**Circa £1k**
Fleet	**Circa £22k**

Underspends in other areas of the service reduce the overall anticipated year end deficit to £421K.

The drivers for these deficits were described as follows:

- **The impact of the shortfall in funding of £150k when budgets were transferred from the HCS to JHA.**
- **Inadequate front-line capacity requiring the ongoing use of agency staff and overtime.**
- **Additional unfunded costs associated with the COVID-19 pandemic response.**

- **Increasing costs of consumables.**
- **Additional consultancy costs.**

By far and away the biggest costs in all ambulance services are driven by staffing costs, and indeed the situation is no different in Jersey where almost all the overspend is in the provision of front-line services in terms of staffing and fleet.

We heard different views on how capable the service was at making savings through efficiencies and in operating within an austerity setting. There were some views within the JHA and HCS that more should be done to achieve efficiencies, and that the default position for the ambulance service was that more funding was always sought, rather than seeking innovative ways to make more efficiencies.

We heard from the ambulance service senior team that they felt that they had made efficiencies where they could but, given the size of the deficits, the only way in which further significant savings could be made would be by reducing the levels of service being provided and reducing headcount. They felt that this would be unacceptable politically and would place patients at risk, due to longer response times and an inability to service the incoming workload.

In discussion with JHA finance representatives it was clear that there was some acceptance that the current budget was not sufficient to prevent a recurring overspend and that there were limited areas left to secure efficiencies. They also agreed that reducing staffing was not an acceptable way forward.

We also learned that at present the provisional budget for next year was essentially a roll-over of the existing budget with an incremental inflationary uplift. This was to be augmented by an additional non-recurrent £100k earmarked for a project to explore the potential to introduce specialist paramedics. When pushed there was an acceptance that if the recurrent budget was not re-visited then the outcome for next year would inevitably be another sizeable overspend by year end.

The view of the review team is that the service is not currently funded in a sustainable manner and will continue to generate yearly overspends requiring a bail out from other underspends within the JHA. Whilst there are of course always further efficiencies to be made we concur with the view that the only way in which the current deficits could be overcome would be to make significant reductions in the headcount and therefore reduce the levels of service being provided which would lead to unacceptable delays in reaching patients.

Given that the majority of the overspends are being generated by the need to increase capacity it is imperative that the service conducts a formal, independently conducted, Demand and Capacity Review. This would ensure that all opportunities for further operational efficiencies were explored as well as determining the correct level of resource required to service the workload now and into the future.

Once this work has been completed and the most efficient operating model has been introduced the recurrent budget needs to be revisited and corrected to reflect the required staffing. The JHA should then hold the service to account in the normal manner for delivering a balanced budget going forward.

1.0 Safety

How effective are measures in place to protect staff and public from abuse and avoidable harm?

1.1 Safeguarding

The lead for safeguarding for adults and children sits within the area of responsibility for the Senior Ambulance Officer (SAO) for Clinical Governance and Risk. SoJAS takes guidance from Health and Community Services (HCS) safeguarding partnership board.

Safeguarding training is provided in relation to protection of children and vulnerable adults. All staff are expected to undertake level 1 training, and frontline staff undertake level 2, with technicians and paramedics doing Level 3. From the data provided prior to the review on site, it is stated as 'unknown' how many staff have actually completed this training over the past three years. We were told that statutory and mandatory training has been taking place however the records have not been updated – a probable consequence of the clinical tutor regularly having to provide frontline response due to capacity issues. This needs to be checked and appropriate records maintained to monitor these requirements on an ongoing basis.

The clinical tutor attends the AACE National Ambulance Safeguarding leads meetings and feeds information and updates into the SoJAS clinical governance meetings. The SAO sits on a number of groups within the HCS structures, where safeguarding is discussed and monitored. SoJAS has not been involved in any serious case reviews for safeguarding in the past year.

It is inevitable with a small service on an island with a small population that inter-relationships within organisations potentially occur. This was raised as a matter causing concern for staff on a number of occasions, but whilst the senior management team acknowledged there is potential for this to cause issues, they did not believe this had any detrimental impact on patient care.

It is the view of the panel that as the likelihood of this issue within the service is increased, the organisation should consider developing a policy on close personal relationships in the working environment. This we feel is very important in the area of potential risk with child and adult safeguarding.

1.2 Infection Prevention and Control

The COVID-19 pandemic has brought the need for diligent IPC practice to the fore in all settings, but especially healthcare. SoJAS has been able to link in with the AACE IPC Leads group throughout, as guidance and information - which changed frequently as knowledge of the virus grew - was updated and disseminated from public health experts and advisors to the UK Government. Many steps were taken by SoJAS to ensure the safety of staff and patients, in accordance with COVID IPC guidance.

In some respects, this was made easier by the relatively small size of the organisation – for example being able to rapidly fit test staff for changing models of FFP3 masks, and the ability to control footfall through the ambulance buildings. On the other hand, the small numbers of staffing meant that there was little resilience to cover shifts and allow for redeployment into other roles when absence due to illness or isolation increased significantly, and the ability to relocate staff groups into separate locations was constrained.

We understand there was significant cooperation and collaboration with colleagues in HCS and their IPC lead and emergency department in particular, and in the setting up of 'hot wards', and SoJAS was included in operational and tactical COVID meetings. The service quickly established a business continuity plan, supported by relevant risk assessments, to ensure core functions could be maintained despite the new challenges faced in the pandemic.

There were no shortages or difficulties in obtaining the appropriate PPE, and we were told that twice weekly audits meant that stocks were managed and replenished efficiently. Additional resources were brought in to assist with the increased levels of cleaning required.

Following concerns raised by staff regarding perceived COVID risks in respect of taking uniform home, the service installed washing machines in the ambulance station at HQ and in the alternative station that had been set up to keep staff separated as much as possible.

IPC in general seems to be well managed and considered in normal practice, led by the EPPR & Operational Support Manager, with Level 1 and 2 IPC training provided via 'Virtual college' plus in-house training.

1.3 Equipment Management

The Government of Jersey's Infrastructure, Housing and Environment Department (IHE) are responsible for the maintenance of all ambulance service vehicles through an owned trading company – Jersey Fleet Management (JFM). They are responsible for the maintenance and servicing of the vehicles along with tail lift assessments and servicing. In addition to the vehicles, IHE take responsibility for the maintenance and servicing of key items of ambulance equipment such as trolley beds, carry chairs, Raizer lifting devices, generators and the service's Major Incident and Decontamination structures. All maintenance records are held by IHE. There are a number of other service contracts in place to manage items such as defibrillators, oxygen equipment etc.

An extensive range of equipment was available to staff, with ambulances and the storeroom well stocked. Lifting equipment was available to assist patients from the floor after falls.

Technology systems in SoJAS currently do not provide a link from the CAD to the satellite navigation systems in vehicles. This means that any staff, new or agency, who are unfamiliar with the geography of the island, have to manually enter the address. This can cause some degree of delay in response times.

Resilience arrangements are in place with St John Ambulance and Normandy Rescue for SoJAS to use their vehicles in the event of any extensive or protracted issues with their fleet – and this was invoked during the height of the pandemic to increase resourcing levels.

We understand that all equipment maintenance contracts are currently being reviewed with JHA Business Support, but that despite annual bids for funding to replace key items, funds are limited and usually prohibitive in this respect.

1.4 Safe staffing

We heard, almost without exception, from operational staff and managers, of concerns regarding pressures on operational staffing levels due to increased demand – leading to more interruptions to meal breaks, shift overruns and occasions when no resources are available to send to incidents. Apart from the potential patient safety risks inherent in such pressures, the negative effect that this capacity versus activity gap will increasingly have on the health and wellbeing of staff needs to be recognised. It is also detrimentally affecting the ability to manage the organisation as the small operational management team in place are frequently having to be deployed to attend calls. This inhibits their ability to effectively manage their day-to-day duties and responsibilities for example, undertaking appraisals, keeping records up to date, revising policies and procedures and engaging with HCS.

The service has never undertaken a formal Demand and Capacity Review (DCR), and we understand that there is no sophisticated forecasting capability within the service, or indeed on Island, to undertake the necessary modelling and accurately determine the resources and skill mix required by the ambulance service, both currently and projected forward over the next 3 to 5 years.

International best practice dictates that all ambulance services should regularly conduct such reviews at least every three years to ensure that they have sufficient capacity to meet demand on a sustainable basis. This also needs to ensure that there is sufficient relief capacity to cover all abstractions such as annual leave, sickness and training, and allow for meal breaks.

The overwhelming majority of UK ambulance services use external professional modelling companies to provide this service as the work is complex and often requires the construction of a bespoke simulation model for the service that accurately mimics the way the service responds. This then allows the optimisation of existing resources to deliver the best possible response times together with the identification of efficiencies. Once this is done additional resources can be progressively added to meet agreed response time targets and deliver the required clinical response models, in the most efficient manner.

A formal demand and capacity review looking at the required resources within 999, PTS and the ambulance component of the CCR would deliver the following benefits:

- **A comprehensive review of the current demand profile across all service lines based on CAD Data.**
- **A projection of future demand over the next 3-5 years based on demographic data and the strategic direction of the service and its wider health partners.**
- **An optimisation of existing resources to understand whether they could be used more efficiently.**

- **A review of existing relief capacity to determine whether it is adequate to cover existing and future planned abstractions**
- **Modelling the additional resources required to meet agreed performance targets going forward.**
- **Optimising the temporal and geographical deployment of those resources to include the provision of "Roster Keys", which allow rosters to be developed which accurately match rostering to the demand profile.**
- **A review of current and anticipated skill-mix to optimise patient care and value for money.**
- **A review of the anticipated specialist paramedic role to determine how they might fit within the operating model, the numbers required and their optimal deployment.**
- **A review of overall fleet capacity should this be required.**
- **Sensitivity modelling around a set of agreed scenarios allowing the service to conduct virtual simulations of various types of resource and operational models to determine best fit for the Jersey Care Model.**

It is essential in commissioning such a review that the scope and specification for the review are set out appropriately. Given the lack of experience within the management team in this area we would recommend that external experienced support is sought to help draw up that specification.

The above outputs would be very helpful in determining the optimal operational delivery model for the service together with the resources required to deliver it in a sustainable way going forward. This would also inform the workforce planning and financial requirements of the service going forward enabling the operating budget to be right sized and thereby preventing overspends.

Finally, determining and then achieving the correct capacity for the service will have a positive impact on the health and well-being of the staff and managers and allow the service to develop its true potential in contributing to the wider health strategy and the Jersey Care Model.

The review team therefore strongly recommend that a formal demand and capacity review is commissioned early in 2022.

1.5 Patient records

The service currently uses paper patient care records. The form has not been updated for some time and it was recognised that some improvements could be made, particularly around documentation of mental capacity and recording of end tidal carbon dioxide. Separate forms exist for Recognition of Life Extinct (ROLE), and for patients that are not conveyed to the emergency department. The non-conveyance form is also outdated and not robust enough in terms of clinical governance requirements for patients not being conveyed to hospital.

Paper care records can lead to storage issues and potential difficulties in retrieving a care record as and when required. Reviews and audits of clinical records are also more time-consuming and labour-intensive when dealing with paper records.

There is no policy, procedure or guidance in place for completion of the care records, nor for their storage or retention. We did hear that the paper records were all stored in a locked room with limited storage space. Older Patient Report Forms (PRF) are stored in a separate location - this location requires review as the boxes have become damp, though we understand that a more secure and rigid storage solution is being investigated.

Although a bid had been submitted and agreed for a Jersey Care Records project to develop an electronic patient report form (ePRF) system, we were not assured of any definite timelines for completion of this. Liaison had also taken place between SoJAS with South Western Ambulance Service NHS Trust regarding the potential of using the same ePRF system as them, but this was proving problematical in terms of data storage arrangements. An options paper to move to ePRF has been written and a procurement strategy is being developed. It was unclear whether the whole project would enable the care records to be linked into the wider health digital systems.

With regard to ready access for ambulance clinicians to patient health care records, and to be linked to ambulance care records, currently this is not possible, and it was unclear what plans there are for this in future. Lack of information about a patient may limit treatment and referral options.

1.6 Medicines Management

The service has an extensive range of medicines available, some of which are not included in the JRCALC UK clinical practice guidelines, such as codeine and intranasal diamorphine. We heard that codeine had been introduced at the request of staff for better management of pain, however no reviews or clinical audits of its use had taken place to provide an evidence-based rationale for its introduction. Intranasal diamorphine had been introduced as part of a study and this has been published.

The service follows the HCS Medicines Management policy, Patient Group Directive (PGD) guidance from HCS and medicines guidance from JRCALC. The HCS chief pharmacist is the senior pharmacist for the service.

Appropriate processes and procedures are in place for medicines management and these are audited once a year by HCS Pharmacy as per HCS policy. There have been no incidents of misuse of drugs. It was noted that only the CAO can sign for the replenishment of controlled drug stocks, apparently this is a legal requirement. This could present problems if the CAO is not available for some reason. So it would be beneficial if these arrangements were reviewed to ensure that there is resilience should the CAO not be available.

Lucozade was in stock for patients with hypoglycaemia, however this was due to be withdrawn as it had been recognised that Lucozade is not the most effective treatment for patients with hypoglycaemia and its administration for this purpose is not in line with JRCALC guidance. We heard that dextrose 40% gel will be introduced soon.

1.7 Serious Incident Reporting and Learning

The service uses the DATIX incident and risk management system administered centrally by the HCS governance team. Incidents requiring investigation are allocated to one of the senior managers by the HCS team, and follow-up is monitored by them. We were told that there have been no Serious Incidents for SoJAS to investigate in the last eight years. This is somewhat surprising in view of the fact that circa 40% of patients are non-conveyed. Where this level of non-conveyance is seen in other ambulance services, it is not unusual to see incidents arising. This may be an area that requires more scrutiny and audit.

The corporate risk register is also held on the DATIX system and added to the JHA risk register. At the time of the review there were eleven organisational risks being addressed by SoJAS. Four of these were graded as red /high risk. Three of those relate to operational performance and the ability to provide appropriate and timely responses to patients. Potential mitigation identified relies on the introduction of a new clinical response model, in line with the ARP model introduced in 2017 by the English ambulance services; and the need for alternative care pathways in the community setting and skill-sets that facilitate 'See and Treat and Refer' responses. The service has recently recruited an Advanced Paramedic Manager, which is a first step in the introduction of more appropriate responses for Category C calls. The request for the recruitment of specialist paramedic roles, which would increase these skill-sets, has however been turned down. As discussed earlier in the report, such roles need to be considered within the wider long-term strategy for healthcare provision so that they are used appropriately and efficiently in improving patient care.

Constraints to the resolution of these risks to performance were highlighted as:

- **Insufficient resources to regularly collate and analyse data.**
- **Patient outcome data is not collected or analysed.**
- **In terms of patient safety outcome being linked to response times, there is no current collection of data or method for determining the links.**

The other red / high risk relates to monthly fire alarm testing not being carried out, which should be easily resolved and needs addressing as a matter of urgency.

Although there are processes in place for any shared learning identified through the DATIX system to be disseminated from the HCS team, and learning is passed down to LAPs to brief staff, the extent of proactive thematic review and analysis taking place internally in SoJAS of incidents and complaints is unclear – maybe because there are few of them and the system is not 'owned' by the service. SoJAS does however have a formal reflective practice process in place for clinical staff which is beneficial. There is also the opportunity for learning from other ambulance services through the AACE Islands network and other national director groups and we would encourage SoJAS to participate in these where capacity allows.

2.0 Effectiveness

What evidence is there that the care and treatment given to patients result in the best possible outcomes and promote a good quality of life?

2.1 Evidence-based care and treatment

The clinical staff use the UK JRCALC clinical practice guidelines to guide their practice. The service does not however purchase the licence for access to the guidelines and staff have to choose whether to pay for subscription fees themselves to enable access. It was not known how many staff have ready access to the guidelines, therefore it was unclear if all staff were routinely following the guidance to support their clinical practice. We heard that some staff may refer to the large, and now out of date, JRCALC reference book and associated pocketbook, as well as to their PGDs. This is a concern, as it is vital that staff are using the most current and latest guidance, which is routinely updated on the JRCALC App. Consideration should therefore be given to purchasing licenses for all SoJAS frontline staff to have access to the App, either on their own personal devices or on a device which the service ultimately provides.

The organisation is not very research active, does not have any research active paramedics and we did not hear of any staff being involved in any planned clinical audits.

We were informed that a study had been conducted concluding the benefits of using intranasal diamorphine for pain relief in children and this is now used under a PGD. The project won a clinical award at national level.

Clinical staff are trained to take prehospital blood samples if required. This has been standard practice for a number of years if a cannula is being sited. It was noted that there had been concerns regarding accurate labelling and the URN number being recorded on the bottles, but that there are no current plans to review this practice. It is not clear where the evidence lies that this practice is beneficial to the patient, and taking bloods prehospital is not in common practice in other parts of the UK.

The skill of intubation had been withdrawn by SoJAS at the start of the COVID-19 pandemic. A subsequent staff survey strongly supported the re-introduction of this skill with a plan to re-train staff by using a simulation mannequin. The reasoning given was that paramedics in Jersey are not supported by specialist response or critical care teams as seen in other parts of the UK. There was recognition of the challenges in maintaining competencies in this skill, however an anaesthetic critical care lead had been approached to provide support for re-training. The decision whether to re-introduce intubation did not seem to have been made yet and it was unclear if this was to be reviewed and decided by the clinical governance committee. Also, there was no clear plan of how to demonstrate that all staff are appropriately re-trained and deemed competent. We would strongly recommend that re-introduction should be in line with the College of Paramedics intubation consensus statement if the decision is to proceed with this.

2.2 Patient assessment

Patients who dial 999 are routinely triaged using AMPDS to ascertain a final determinant and what priority level their response from the ambulance service should be.

In the last few months, a clinical dashboard has been developed enabling the monitoring of clinical performance indicators. Details of each cardiac arrest are captured so that analysis can be done on aspects of resuscitation and outcomes. The hospital outcome of any cardiac arrest that has been conveyed to the emergency department is currently not part of the dashboard, but there are plans to include this in future which will be helpful. Care bundles for a range of conditions have been reviewed for a number of years and the dashboard demonstrates that the standard of care in these of these bundles was high. A suggestion discussed was to also collect information around non-conveyed patients, length of time spent on scene, and if the patient was referred to other services.

Staff are unable to review their own individual clinical performance on the dashboard but this is a development in progress and will link with new Clinical Audit Review (CAR) process planned to start soon. Currently one in ten patient care records are routinely reviewed. Areas of poor documentation or any concerns about the clinical care provided are addressed with the member of staff concerned. This has led to improvements in clinical documentation and accuracy of clinical records.

The quality of documentation for patient assessment, within the care records, had been reviewed and points noted for learning. Bespoke sessions had subsequently been developed and delivered to staff, supported by the medical director. The 'medical model' of documentation had been covered and noticeable improvements in care records had since been observed by re-audit of forms.

Clinical staff have previously received training in wound management, such as being able to apply steri-strips and glue. The clinical tutor is trying to access courses so that staff can maintain these skills but there is a suggestion that they would have to do this in their own time as it is not currently planned in the training schedule. Referral pathways to district nurses for wounds are in place. We would recommend that a review of wound care skills and refresher training is undertaken, to ensure that the care of wounds is effective and appropriate.

2.3 Patient outcomes

We noted rates of non-conveyance to ED were around 40 %, which is similar to rates in services in the rest of the UK. It is well recognised that this is an area that carries patient safety risks and relies on good clinical decision-making, however in SoJAS these cases are not proactively reviewed or audited at present. That said, we explored types of incidents or complaints around non-conveyance and no SIs had been reported nor major concerns noted. We would suggest that reviews of rates and clinical practices and decision-making for non-conveyance to ED are conducted on a regular basis. This may identify opportunities for the development of new clinical pathways towards ensuring patients can be cared for closer to home, avoiding admission and wherever possible meeting the wishes of patients. This is particularly important for patients that may be nearing end of life, or patients already deemed to need palliative care.

2.4 Training

A very busy and tight schedule of training was described to us, with an excel sheet showing the timelines for required training and completion days per member of staff. It was noted that some training records are out of date but this had been recognised and was being addressed. The clinical tutor recognised that training records are currently very paper based (this includes the process for the PGDs). It was recognised that this should be improved and ideally converted to an electronic system.

Most weeks are booked with various courses and any ad hoc training as required in addition. The service has one clinical tutor and three mentors. Resilience within the training provision was seen as a concern, for example if the tutor was off work or responding to calls due to demand pressures, and there is also a need for succession planning in this regard.

It was felt that there is a need for more training to be able to better manage and provide optimum care for patients that present with mental health problems and wherever possible avoid conveyance to ED.

Concerns were expressed that when SoJAS moved from HCS to JHA many contacts and connections into the wider health training courses were lost. This has meant having to rebuild links and ask if ambulance staff can 'tag onto' various courses. Examples included resuscitation and safeguarding. This arrangement requires a more robust process for ensuring access to relevant and appropriate courses particularly relating to health and multi-disciplinary training.

2.5 Personal development

Several of the SoJAS managers have attended the Team Jersey half-day sessions and an internal mentorship programme has recently been introduced for aspiring first line supervisors, along with the opportunity to 'act up' into the LAP role – leading to the substantive appointment of two LAPs. This could be developed further to improve clinical supervision and leadership.

Unlike for other healthcare professions on the Island, however, there is a lack of a clear clinical career pathway and development opportunities in place for ambulance clinicians, which is building some frustration among staff. This needs to be addressed so that the service can attract and recruit high-calibre staff and retain a relatively young-in-age, motivated and aspirational workforce. There are many opportunities for clinical development in the ambulance sector, and we would recommend adherence to the College of Paramedics post-registration clinical career framework.[2]

A new process of clinical assurance reviews (CAR) has been developed in SoJAS and is hoped to start soon, although has already had some slippage in implementation. The process will involve the clinical tutor and the advanced paramedic going out on operational shifts with a crew as a third person directly observing clinical practice and undertaking clinical reviews. The process will also involve reviewing and assessing competencies, clinical documentation and safety netting, identifying learning opportunities, communicating with patients, driving, attitudes and behaviour and discussions around appraisal objectives and aspirations for career development.

The CAR process presents a positive opportunity to introduce some regular performance review and individual development plans, for clinical staff at least. This would be welcomed by staff who

2. Post-Reg Career Framework (collegeofparamedics.co.uk)

expressed disappointment over the ineffectiveness of, and inconsistency in, the appraisal process 'My conversations – My goals' administered by the People Directorate and designed to link personal objectives back to Government objectives, which are not necessarily relevant to frontline ambulance staff. Either way, attention to personal development and performance management is often hindered by lack of capacity and dedicated time, and there are concerns that introduction of the CAR process could continue to slip and may be difficult to maintain due to current resourcing pressures. The lack of a reliable and meaningful appraisal process is detrimental to any organisation, and added to the lack of a clear career framework, poses a risk to SoJAS in terms of instilling and demonstrating the values promoted within the Team Jersey vision and values: "Be respectful – Better together – Always improving – Customer focused – We deliver".

2.6 Multi-disciplinary working

We heard many examples of effective multi-disciplinary working. It was noted that the clinical tutor is often called out to attend calls where there is no available crew and this is happening on an increasingly regular basis each week. The tutor did feel that responding helps to maintain individual competence and gives credibility as a trainer. Attending an incident as a single responder clearly does not allow conveyance, so common practice is to quickly muster an available fire officer to go out on the incident to make up a crew and be able to drive the ambulance to enable conveyance of the patient if needed. It was also noted that fire personnel are given a payment of around £100 per year that is in recognition of the need to assist with ambulance calls, but fire staff were noting an increase in these requests for assistance.

SoJAS does not have a dedicated Hazardous Area Response Team (HART) but based on risk assessments, a number of operational staff are trained in additional skills such as Urban Search and Rescue (USAR) and working in water. This training, and the response, is delivered with input from other emergency response agencies. Commander training is undertaken through the National Ambulance Resilience Unit in England and the service also has three National Interagency Liaison Officers (NILO) in-post.

As well as operating the CCR as a combined agency function, joint training for major incidents takes place with fire and police, including live exercises, although these do not happen as regularly as you would see in parts of the mainland due to the lack of resources.

We heard that there are good relationships with GPs, and ambulance clinicians do contact GPs about patients to ensure appropriate safety netting is in place if the patient is not conveyed to ED.

The relationships with the ED and staff are strong and again, operational staff are able to contact the ED for clinical advice. It was noted that the governance around this is that the ED will record who was spoken to and a brief summary of the conversation and any advice or decisions made.

3.0 Care & Compassion

How does the organisation demonstrate values of compassion, kindness, dignity, and respect in the behaviour of its staff?

3.1 Compassionate care

There was, unfortunately, limited ability for the reviewers to engage with patients or patient group representatives, or to observe patient care by riding out with crews in the time available for the review. We did hear though, from those interviewees external to SoJAS, that the service has a very good reputation with the public and overall care and kindness provided is outstanding. Staff that we spoke with demonstrated a passion for their service and strove to provide high standards of care for patients. Overall, patients are treated with dignity and respect, and we didn't hear of any concerns raised during interviews.

We heard that privacy and dignity is always a consideration when procuring new equipment and vehicles, such as the use of privacy glass and the ability to use doors to screen the patient from external view. Blankets are used to maintain patient dignity, screens can be requested at sensitive incidents, and each vehicle is fitted with blinds that are used to maintain privacy. The vehicles have a knock and wait sign on the rear door and relatives/friends may be asked to wait outside while patient assessments are undertaken.

Assessment and review of attitudes, behaviours and demonstration of core service values are important elements of an appraisal system and could also be included in the planned CAR process for clinical staff.

3.2 Feedback – complaints and compliments

At the time of the review, only four written complaints had been received since January 2021, which had been dealt with appropriately. Whilst we were given the impression that the numbers of complaints were increasing, due to delayed responses, there was no evidence of this within the complaints database.

Relative to this, the service has received a large number of compliments and thank you letters, commending staff for the care and treatment given. These include thanks and recognition from hospital staff, which is particularly good to note. For example:

> **"The support that we received from our ambulance colleagues was second to none, we absolutely could not have asked for more. They were dynamic, quick thinking, but above all, compassionate. They were both tenacious in supporting the ward team to resolve unforeseen last-minute issues, at one point even liaising with the fire service – in order to have a contingency plan. We are aware of the pressures that our colleagues in ambulance face, it is a challenging time for all, but in particular, [A and B] were a credit to the organisation, and we would like to wholeheartedly thank them for the kindness that they showed to both the patient and the ward team."** *March 2021*

4.0 Responsiveness

How well is the service able to meet the needs of the population it serves?

4.1 Operational performance

We understand that there are no set targets to achieve regarding operational performance, and no commissioning arrangements regarding expected responses. SoJAS does however benchmark their own performance against UK standards as far as they are compatible. SoJAS currently reports on percentage achievement against a response requirement target of 8 minutes for RED 1, RED 2 calls and 19 minutes for GREEN 1,2 and 3.

The review team was able to look at performance reports and has seen evidence of deterioration in operational performance, both in the data that was sent to us prior to the review and whilst conducting the review on site. These challenges with operational performance closely correlate with the sustained increase in activity levels. They are also indicative of the increasing challenge whereby operational capacity is now often being outstripped by increased demand.

In relation to the non-emergency Patient Transport Service (PTS), this service is also struggling to meet demand based on the current level of capacity, and as a result is also challenged with their outturn performance, in terms of specifically aborted journeys and late attendances. This particular service offering should be fully included in any demand and capacity review.

We were assured that the service is doing what they can to try to minimise the impact on patients in coping with these pressures. Some of the actions taken have involved trying to bolster resourcing with additional overtime from core staff, the use of agency staff, and also more frequently tasking managers to attend calls to reduce waits for patients in the community.

These measures are not sustainable in the longer term and will have an adverse impact on health and wellbeing of the frontline and control room staff. There are already warning signs evident, such as the increased level of sickness absence, which may well be associated with the increase in utilisation. Whilst historically the service has a very low rate of complaints some managers told the panel that these have been on the increase in relation to delays in response, although this did not seem to be reflected in the complaints database, and that the service has also received some recent negative press coverage in relation to the deteriorating performance picture.

Increasing operational pressures are also making the managers role in the organisation more challenging as they are routinely being tasked to respond to calls, inhibiting them in the delivery of their core day-to-day responsibilities. Some of the areas of improvement we have identified within this report could be, in part, due to the capacity squeeze the organisation is feeling. As discussed earlier, this drives a requirement for a demand and capacity review for the organisation to, through evidential data, re-set the operational capacity to meet both current demands and future growth based on what is known about the Island's population demographic.

4.2 Patient needs

SoJAS use the AMPDS triage tool in CCR to undertake initial assessment of the nature of the 999 call and categorise it into priority level (Reds and Greens). This will determine the timeframe within which the service will aim to reach the patient, but in terms of range of response, the vast majority of calls all receive a Double Crewed Ambulance (DCA).

Conveyance rates are approximately 60% of all emergency calls attended. We did not hear of any serious incidents from patients that were not conveyed, but discharging care of patients is an area of clinical risk, and the further development of referral pathways and alternatives to hospital should be expeditated as part of the Jersey Care Model, and as part of the specialist paramedic development if a decision is taken to progress this, to ensure that patients can be cared for at home if those are their wishes and this can be done safely.

During 2020 and the COVID-19 pandemic, many patients were not conveyed to ED through collaborative decision-making with GP's and other parts of the HCS. These pathways and new ones should be further developed, particularly for older patients and those living with frailty.

Currently there are no clinicians in the CCR and therefore no formal provision of ‘hear and treat’ responses. We heard from many operational staff of frustrations regarding some of the types of calls they attend, for whom an emergency ambulance was not the appropriate response, and unnecessarily tied up this resource. This is leading to some ‘stacking’ of calls waiting for an ambulance. There was strong support for development of clinical roles working in a ‘hear and treat’ setting within CCR. Some staff said that they had provided clinical advice to CCR, and on some occasions have rung some patients back to undertake further triage. The processes and governance arrangements for this do not yet exist which exposes a significant risk, and we would therefore recommend that if this kind of support to CCR is to take place, these need to be developed.

All clinical staff are trained on their initial training courses, to recognise patients with complex needs. Such patients may have care plans in place and crews are able to liaise with key workers to ensure care plans are followed.

SoJAS has several strategies in place to help manage the needs of patients with complex needs: alternate pain scales, The Big Word, fax/email for the deaf community, disability cards, language books in frontline vehicles. Some staff are trained in Basic Sign Language skills.

A generic communication tool is being considered that would help overcome communication barriers.

4.3 Mental health

SoJAS are a key partner involved in the management of patients with mental health illness. Capacity and decision making is governed by the Capacity and Self Determination (Jersey) Law 2016 and ambulance clinicians have been trained and use a flowchart to appropriately assess capacity. In addition, they adhere to the JRCALC guidelines for mental health patients and are encouraged to use the Intent Plan Action Protection (IPAP) risk assessment tool.

When crews are presented with a patient in a mental health crisis, they are able to access additional support and assistance from the Community Triage Crisis Team. The team are able to offer advice and can signpost either the patient or the crews to the relevant support teams. They can also attend the incident if appropriate and can facilitate direct referral to mental health inpatient units or outpatient clinics.

SoJAS sit on the Article 36 monitoring group and were involved in the ratification of the "Place of Safety Joint Protocol" in November 2020. The policy details the powers the police have to remove persons in a public place to a place of safety. Requests for ambulance assistance will be triaged by the JCC in accordance with policy and procedures in place.

All frontline and CCR staff and volunteers are required to undertake MAYBO conflict resolution training, although training records are not up to date in this respect to it was not possible to confirm how many have received this in the last 3 years. This training teaches respect, proportionate action and de-escalation techniques to help control and diffuse situations with patients in mental health crisis. The service has plans to upskill staff to MAYBO level 3 which would enable staff to use guiding and seating holding techniques to be implemented in a safe and controlled manner. Whilst the review panel welcome the fact that SoJAS staff are to receive this training it will be important for the organisation to regularly review cases where these additional patient management techniques are deployed. The planned introduction of Clinical Assurance Reviews would be ideally placed to facilitate this.

4.4 Resilience

Emergency preparedness resilience and response (EPRR) for major and mass casualty incidents is led by senior manager with a significant level of SoJAS experience, although this forms only part of their overall responsibilities. The current medical director is included in the major incident plans and we were informed he has completed the appropriate Command course. It is, however, unclear who is the Accountable Emergency Officer (AEO) or Jersey equivalent for the organisation.

There is a resilience forum in place on the island, made up of the emergency services and the critical national infrastructure community. The range of operational procedures in relation to EPRR are to an acceptable standard and the service works closely with SWASFT to ensure that the development and maintenance of such policies and procedures are maintained.

The service has a number of bespoke assets in relation to their preparedness and resilience responsibilities, these include dedicated vehicles to support the core ambulance response to a major incident and specialist equipment, such as decontamination equipment and temporary structures for triage and casualty clearing on scene. It was noted that there is no decontamination capability at the only hospital on the island, which should be viewed as a significant risk to this vital healthcare facility. There is no dedicated HART unit within the service, although a number of staff have received additional training in specialist areas such as USAR, Marauding Fire Arms, and working in water, based on island risk assessments. SoJAS have three trained NILO's in post, but interestingly the Fire and Rescue Service and Police Service do not have any in post within their own organisations so it is not clear who they would liaise with in the event of an incident. There is also no Medical Emergency Response Incident Team (MERIT) based on the island. SoJAS does have formal Memorandum of

Understanding (MOU's) signed with Guernsey St John Emergency Ambulance Service, South Western Ambulance Service NHS Foundation Trust, and Normandy Rescue for their support in the event of major incidents.

We were informed that SoJAS used to lead the hospital major incident group but that arrangement had been brought to an end. There were also some concerns raised that the hospitals own major incident plans needed updating.

Whilst there was a good appreciation of what the major risks and threats were in terms of potential major incidents it felt as though the plans to manage any of those potential incidents were not sufficient enough, accepting the limitations on resources available. The fact that Jersey is an Island with limited opportunity for rapid uptake of mutual aid, it does however, make the need for robust and self-sufficient arrangements to be in place and regularly exercised. An example of this is the fact that Jersey has a commercial airport with commercial flights with up to 180 passengers arriving and departing on a regular basis yet the island does not have a comprehensive and tested mass casualty plan. We were told that for mass casualty incidents GPs would be involved, and there is a review as to whether GPs could be trained to manage P3's.

Commander training is in place and consists of an initial course followed by half day CPD sessions each quarter although it should be noted that we did not see evidence of the latter actually consistently taking place. This is for a number of reasons a significant risk, there is only a small team of commanders and they have multiple responsibilities to deliver as part of their day job and now they are increasingly being asked to respond routinely as the operational pressure increases as activity rises. Due to their overall lack of capacity their capability to manage a major incident effectively could potentially deteriorate. Further to this, the major incident training for frontline staff that was stopped when the service was responding to the impacts of the pandemic needs to be restarted as soon as is practicable.

There is according to some of the people interviewed a considerable disconnect between the staff that work in the CCR and frontline operational staff and managers. Some believe this is creating a risk when it comes to dealing with a critical or major incident. This is an aspect that is often overlooked when conducting major incident exercises. We would recommend that this is reviewed further either internally or by an independent external review in to specifically look at the organisations capacity and capability to effectively manage such an event.

The review team were not assured that there were adequate business continuity plans in place across the organisation. There did not appear to be a business continuity plan in place if the CAD system were to fail. There is a small back-up control room facility in the HQ building, which is some distance away from the CCR, that provides a temporary fall-back system. Testing these fall-back arrangements has happened out of necessity during the pandemic whilst equipment was moved around at Police HQ; and staff are required to switch to a paper-based system on occasions when the CAD and triage system are updated. The staff present during the review however did not seem familiar with this, and a regular schedule of testing needs to be in place to ensure all staff are, and remain, competent in the fall-back situation.

5.0 Leadership & Governance

What assurance is there that the service is well-led, with an open and fair culture, supporting learning, development, and high-quality care?

5.1 Leadership development

Currently most of the formal leadership and development training for managers is provided through existing government supported initiatives such as Team Jersey and the World Class Manager Programme.

The Government's Organisational Development team is also offering a series of 'Espresso' Management Development sessions focused on People, Performance and Customer Experience providing essential training on key topics such as managing performance, induction and probation, 'My Conversation - My Goals', setting objectives, diversity and inclusion and finance and budget management. These will be available to all managers throughout 2021.

A range of views were expressed to us during the review, about the leadership capacity and capability of the ambulance service, which are summarised below:

- **There was universal acknowledgement that the senior managers within the ambulance service were dedicated and professional individuals who worked tirelessly within a constrained environment to do the best they can for staff and patients.**
- **It was recognised that given how small the service was ambulance managers inevitably had to take on several different roles and had complex portfolios to manage.**
- **It was recognised that capacity issues constrained some aspects of management development as managers simply could not be released for long periods of time due to an inability to backfill them.**
- **It was felt that some senior managers would benefit from formal mentoring arrangements designed to encourage challenge and innovative thinking.**
- **Views were expressed that the ambulance service needed to be more innovative in its thinking and more challenging of themselves. It needed to be prepared to do more and take on more of a leadership role in the design and delivery of urgent and emergency care going forward.**
- **Some views were expressed that the service does not cope well with austerity and struggles to lead the way on making efficiencies.**

- **Some views were expressed that senior managers were not as good as they should be at holding more junior managers and staff to account.**
- **Views were expressed concerning a lack of robust clinical leadership of the service in part due to the fact that the current Medical Director has very limited time (4Hrs/week) to devote to the service and appears not to be directly involved in shaping the strategic direction for the service within an overall HCS Strategy.**

Whilst in overall terms it is clear that relevant leadership and development packages are being made available, these may not always be sufficiently relevant to the ambulance service, and progress is constrained due to capacity issues which make it difficult to release staff for development in the numbers or for the duration that might be required.

COVID-19 has added further complications as travel off-Island has been very difficult, requiring virtually all development to be accessed and delivered on Island. In terms of the ambulance service, it restricts access to other UK ambulance services and exposure to different ways of working and thinking. Once the travel restrictions have receded the ability to release managers (capacity allowing) to gain experience by visiting other health settings including other ambulance services should be explored.

The review team concurs with the view that certain senior managers would significantly benefit from having a formal mentor who could provide appropriate challenge and encourage more innovative thinking going forward.

5.2 Vision and strategy

Accepting that SoJAS sits within the JHA, it is particularly disappointing that there is no mention of the ambulance service within the HCS Jersey Care Model, which details the strategy for healthcare provision as “a clinically led model for how health and care services are delivered across all sectors on the island.”

The rationale for moving the ambulance service into JHA in 2019, away from HCS, is not clear, but presumably has been based on the premise of having emergency services in one directorate. How Government departments are structured is a matter for Government, however, whilst being an emergency response service, the ambulance service is primarily a healthcare provider. It is therefore essential that the linkages and engagement between JHA and HCS in this respect, and for SoJAS with the HCS leadership and other health and care providers, are maintained both strategically in terms of planning and integrating services, and on a day-today basis in respect of ensuring high quality patient care and clinical governance arrangements.

What was apparent in our review was the disconnect between SoJAS and HCS, and this is clearly demonstrated in the absence of reference to the ambulance role and contribution in the Jersey Care Model. Although there are good working relationships between frontline staff across sectors, at the strategic level these seem more strained. There is some direct engagement for SoJAS with certain HCS committees and functions, but this does not always seem to be consistent or proactive,

from either direction. If the delivery of the Jersey Care Model is to be successful, there needs to be tangible recognition and incorporation of the contribution and role of the ambulance service as a key access point and healthcare provider.

SoJAS is developing its own strategy for the next five years, seemingly somewhat in isolation, whilst endeavouring to align with the objectives of the Jersey Care Model. It was clear from our interviews however, that HCS have not been able to articulate what they want from the ambulance service, and some of the proposals from SoJAS, such as introducing Specialist Paramedics, whilst with good intent, will only make sense if they are part of the wider aims of HCS.

What happens in other parts of the health and care system, both on a daily basis and in terms of service developments, will impact on the activities and demand on the ambulance provision, and vice versa.

The requirement for residents in Jersey to pay for seeing their GP, and pay more for out of hours GP care, will inevitably affect the number of calls to the ambulance service. We were told that people will ring an ambulance to be taken to ED and treated for free, rather than having to stay at home and call a GP and pay for this service. We heard there is a lot of misuse of ED for lower acuity conditions, and this is reflected in data showing low admission rates compared to other acute hospitals in the UK, and higher numbers of lower acuity patients seen, treated and discharged.

The plan for a hub model, staffed by care navigators 24/7 (HCS24) is a promising development and presents opportunities for the introduction of new care pathways and alternative, more appropriate response models to meet patient needs. We understand the HCS24 function will be to promote self-care; will include telecare and telehealth functions; will consider alternatives to ED; will use pharmacists and social prescribing and will be staffed by clinicians, to include mental health nurses. This would be similar to clinical hubs in ambulance control rooms, or Clinical Assessment Services (CAS) that support the NHS111 and 999 services on the mainland and consideration should be given for this to be coordinated by SoJAS.

Within the Jersey Care Model, the development of intermediate care is being planned. Currently there is very little provision of community rapid response services, re-enablement and discharge services. In terms of community healthcare professionals there is very little advanced care practice, few therapists and no therapy provision at weekends. Once an intermediate care service is established this could potentially respond to some ambulance calls, for example with equipment and expertise to attend and assess patients who have fallen.

It was noted that there is no substantial falls prevention work on the island, with only one physiotherapist that working part-time in this respect. The ability of ambulance clinicians to refer patients after a fall into falls prevention services would be highly beneficial for these patients, and should help to reduce the risk of falls in older adults.

Given the older population on the Island it seems significant that there is no geriatrician and also no neurological rehabilitation services on Island.

We heard that the care sector is struggling to recruit and retain staff and that the majority of care is provided in care home settings as opposed to domiciliary care. Lack of home care provision does lead to increased demand on the ambulance service. We were told there are in-patients that are waiting

around four weeks to be discharged back into the community (at the time of our review numbers were around 20 patients) and that these may not receive an appropriate care package once home. This will again lead to more ambulance calls and is likely to be a contributory factor for the rising demand.

We understand that as part of the Jersey Care Model objectives to transform services to provide care closer to home, there are plans to build a new hospital with reduced bed capacity. This will potentially impact on the ambulance service but it should be recognised that the service can also contribute in many ways to keeping patients out of hospital.

We are aware of proposals to develop a specialist paramedic service on the Island to enable amongst other things the management of more complex patients through a combination of 'Hear and Treat' over the phone within the CCR and 'See and Treat' on scene.

A comprehensive business case is being developed describing the case for change and the potential benefits that could be delivered for both individual patients and the wider Jersey Health System should such a scheme be approved and implemented. An advanced paramedic has been recruited and is leading on the business case development.

The JHA has allocated £100k for next financial year to explore the subject in more detail and potentially pilot an SP programme.

There are a wide range of potential benefits outlined in the draft business case including:

- **Delivery of 'Hear and Treat' within the JCC leading to less ambulance responses and greater signposting of patients to other areas of healthcare.**
- **Delivery of 'See and Treat' on scene leading to less patients being conveyed to ED through a combination of treatment on scene or referral to primary care or other community health services.**
- **Support for Emergency Ambulance Crews from a senior ambulance clinician to improve decision making.**
- **Reduction in the need for additional emergency ambulance capacity by a reduction in overall responses and conveyances to ED.**
- **Improved career progression for existing paramedics.**
- **Improved contribution from SoJAS to community health provision.**

The review team were very impressed by the enthusiasm and intent of the staff involved in developing this concept and particularly by the advanced paramedic who is leading on this initiative. That said, we are of the view that the service needs to think very carefully about the way in which such a scheme might be introduced, the timing of such an initiative and the overall cost effectiveness of investing in these specialist practitioners.

Specialist practitioners in various forms are present in every mainland UK ambulance service but the way in which they are configured and trained, and their scope of practice varies significantly as

services attempt to align them to their individual operating models and their local health systems. In overall terms they do aim to achieve the SoJAS perceived benefits described above but often the context in a busy regional ambulance service will be different to those in Jersey.

What is essential in order for them to be successful and to offer value for money is a clear understanding of how they fit within an overall health system and the contribution they make. The availability of well-developed alternative care pathways is also vital in providing safe suitable alternatives to ED.

As we have mentioned previously in this review at present there is no clearly articulated and agreed role for the ambulance service in the provision of urgent and emergency care within the Jersey Care Model. In addition, the strategic linkages between the ambulance service and the HCS are no longer robust and need to be strengthened. The advanced paramedic working on the business case is making progress here in terms of building relationships, but there is more to be done.

The direction of travel for Jersey is of course to manage patients more appropriately within the community and avoid hospitalisation wherever possible and advanced and specialist ambulance practitioners could have a meaningful role in this, but it is not yet clear what that role would be, what the governance arrangements would be and how they should best be deployed and in what numbers against what caseload.

Another issue is that HCS confirm that the ED has sufficient capacity to cope with current demand, and the HCS DG was clear that ambulance-borne patients are not a particular problem and therefore reducing the ambulance conveyance to ED is currently not a priority. This is a very different context to mainland regional services where it is an absolute priority, not just in terms of alleviating pressures in EDs, but primarily in ensuring patients receive the right care, in the right place, which, in many circumstances, is not necessarily in ED.

SoJAS is conveying only about 60% of its patients to ED at the present time which is a little surprising as this compares well with the best regional mainland services who only achieve this with complex and sophisticated operational models complete with comprehensive senior clinical input and alternative pathways available. This needs to be explored in more detail to understand how this is being achieved in Jersey and how much more can realistically be added to this and what cost.

In summary then the view of the review team is that the decision on whether to introduce an advanced/specialist paramedic model in Jersey needs very careful consideration. It should only be done as part of a long-term strategy designed in collaboration with the wider HCS. The problem it is setting out to achieve must be clearly understood by all and a detailed cost benefit analysis should be carried out to ensure value for money going forward.

The DCR should be used to model various scenarios involving the introduction of such a scheme to understand the potential caseload they could be used to attend, the numbers required and the potential trade off against the requirement for additional core ambulance capacity.

Finally, if a decision is taken to develop such a scheme it would be helpful to explore a rotational employment model whereby these highly skilled paramedics are retained in ambulance employment but rotate out into a variety of community and primary care services. If this is not done there is a very real danger that these staff are recruited to community roles and leave the ambulance service as fast as they are trained. There are many lessons to learn from other services in introducing such roles, so engagement with the wider ambulance community is strongly recommended.

5.3 Assurance and governance arrangements

There can be advantages in being a relatively small organisation, with a lean management structure, but this can also pose challenges in terms of having robust assurance and governance arrangements. SoJAS are endeavouring to instil greater clarity in accountabilities and responsibilities within their new, reduced structures with, inevitably, leadership roles involve 'wearing more than one hat'. This can create difficulties and conflicts in resilience and maintaining clear oversight with internal challenge and scrutiny. In addition, frameworks for assurance, for example in relation to organisational risks, tend to be part of the wider One Government structure and sit at Directorate level which can potentially lead to risks not being 'owned' or given appropriate priority. There is also the conundrum for SoJAS in sitting in one directorate (JHA) but requiring governance and leadership from a clinical perspective from another (HCS). This does not always result in the necessary level of engagement, with regular monitoring and learning discussions, for example in relation to activity, performance (particularly as there are no set standards for this), quality and safety. Again, this relates back to the need for stronger linkages with HCS.

We were told that there are sometimes difficulties in readily accessing policies and procedures due to them being on the Government website. There were also concerns that some of the policies and procedures are simply not relevant or directly appropriate for an ambulance service. It was felt that the ambulance service should have its certain bespoke polices and support, for example in respect of workforce issues, and this may well become more attainable as the 'Business Partner' model is developed in the People directorate.

5.4 Information management

We have highlighted concerns regarding storage of patient records and the need for greater document control, and information governance in general.

The service currently utilises the MIS C3 Control and Dispatch system to manage the process of flagging - allowing specific information, for example about the potential for violence and aggression, to be flagged against a property address. Within the patient master index element of this software warnings and medically significant information can be applied against an individual person. This warning can be colour coded in line with priority and is readily displayed to the Combined Control Officer within the system display as a call is recorded and the information passed to the responding crew.

It was noted that there is no policy or procedure relating to flagging, and due to lack of resources there is no active management or review of warnings either flagged to a specific location or individual, beyond inputting them when received. This poses significant risks in terms of inaccurate or out of date flagging information.

It is recommended that the service undertake a comprehensive review of this process and ensure that it is thoroughly overhauled to include the introduction of the necessary policies and procedures including information governance requirements. Further to this, training and education will need to be delivered to those staff and managers who may need to use such a process as part of their routine duties. A robust review and audit process needs to be adopted as part of this policy, to ensure the process is being applied and managed correctly. Much can be learned from other ambulance services in this regard as such systems are commonplace. To support SoJAS with this particular recommendation, a best practice policy and Standard Operating Procedure (SOP) for flagging have been shared with them.

We heard concerns raised by several people that the Motorola Tetra radios operate on a channel that is open to all crews on duty and messages received and transmitted can be heard by all in the vicinity of a radio call. For example, an alert may go out to ask if any crew is available to attend an incident, potentially including patient identifiable information, and this message can be heard by patients that are being attended to and/or surrounding public if in earshot of a crew member's radio handset. We understand that staff have been issued with earpieces, however it is not clear, from the comments made, whether the use of these has been mandated and they are routinely being used. No patient identifiable information should be conveyed via an open channel radio system. Ideally a closed channel should be used so that radio communications are secure.

We learnt that at the point of 999 call the patients name is not routinely collected by the call-taker, and often this is not possible in any ambulance control room. Every day, however, the LAP reviews each paper care record from the previous day, to enter the patients name into the CAD. This is time-consuming and distracts the LAP from other priorities. It is questionable as to whether this is an appropriate use of a senior clinician's time, particularly as there is no need for the LAP to have access to patient identifiable information of every incident as this is recorded and accessible, if needed, within the patient care record. If there is a need to investigate a particular case, a simpler system would be to search for the record using other data that will be known, such as date, address, time of call. Better still, if the CAD reference or incident number was recorded on the PRF for each job, a search can be made using the CAD number. It would be helpful to review this process to make better use of the LAP's time.

5.5 Organisational culture

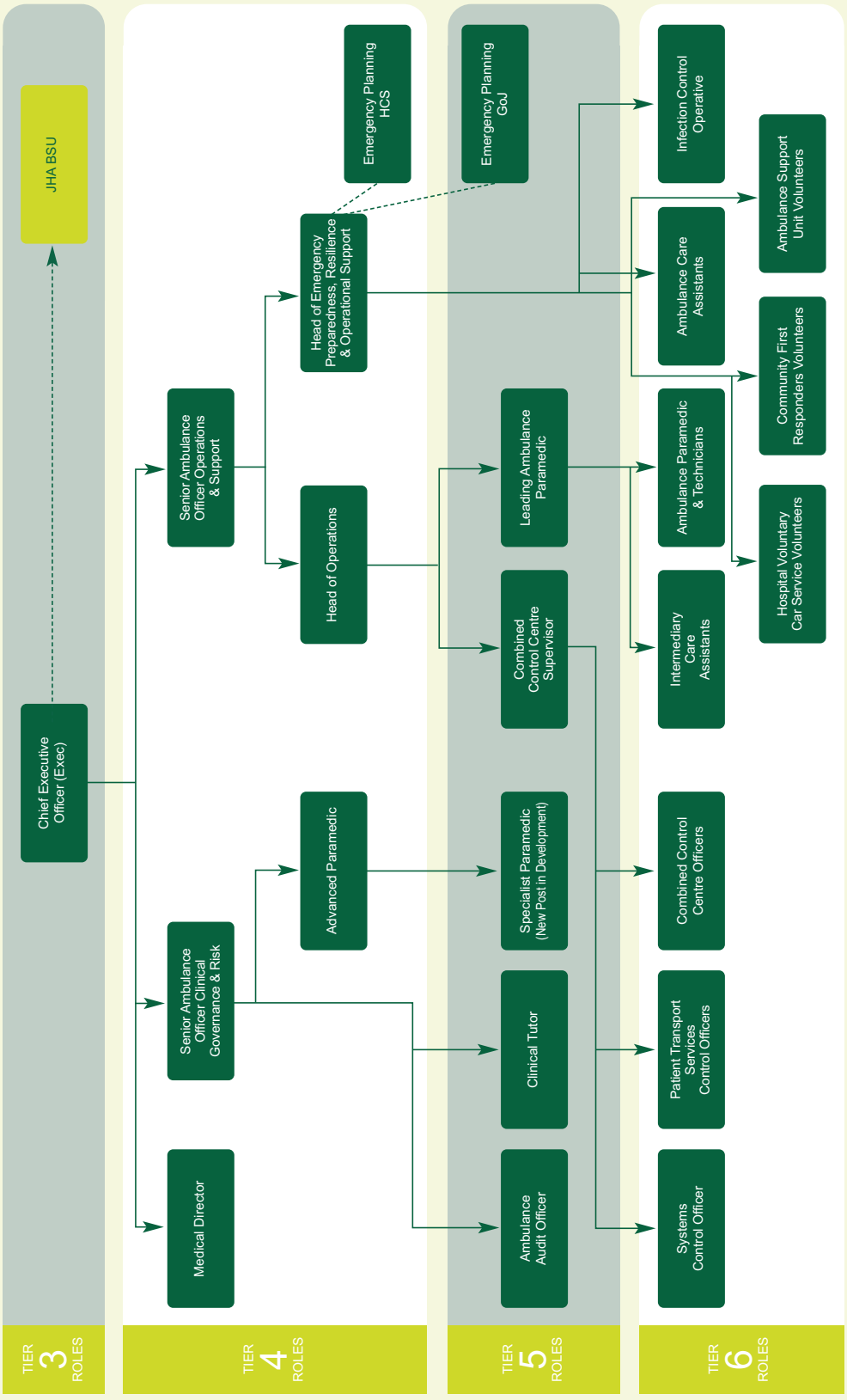
Whilst the majority of staff seemed to be in the main reasonably content in their job with SoJAS the review panel have made the following observations. The main operational ambulance station and headquarters building are clearly showing signs that this facility is no longer fit for purpose to run a modern-day urgent and emergency pre-hospital healthcare operation. The non-emergency Patient Transport Service (PTS) is managed and controlled in isolation from a temporary building adjacent to the main building which is not ideal and the Service should explore ways to fully integrate this part of the business in to mainstream operations.

Managers in the organisation all work in individual small offices across the building and we saw evidence of the closed-door syndrome potentially driving a perception of 'upstairs downstairs' / "them and us" for the frontline staff. It also felt that the senior management team did not feel as cohesive as it should be in a service this size.

Despite this, there were examples of some staff getting involved and being encouraged to contribute to projects and to put forward new ideas. One member of staff had been exploring a new pathway for referral of patients attended due to substance misuse. A survey had been conducted by staff regarding whether to bring back the skill of paramedic intubation after it had been suspended at the start of the Covid pandemic, and a group of staff were involved in setting up wellbeing sessions such as yoga and mindfulness.

Overall, we felt that managers of the organisation need to be more visible and engaged with staff on a much more frequent basis. They need to be more proactive in the management of underlying unresolved issues; be more open and transparent with staff and involve staff more in the future development of the service to give them more of a voice in the decision-making processes that affects their day-to-day roles.

Appendix 1
States of Jersey Ambulance Service



Notes

ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

AACE contact details

For more information please contact:

The Association of Ambulance Chief Executives
25 Farringdon Street
London
EC4A 4AB

0207 118 0977

info@aace.org.uk

www.aace.org.uk

@AACE_org

APRIL 2022