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Developing Ambulance Trusts for the Future – A Review of the Ambulance Trust Configuration in the Avon, Gloucestershire and Wiltshire SHA Area

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1 Executive summary

1.1 Setting the context and background

In March 2005, PricewaterhouseCoopers were commissioned by the Avon, Gloucestershire and Wiltshire Strategic Health Authority (AGW SHA) to undertake an independent assessment of the benefits and risks of three options for the future configuration of Ambulance Trusts within its region. The terms of reference of the review are set out in Appendix 1. The three options were:

- Retention of the existing organisational arrangements (Option 1);
- The creation of an integrated management team across the three organisations (Option 2);
- The establishment of a single new NHS Trust with a distinct divisional structure (Option 3).

The perceived structures under these options are set out in Appendix 2.

The SHA formed a Steering Group in March 2004 to consider performance issues at Wiltshire Ambulance Service NHS Trust (WAST). Subsequent work recognised the benefits of a common approach to service improvement across the three Ambulance Trusts.

This review has not considered whether there are adequate resources for the services to achieve the national performance standards, or what the history of the funding is, or what might happen about funding in the future. This review focused on the suitability of the structures to support the future development of services to patients in line with the Government's objectives which have been defined in a number of policy documents. These have been summarised as:

- To improve their response times for dealing with life threatening emergencies;
- To ensure that ambulance staff are appropriately trained and have the opportunities for further development;
- To ensure that patient outcomes improve; and
- To ensure that the service has good quality management which is able to work towards developing an ambulance service integrated within the health community and that is capable of developing new and innovative ways of working in partnership with other stakeholders.

Key criteria for considering the options in this review are identifying what benefits the different options may bring for patients. From the patient perspective probably the most important issues are as follows:

- There is a rapid response to an emergency call which is dependent on state of the art emergency control and dispatch technology;
- The ambulance paramedic or technician is well trained in best practice in relation to clinical protocols and guidelines;
- Modern and reliable equipment is available;
- The service provided is of good quality and that prompt attendance will result in a potential better clinical outcome for the patient; and
- The Ambulance Trust is using the most appropriate form of response, including the effective triage of calls.

The three trusts are viewed as poorly performing in terms of responding to emergency calls and not fully engaging in the opportunities to make a valuable contribution to service delivery in primary, community and secondary care settings.

1.2 Process of conducting the review

A Steering Group was established for this review with responsibility for direction and key decisions. The members of the group are set out in Appendix 3. The three Ambulance Trust Chief Executives formed a technical sub-group. We provided an outline of the evaluation criteria and proposed weightings on 6 May 2005 (Appendix 5) and a final report identifying the preferred option on 23 May.

We interviewed over 30 key stakeholders in AGW and several Chief Executives from other Ambulance Trusts (Appendix 4). We analysed their views on the three options based on a strengths, weaknesses, threats and opportunities (SWOT) analysis. We also asked stakeholders to consider the relative risks and benefits of each option.

The evaluation criteria were informed by the interviews, our work elsewhere and the views of the Steering Group. The criteria were then grouped into four broad categories with the following weightings:

Evaluation criteria groupings	Weightings
Patient benefit – now	45%
Patient benefit – future	25%
Patient safety	18%
Value for money	12%
Transitional issues	Considered separately

We completed an initial evaluation which was reviewed with a Technical Sub-Group to confirm our understanding of the criteria and to agree the logic of our scoring.

Each criterion was assessed and given a score of one, two or three, and the weightings were then applied. We then tested the evaluation using different weightings (Appendix 6), and considered the potential transitional risks with each of the options (Appendix 7).

We benchmarked the AGW Ambulance Trusts against other merged Ambulance Trusts (Appendix 8). We also contacted the Chief Executives of other merged Ambulance Trusts to ascertain what the benefits and risks were associated with becoming a merged organisation. Contact was also made with a Chief Executive of a highly performing non-merged trust.

1.3 Assessment of options

Patient benefit – now

Of the three options, the single trust (Option 3) provides the greatest benefit to patients as the new organisation will have the critical mass to attract good quality senior management to provide direction and have sufficient resources to focus on the national performance targets and the emerging national agenda for Ambulance Trusts. Under Option 3, good practice can be more effectively shared between the existing three services and the larger organisation provides greater opportunity to use resources flexibly. There would also be capacity to achieve significant service improvements.

In the short term, the benefits will be the introduction of good practice particularly in relation to the deployment of resources, clinical protocols and staff training. In the longer term Option 3 will release resources to be re-invested in service improvements.

Patient benefit - future

Retaining the existing organisations would not provide the patient benefits that are offered by Options 2 and 3.

The existing organisations are endeavouring to address the strategic issues facing Ambulance Trusts but since they have difficulties in meeting the national performance targets, management attention is focused on the targets rather than strategy and plans. Training and development opportunities exist in the current organisations but there would be scope to improve the arrangements if the strategic issues could be more effectively addressed. We concluded that Options 2 or 3 better serve this purpose.

Options 2 and 3 provide greater potential increase in patient benefit as Ambulance Trusts would be able to provide a more appropriate healthcare service ensuring that patients were being treated by the right people, at the right time and in the right setting to the whole population of AGW rather than particular areas. Option 2 and 3 provide more opportunities for resources to be devoted to developing strategies, plans and engaging in more partnership working with the wider health community including local authorities and other agencies. There will also be the opportunity to deploy resources more effectively in the future and this could provide time for staff development around the new skills and competencies required to address the modernisation agenda.

Patient safety

All three Ambulance Trusts are improving their clinical governance arrangements. However each trust felt that more clinical input would be beneficial. Option 3 has the greatest potential to improve clinical governance. There would be the potential for a less fragmented approach to clinical leadership and better accountability with one Medical Director across AGW. This individual would liaise with the three county divisions, promote good practice within the integrated Trust and provide a single point of contact with other AGW healthcare organisations, promoting common protocols such as Patient Group Directives (PGDs).

Value for money

Our financial evaluation of revenue issues has concentrated on savings and costs which are likely to be material, both recurring and non-recurring. We have not evaluated the financial impact of the organisational options on training and operations, including middle management structures, rotas and shift patterns.

Our analysis of the cost base of the three trusts combined and compared to other large trusts indicates the potential for significant opportunities to release resources from the following areas to invest in service improvements for the benefit of patients:

- Board and director costs
- Administration support costs
- HR, IT and Finance functions
- Headquarter estate costs
- Procured spend
- Audit fees
- Fleet maintenance costs

We have undertaken a high level overview of the potential costs and opportunities to release and redeploy resources over the next 10 years under Option 3. The financial summary is intended to provide an assessment of whether the creation of a single integrated Ambulance Trust serving the whole of AGW is a capable of releasing resources that can be reinvested to create additional benefits for patients. From year 1 (2006/07), we have calculated that approximately between £391k and £491k will be available for reinvestment in ambulance trusts, rising to between £819k and £1.2m per annum by year 4 (2009/10).

1.4 Transitional issues

Option 1 has the fewest transitional issues, whereas Option 3 has the greatest risk because of the major changes that would take place. Steps will need to be taken to mitigate risk, and we would advocate a structured approach to risk management during this period, where steps would be taken to assess the impact of risks and likelihood of occurrence.

Whilst transitional issues are extremely important, they need to be seen in the overall context of the benefits to be gained from the change process. Whilst Option 3 identifies significant transitional issues for the new trust, we believe these can be addressed through the use of good project management and should not deter the trusts from pursuing Option 3.

1.5 The preferred option

The detailed evaluation exercise carried out with a broad range of stakeholder involvement supports the choice of Option 3 as the preferred way forward.

1.6 Organisational transition

We have identified a number of workstreams that will have to be developed for the successful implementation of Option 3. These include:

- AGW SHA taking a leading role in project managing the transition;
- The formation of the Trust;
- Appointment of Chairman and Non-Executive members of the Board;
- The appointment of a Chief Executive and Management Team;
- Developing organisational vision for the single Trust;
- Preparing plans and strategies to deliver the vision;
- Reviewing the organisational structure; and
- Consultation and communication with all stakeholders.

The following need to be considered in more detail:

- The transition process needs to be funded and have dedicated support. A change programme such as this cannot succeed without having dedicated project management; and
- It will require effective co-ordination of actions across all key stakeholders, while ensuring that existing operations continue unaffected.

For the changes to have maximum impact, they need to be implemented as soon as possible, recognising legal and recruitment timescales.

1.7 Conclusion and way forward

Option 3 is the preferred option as it will achieve the stated purpose of this review – to recommend an option which will deliver the best service to people in Avon, Gloucestershire and Wiltshire in line with the service framework.

In determining the way forward we recommend that:

- The content of this report should be considered by each organisation;
- There should be consultation involving all stakeholders;
- Once a decision has been made in principle based on internal and external consultation, further detailed legal advice should be sought on the legal process to be followed;
- A Project Board should be established to direct the integration of the three Ambulance Trusts. This Board should encompass senior representation from each of the three Ambulance Trusts;
- Subject to remaining within legal frameworks and NHS Regulations, the SHA should proceed with the appointment of a single Chief Executive to provide leadership for the proposed single Ambulance Trust;

- Once the Chief Executive is appointed, a Project Group needs to be established to direct and drive the change process;
- Specific project management support for the Project Board should be identified and deployed;
- The Project Board should appoint a Project Manager to drive the day to day progress of the integration project; and
- The Project Board should oversee the work of the Project Manager who should produce a detailed project plan, in consultation with the relevant stakeholders, to achieve the integration of the three Ambulance Trusts by April 2006. The project plan must include key milestones and detailed steps and actions required.

1.8 Acknowledgements

We would like to thank all those involved in this review for making time to see us at a very busy time of year. This commitment has enabled us to achieve the very challenging deadlines set for the project.

2 Setting the context

2.1 National context

The NHS is changing to bring about radical improvements in patient care and Ambulance Trusts have an increasingly important role to play in the development of a modern health service.

Since 1974, Ambulance Trusts have been an integral part of the health service, and the Community Care Act (1990) paved the way for ambulance organisations to receive NHS Trust status. Over the last 30 years, the number of Ambulance Trusts has reduced steadily as a result of mergers and amalgamations. Currently there are 31 Ambulance NHS Trusts in England, of which 8 are urban Trusts. There is considerable diversity in terms of size and income. For example, Greater Manchester Ambulance Trust NHS Trust is regarded as one of the biggest Ambulance Trusts in England and has an income of approximately £200 million, whereas Gloucestershire Ambulance Service NHS Trust has an annual income of £14 million in 2004/05.

With the publication of *The NHS Plan (2000)* Ambulance Trusts were given challenging targets to improve their response times. The response times (2005) are summarised below:

- Responding to 75% of ambulance category A (life-threatening) calls within eight minutes or less;
- Responding to 95% of category A calls within 14 minutes in urban areas or 19 minutes in rural areas;
- Responding to non-life threatening (Category B) calls within 14 minutes in urban areas or 19 minutes in rural areas;
- Ensuring GP urgent calls arrive at hospital within 15 minutes of the time stipulated by the GP;
- Thrombolysis (clot busting drugs) should be delivered within 60 minutes of the call for help. In 2003 - 04 48% of patients were treated within this time, the target is to increase by 10% each year. [1]

Despite the work that is being done to achieve these targets, the demands placed upon Ambulance Trusts are ever increasing:

> *"The latest figures for 2003-4 show an increase on the previous year of eight per cent in the number of calls made with a seven per cent increase in incidents attended."*[2]

> *"Pressures to meet rising demand for emergency services have been intensifying creating a consistent and increasing pressure to modernise Ambulance Trusts."*[3]

To tackle the increasing demands on Ambulance Trusts, there is a need for further improvements in performance management and models of service delivery. A national review of ambulance policy and strategic direction for ambulance services is currently being conducted for the Department of Health by Peter Bradley (Chief Executive of the London Ambulance Trust and National Ambulance Advisor) and will be presented to the Department of Health in July 2005. We understand that this will include:

- **Improving integration with the wider NHS** – The ambulance service will be building on the work it has done to integrate with other unscheduled care providers, particularly GP Out of Hours (OoH) providers. The document *Driving Change* refers to a 'whole systems' approach to planning and commissioning Ambulance Trusts, within integration not just with the NHS, but also within the context of the wider community.

[1] Department of Health Policy & Guidance Ambulances (2005)

[2] Transforming Emergency Care in England (2004)

[3] Driving Change (2004)

- **Future role of Ambulance Trusts personnel** - There will be more opportunities for career progression and development of ambulance staff, for instance placing Emergency Care Practitioners (ECPs) in Control Rooms or GP surgeries. There will be an impetus to provide more 'on scene diagnosis' which will place a skills demand on the paramedic staff with a need to train more ECPs. These changes will require an increase in staff education and training, providing more opportunities for Continuous Personal Development or providing more coaching and mentoring programmes.

- **Clinical indicators & outcome measures** - Developing more clinical indicators and outcome measures to assure quality of care will place a demand on Clinical Teams and Information Analysts to provide data on the quality of care patients are receiving.

2.2 Local context

In March 2004 a Project Board was formed in response to performance issues at the Wiltshire Ambulance Service NHS Trust (WAST). The Board consisted of an appointed project manager, representation from WAST Ambulance Trust, lead Primary Care Trusts (PCTs) in AGW and external advisors. The board prepared a report which detailed the framework for improving unscheduled emergency care which provided the strategic direction for the whole of AGW. This would lead to improved ways of working and ultimately providing a service that would more appropriately meet patient and health care system needs. In August 2004 building on work which had been carried out by the project board earlier in the year, management consultants were commissioned to undertake a desk top review of three organisational options to deliver service improvements in ambulance services in Wiltshire. The options were as follows:

- Stand alone (with service development to implement a new model of care);
- Integration with a PCT; and
- Integration with other Ambulance Trusts.

The review of these options was based on four criteria:

- Organisational viability and sustainability;
- Management capacity;
- Deliverability; and
- Strategic fit.

The review recommended that integration offers the greatest opportunity for developing ambulance services in Wiltshire and that a merger with another Ambulance Trust offered more potential for the transfer of expertise and integration of technology. However, the report did recommend that a wider understanding of the stakeholder perspective be developed which would encompass Avon and Gloucestershire Ambulance Trusts, especially with regard to the impact that any potential mergers could have on these organisations.

In November 2004 a paper was presented to the AGW SHA Board by the Director of Corporate Affairs recommending that a common approach to ambulance service improvement be adopted across AGW.

As a separate exercise, Adrian Lucas, Head of the Scottish Ambulance Trust conducted an independent review of Ambulance Trusts in AGW. This review concluded that though there were significant strengths within each trust, there were also challenges which were hindering their current and/or future performance. Common themes emerging from the review were the need for:

- Improved commissioning arrangements;
- Retaining local identities for Ambulance Trusts;
- Clarification about why a merger was needed and what would be the long term benefits for patients; and
- An early decision about the long term vision for the service.

The Chief Executives of the three Ambulance Trusts produced a report in January 2005 detailing their findings in respect of two potential options for the future delivery of ambulance services in AGW:

- The creation of an integrated management team accountable to the three organisations; and
- A single organisation with a distinct geographical or divisional structure.

This report and the others which have preceded it have formed the background for this independent assessment of the benefits and risks of three options for the future configuration of Ambulance Trusts in AGW SHA:

- Retention of the existing organisational arrangements;
- The creation of an integrated management team across the three organisations; and
- The establishment of a single new NHS Trust with a distinct divisional structure.

The existing structure (Option 1) together with possible organisational structures for Options 2 and 3 are set out in Appendix 2.

3 Background

This section contains a brief description of the three Ambulance Trusts within AGW and some of the key issues that are currently being addressed locally.

3.1 Overview

Despite being predominantly rural in character, Avon, Gloucestershire and Wiltshire cover a large and complex geographical area situated in South West England, with a mixture of urban and rural communities covering a land area of 3,000 sq. miles and a resident population of approximately 2.2 million. The area also receives over 7 million visitors a year[4].

AGW, on the whole, is economically prosperous although there are some deprived areas. Residents in these deprived areas are likely to suffer from reduced life expectancy, increased child poverty, poor health, poor housing, unemployment, low income and low educational attainment.

3.1.1 Avon

The former county of Avon is now divided into four unitary authorities: Bristol, Bath & North East Somerset, North Somerset and South Gloucestershire. The area is bordered by the Bristol Channel to the west and the counties of Gloucestershire, Wiltshire and Somerset to the north, east and south respectively.

Avon is an area of considerable diversity. Population profile is illustrated in the table below:

Population	%	Number	Density (no. for people per hectare)	0-14	14-74	75 plus	Average Age
City of Bristol	39%	381,618	34.72	19.1%	73.3%	7.6%	37.19
South Gloucestershire	25%	246,273	4.94	20.8%	72.9%	6.3%	38.13
North Somerset	19%	189,492	5.04	19.0%	71.2%	9.9%	41.53
Bath & NE. Somerset	17%	169,560	4.89	18.2%	72.9%	8.9%	39.94
Total sub-region	100%	986,943		19.3%	72.6%	8.2%	39.20

(Source: ONS 2002 projection and 2001 Census)

The City of Bristol, with the largest population in Avon, is the regional capital for the West but offers easy access to other parts of the UK. It also has the second strongest economy in England outside of London when measured by GDP per head. The projection shows that in the next year, only a small increase in population is expected.

Bath & North East Somerset runs from the outskirts of Bristol, south into the Mendips and east to the Southern Cotswolds and Wiltshire border. Two thirds of the area is green belt with some of the most significant historical treasures found anywhere in Europe. Approximately half the population lives in the City of Bath.

North Somerset extends from the edge of Bristol and the River Avon to the North, to the river Axe and the Mendip Hills in the south and covers a mixture of rural and urban areas. A third of its population lives in Weston-Super-Mare. North Somerset is an increasingly attractive place to live and work.

South Gloucestershire is an area of diversity and contrast with a variety of communities, attractive landscape combining fine unspoilt towns and villages with major areas of new residential, industrial and commercial development. The area stretches from the River Severn in the west to the Cotswolds in the

[4] Source: South & West Tourism Statistics 2003

east. Its southern boundary skirts Bristol, abuts the River Avon and extends almost to Bath, and its northerly boundary lies beyond Falfield on the A38. It is the fastest-growing area in the South West.

This sub-region is the South West's principal economic driver, a key wealth generator and a leading centre for business, culture and learning. It is among the largest employment bases in financial services in the UK outside London and is home to the national HQ of 160 major companies. Key business sectors in this sub-region include aerospace and defence, printing and packaging, financial services, electronics and electrical engineering, and creative industries.

3.1.2 Gloucestershire

Gloucestershire County is situated at the northern edge of the south west region of the UK. Geographically, Gloucestershire County splits into three areas, the Cotswolds, the Royal Forest of Dean and the Severn Vale. Gloucester and Cheltenham lie at the heart of the county, linked by the A40 and either side of the M5. There are good highway links to rest of the country.

The county is best known for farming, forestry and horticulture with an industrial history featuring the wool trade. Key economic indicators show that unemployment is low and economic performance is around the UK average. Deprived areas are mainly located in Gloucester and Cheltenham.

The county has a population just over 560, 000 and is expecting its population to grow by 3-12% by 2026, with greatest projected increase in Gloucester and Tewkesbury incorporating planned houses to be built. However, the trend shows that a growth in elderly population is also expected in the next 20 years while the number of children is projected to decline. This will have an impact on future public sector provision.

Population	Density (no. for people per hectare)	0-14	14-74	75 plus	Average Age
Gloucestershire	2.13	19.7%	71.7%	8.6%	39.27

3.1.3 Wiltshire & Swindon

The former County of Wiltshire is now divided into Wiltshire County and Swindon Borough. The area is a predominantly rural. Wiltshire and Swindon has a combined population of 600,000 (Swindon has a population of 190,000). In Wiltshire, half its population lives in towns or villages with fewer than 5,000 people. A quarter of the county's inhabitants live in settlements of fewer than 1,000 people. Bigger concentrations of population can be found in Swindon, Salisbury, Trowbridge, and Wiltshire's many market towns.

Population	Density (no. for people per hectare)	0-14	14-74	75 plus	Average Age
Former County of Wiltshire	1.76	20.6%	72.0%	7.4%	38.66

It is projected that the elderly population (over 80-year-old) within Wiltshire is likely to increase by 20% in the next 10 years. The mortality ratio for the most common causes of death is below national average.

Wiltshire has a rich and unique heritage – inside the county boundaries are the world heritage sites of Stonehenge and Avebury. About three quarters of the land in the county is protected as an area of outstanding natural beauty, special landscape or green belt. Salisbury Plain, the largest remaining expanse of chalk grassland in England, divides the county from north to south.

The unemployment rate in Wiltshire is below the national average. The armed forces have a significant presence, particularly in the south of the county. Swindon has a long history of industrial success, and because of its location, the town is attracting more and more investment. The Borough Council is also planning to build more houses in the next few years.

3.1.4 Health services in AGW

AGW SHA covers the counties of Avon, Gloucestershire and Wiltshire. Within AGW SHA, there are 13 NHS Trusts which include 8 hospital trusts, 3 ambulance trusts and 2 mental health services. There are also 12 primary care trusts which take the leading role in patient care and are responsible for the planning and securing of health services and improving the health of the local population.

The three Ambulance Trusts provide the local population with emergency and urgent ambulance services and patient transport services.

3.2 Avon Ambulance Service NHS Trust (AAST)

Avon Ambulance Service NHS Trust (AAST) was formally established in 1992 and provides emergency ambulance, urgent ambulance and non emergency patient transport services (PTS) to a population of around one million. AAST has 12 ambulance stations covering an area of 520 square miles, including Bristol, Bath, North East Somerset, South Gloucestershire and North Somerset.

(Source: Avon Ambulance Service NHS Trust)

AAST has its HQ in Bristol and employs 494 WTE (whole time equivalent) staff with an income of around £20 million per annum.

Of the 494 WTE staff, 273 are Accident and Emergency (A&E) staff. The emergency service consists of 43 front line ambulances and 12 rapid response vehicles. There is also a first responder scheme, consisting of Royal Air Force volunteers who have been trained by the Trust in emergency aid and advanced driving. AAST undertook over 61,700 emergency journeys in 2003/04. The emergency medical dispatch centre receives emergency calls, dispatches vehicles and provides appropriate first aid advice to callers before the ambulance arrives.

The ambulance service feeds into five main A&E hospitals: Frenchay Hospital, Southmead Hospital and Bristol Royal Infirmary in Bristol, Royal United Hospital in Bath and Weston General Hospital in Weston-Super-Mare. AAST is required to meet Government response time targets for an urban area, but its operational areas covers both densely populated cities and remote rural areas, which makes achieving response times a challenge especially in the remoter parts of North Somerset and South Gloucestershire.

The High Dependency Transfer Service undertakes doctor's urgent admission and inter-hospital transfers. In 2003/04, the HDTS undertook approximately 2,500 urgent admissions, 400 inter-hospital transfers and responded to 3,000 incidents as first responders.

The PTS employs 79 WTE staff and has a modern fleet of 44 multi-purpose vehicles which take non emergency patients who needs transport to access health services. In 2003/04, over 237,800 journeys were provided for patients with restricted mobility and / or special needs.

Having hosted the services in the past, AAST also has a good working relationship locally with NHS Direct Avon, Gloucestershire and Wiltshire (NHS Direct AGW). In the 2004 performance rating, AAST achieved 0 stars, whereas in 2003 they received 1 star. A lot of work has occurred since the 2004 rating was published to address the issues which led to the dip in its performance.

3.3 Gloucestershire Ambulance Service NHS Trust (GAST)

Gloucestershire Ambulance Service NHS Trust (GAST) provides emergency treatment and patient transport services to a population of 560,000 in the county of Gloucestershire. GAST has 10 ambulance stations covering a mainly rural area of 1000 square miles.

(Source: Gloucestershire Ambulance Trust NHS Trust)

GAST, with an income of around £14 million, employs 312 WTE staff. In late 2002 and early 2003, GAST moved its headquarter and control room operations into a tri-service (Fire, Police, Ambulance) shared facility with new IT systems being installed.

GAST has a fleet of 71 vehicles, of which 31 are A&E ambulances. In 2003/04, a total of 165,000 journeys were undertaken, of which 32,000 were emergency, 12,000 were urgent and 121,000 were planned or special.

The ambulance control room receives forwarded emergency calls from the national 999 call centre, dispatches vehicles and provides appropriate advice to callers before the ambulance arrives. The ambulance service feeds into two main A&E hospitals: Cheltenham General Hospital and Gloucestershire Royal Hospital.

Given its geographical coverage, GAST is required to meet Government response time targets for a rural area. However, as the county is divided by the River Severn which only has two bridges, this creates a number of challenges for the service in serving the population of the Forest of Dean to the levels of the national performance targets. In the 2004 performance rating, GAST achieved 2 stars. Since November 2004, GAST has also provided the Out-of-Hours service for the Gloucestershire PCTs.

3.4 Wiltshire Ambulance Service NHS Trust (WAST)

Wiltshire Ambulance Service NHS Trust (WAST) was established in April 1993 and serves the former county of Wiltshire which has a total population of 600,000. WAST, with its headquarter in Chippenham, has 9 ambulance stations covering an area of 1,420 square miles. The area is largely rural, with large and densely populated areas in Salisbury and Swindon. There is a large unpopulated area in the centre of the county (Salisbury Plain) and a number of military establishments in the area.

(Source: Wiltshire Ambulance Trust NHS Trust)

WAST is also responsible for the operation of the Greenways Centre (Southern Ambulance College), an education establishment, which provides ambulance training for staff from services throughout Great Britain.

WAST with an annual income around £10 million is one of the smallest Ambulance Trusts in the country. It employs a total of 302 staff, of which 187 are A&E staff, 31 are PTS staff, 27 are employed in the Control & Planning Centre and 52 work in "fleet" and general support and management. Wiltshire Air Ambulance is a joint project between the Trust and Wiltshire Constabulary and has been in operation for 10 years.

In 2003/04, WAST undertook a total of 164,500 journeys, of which 29,000 were emergency calls, 11,600 were urgent and 123,800 were planned or special. Call taking and dispatch are dealt with by the Control Room located in Devizes. The ambulance service feeds into three main hospitals: Great Western Hospital in Swindon, Royal United Hospital in Bath and Salisbury District Hospital. In the 2004 performance rating, WAST achieved 0 star. The report did show that they achieved the required standard in financial management, but they failed to achieve the targets for performance and Improving Working Lives.

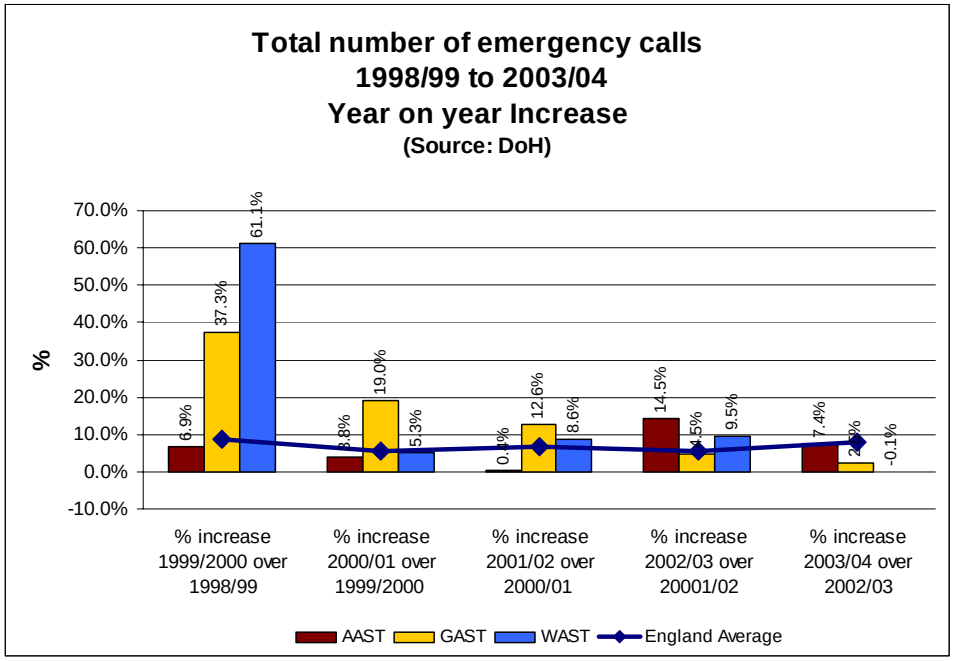
3.5 Key Issues

Over recent years, all three Ambulance Trusts have been subject to a number of internal and external reviews. It has been recognised that all three Trusts have made some progress in terms of service development and performance improvement. However, all three trusts are still facing a number of challenges:

- Managing demand;
- Lack of investment;
- Recruitment and retention;
- Stretched management capacity; and
- Delivering the national targets on response times

3.5.1 Managing demand

The following chart illustrates the volatility of emergency demand in AGW in the last 5 years in comparison with the national average. According to national statistics, the emergency demand is growing at an annual rate around 7% nationally. Increasing local demand has also been highlighted in CHI's 2002 Clinical Governance Review. This has put a strain on all three trusts' resources and capacity.



3.5.2 Lack of investment

In a review conducted in December 2004 by Adrian Lucas, the Chief Executive of Scottish Ambulance Trusts, all three trusts have been commended for their track records of meeting financial targets. However, financial deficit in local PCTs and the whole AGW health economy meant that investment in Ambulance Trusts for foreseeable future is likely to be limited. In addition, service commissioning, particularly in Avon and Wiltshire, is considered to be an area in need of improvement. With constraints on "new" money, the focus will have to be on creating internal efficiencies and re-investing savings in the service.

3.5.3 Recruitment and retention

2002 CHI Clinical Governance Reviews highlighted that all three trusts had a varying degree of difficulties in terms of recruiting and retaining high calibre staff. The workforce plan was not robust and deployment of staff was not fully meeting the service needs. Low morale was also an issue in Avon and Wiltshire and staff felt undervalued. Results of 2004 NHS National Staff Survey confirmed that low morale continued to be an issue among all three trusts.

3.5.4 Stretched management capacity

Having reviewed the current structure of each organisation and roles and responsibilities of individual senior managers, we noted that management capacity within all three trusts is stretched with senior managers having a broad range of responsibilities and covering a number of functional areas. The 2002 CHI Clinical Governance Review identified the lack of strategies and policies in many service and operational areas. Clinical governance function was either not fully developed or compromised, although some actions have been taken, currently none of the three trusts has a full-time medical director.

3.5.5 Delivering the national targets on response times

In 2003/04, GAST was the only Ambulance Trust in AGW which managed to achieve the national targets on response times for Category A (life threatening) calls. Both AAST and WAST failed to achieve these targets with WAST the poorest performer nationally. In 2004/05 AAST concentrated its effort on delivering the Cat A8 target and successfully achieved it. However GAST failed to maintain its performance and WAST continued to fall short of the target. All three trusts have responded to these challenges by developing local projects aimed at service improvement.

4 Process of conducting the review

4.1 Introduction

The review commenced on18 March 2005 following an initial meeting with the Chief Executive and Director of Corporate Affairs of AGW SHA on 15 March to discuss our proposed approach in more detail and to clarify our approach to the review. During the meeting we agreed that we would deliver our work against the following milestones:

- Milestone 1 – Provide a brief paper outlining high level findings by 22 April 2005
- Milestone 2 – Provide an outline view of our evaluation criteria and proposed weightings by 6 May 2005
- Milestone 3 – Provide a final report that identifies a preferred option by 23 May 2005

In the early phases of our work we explored the remit of the proposal and confirmed that we would not look at detailed service level issues. Our review would concentrate on organisational configuration. We clarified this again at a meeting on 15 May and in e-mails to the Director of Corporate Affairs, our key contact at the SHA.

4.2 Stakeholder engagement

A wide range of stakeholders were interviewed to appraise the three options. Those we interviewed were asked to complete a strengths, weaknesses, opportunities and threats (SWOT) analysis for each of the options. We also asked stakeholders to consider the relative risks and benefits of each option.

A range of documentation from the three organisations involved was also considered, along with material produced from earlier investigations by external consultants, and other agencies such as the Commission for Healthcare Audit and Inspection (CHAI). We also spoke with Peter Bradley, Chief Executive of London Ambulance Trust to discuss the National Strategy for Ambulance Trusts.

4.3 Communication

A strong internal project management approach was adopted so that we could achieve the challenging timescales for completion of this review. The project plan provided a key vehicle for week to week liaison with the Director of Corporate Affairs.

A confidential e-mail communications channel for staff of the three organisations involved was established so that they could express views in confidence. This would remain completely confidential and any views expressed would be used in summary to help us inform our findings. The e-mail address was personalised for this project as follows: ambulanceservicereview@uk.pwc.com. The responses to the confidential e-mail were limited; in total 8 e-mails were received.

4.4 Project management

A Steering Group was established to provide the project with direction and guidance. For professional and technical guidance a Technical Sub-Group was formed that comprised the three Ambulance Trust Chief Executives and a former Ambulance Trust Chief Executive who now operates as an independent advisor. A full list of Steering Group members can be found in Appendix 3. The Steering Group met twice for the purposes of this review: on Friday 6 May to agree the weightings that should be applied to the evaluation criteria, and on Monday 23 May to receive the draft final report.

4.5 Gathering of evidence

At our meeting on 15 March we agreed with the SHA Chief Executive and Director of Corporate Affairs of AGW SHA that we should interview a number of key stakeholders. A list of the stakeholder groups interviewed can be found in Appendix 4. Many of those interviewed received a copy of a SWOT Analysis template and were asked to complete the SWOT Analysis with respect to the three options. The completed SWOT Analyses were used as the basis for conducting those interviews. In considering Option 3 we also talked to the Chief Executives of a number of Ambulance Trusts in other regions, including Ambulance Trusts which have experienced mergers.

4.6 Options and evaluation criteria

4.6.1 Options

The project brief asked us to consider three options:

- Option 1 - Retention of the existing organisational arrangements;
- Option 2 - The creation of an integrated management team across the three organisations;
- Option 3 - The establishment of a single new NHS Trust with a distinct divisional structure.

Some of those we interviewed felt that the options were too narrow and that the brief should have included consideration of a wider range of options. Suggestions such as merging two out of the three were made, along with a 'status quo plus' version.

At the meeting of the Steering Group on 6 May we reported that based on our early findings there was little appetite for Option 2 with a polarisation of support for Option 1 and Option 3. Discussion was held with the Steering Group regarding the value in further evaluation of Option 2 and after careful consideration it was agreed that we should continue to review this option.

Similarly, there was also debate around what was meant by Option 1 – effectively the status quo. It was felt by some members of the Steering Group that there should be an evaluation of a 'status quo plus' version meaning that standing still was not an option and that to assess where organisations currently stand will present an unfair bias in favour of the other options. After some debate, it was agreed by the Steering Group that we should continue with our evaluation as set out in the original brief. We would have had considerable difficulty in defining what 'status quo plus' actually means, and suspect that we might have been drawn into a debate on the equity of funding of the Ambulance Trusts in AGW. This debate falls well outside the terms of reference set for our work.

4.6.2 Evaluation criteria

Based on our experience, we developed evaluation criteria incorporating a range of issues. For clarity and ease of understanding we assigned each criterion to one of the four groups, each of which had a weighting applied to it:

Group 1 weighting 25%
• Strategic issues
• Training & Development
Group 2 weighting 40%
• Operational performance
• Access to services
• Organisational efficiency
Group 3 weighting 15%
• Use of resources
• Potential for efficiency savings
• Savings in operational costs
Group 4 weighting 20%
• Corporate & clinical governance

Draft evaluation criteria

We then asked the Steering Group to comment on the evaluation criteria and the sub-criteria within each group. We incorporated the comments received into the revised evaluation criteria.

At the Steering Group meeting on 6 May, the allocated weightings of each criterion were tested (Appendix 5). They were also tested with the Technical Sub-Group at a meeting on 13 May 2005. Following these tests we developed an agreed set of evaluation criteria and baseline weightings.

The agreed evaluation groupings and sub-criteria are shown in Appendix 6 and listed below are the category groupings and their percentage weighting:

EVALUATION CRITERIA GROUPINGS	WEIGHTINGS
Patient Benefit Now	**45%**
Operational Performance	15%
Access to Service	20%
Organisational Efficiency	10%
Patient Benefit Future	**25%**
Strategic Issues	15%
Education, Training and People Development	10%
Patient Safety	**18%**
Clinical Governance	18%
Value for Money	**12%**
Use of Resources	4%
Potential for Efficiency Savings	4%
Savings in Operational Costs	4%
Total	**100%**
Transitional Issues	**100%**

In agreeing the names of the groupings, we reflected the Steering Group's view that patient benefit should be regarded as the primary driver for the review. The relatively low scoring of 'Value for Money' (12% of total score) reflects the fact that the review is not a cost reduction exercise but is regarded as focussed on improving ambulance services in the future for the benefits of patients. At our meeting with the Technical Sub-Group on 13 May it was also stressed that we should ensure that staff benefit is also reflected in some way. We subsequently agreed that the sub-criteria regarding training and development should be broadened to cover education and people development issues.

The other important change recommended by the Steering Group was to group each section into four key areas:

- Patient benefit – now
- Patient benefit – future
- Patient safety
- Value for money

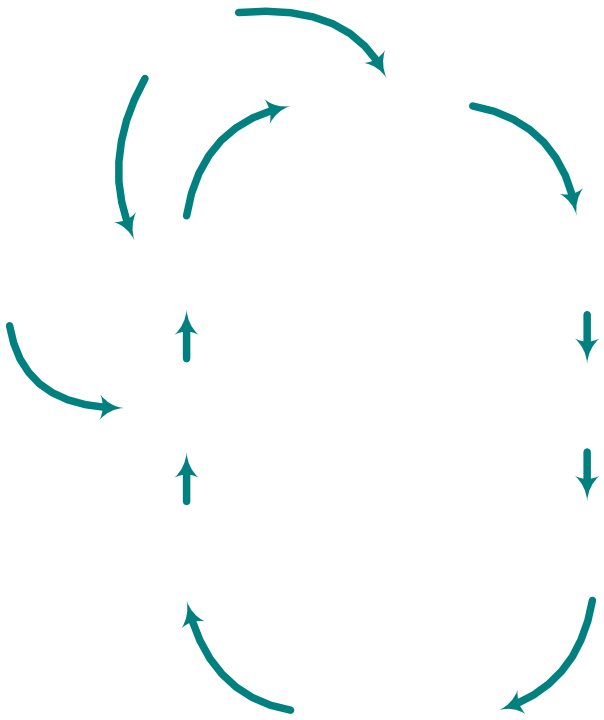
It was also agreed that the weightings should be ordered as follows: 'Patient Benefit – Now' followed by 'Patient Benefit – Future', then 'Patient Safety' and 'Value for Money'. It was also agreed that the weighting of 'Transitional Issues' should be dealt with separately.

All data was then collated together and analysed against each of the evaluation criteria for each option. Each option was scored 1, 2 or 3 and colour coded in a "traffic light system", as follows:

Definition of the Scores	Red 1 point	Yellow 2 points	Green 3 points
Potential	NONE	SOME	SIGNIFICANT
Savings: Reduced Cost; Cost avoidance, Increased Efficiency.	LOW	MEDIUM	HIGH
Sustainability	SHORT TERM	MEDIUM TERM	LONG TERM
SWOT analysis			
Interviews			
Documentation reviews			
National Guidance			
Comparative data / information			

Supporting evidence and information

To further clarify how well each option was performing against the criteria, we used 'The Continuous Service Improvement Wheel' (see the figure below) as a framework to judge the effectiveness each option would have in implementing service delivery. For many of the criteria we considered each option in turn and assessed whether that option would most effectively meet the criteria and satisfactorily supports all the elements of the model. If the option did not achieve this we reflected on what were the barriers preventing this from happening.



On the basis of the above, each sub-criterion was scored as Red (R), Yellow (Y), and Green (G). This scoring was tested with the Independent Advisor who is a member of the technical group.

On 13 May we asked the Technical Sub-Group to undertake an evaluation of the options. From this exercise a high degree of consensus emerged between GAST and WAST as to the scoring, but there was limited agreement from AAST. The overall result was marginal support for Option 3.

We used the findings from that exercise to test our logic and scoring. In some cases we revised our initial findings and made changes to reflect the opinion of the three Chief Executives where we felt that the reason to do so was robust and based on objective opinion. Section 4 displays the traffic light scoring of each of the criteria and the rationale behind that scoring and Appendix 6 tabulates the total scoring of all the criteria. It is this total score which informed the selection of the 'Preferred Option'.

4.7 Sensitivity analysis

Two sensitivity tests were conducted to assess what difference a change in the weightings would have on the final outcome. The 'Baseline' weighting were those percentages as agreed by the Steering Sub-Group. The transitional issues were considered outside of the sensitivity analysis but were incorporated with the sensitivity analysis findings to inform selection of the 'preferred option'. The sensitivity test percentage adjustments are described in the table below:

	Baseline	Test 1	Test 2
Patient benefit – now	45%	25%	30%
Patient benefit - future	25%	25%	20%
Patient Safety	18%	25%	35%
Value for money	12%	25%	15%

4.8 Benchmarking

In Appendix 8 we have displayed benchmarking data which provides comparative information on the three trusts. Where possible, we have used national data to compare AAST, GAST and WAST to other Ambulance Trusts in the UK.

5 Assessment of Options

5.1 Introduction

This section describes the following:

- An understanding of each of the evaluation criteria groups;
- A definition of each of the individual criterion;
- Traffic light scoring for each option and a rationale to support this scoring;
- Conclusion for each group of criteria

The table overleaf presents the evaluation criteria and their groups.

Grouped Evaluation Criteria

EVALUATION CRITERIA GROUPINGS	WEIGHTINGS
Patient Benefit Now	**45%**
Operational Performance	15%
Ability to achieve service improvements	
Capacity and capability to achieve performance targets	
Access to Service	20%
Improves integration with primary and secondary care services	
Enables a seamless service to be developed with common protocols	
Coverage of trust area, staff per '000 population	
Generates equity between communities	
Organisational Efficiency	10%
Ability to deploy resources across the Trusts in a flexible manner in order to match demand	
Ability to be a financially and operationally viable organisation in the long run	
Provides a critical mass to cope with future change and has capacity & capability to grow	
Improves corporate governance arrangements	
Patient Benefit Future	**25%**
Strategic Issues	15%
Consistency with national and local ambulance/NHS Strategies	
Addresses local issues	
Capacity and capability to respond to new market opportunities	
Improved response to commissioning	
Education, Training and People Development	10%
Enables a better equipped workforce	
Increased liaison with tertiary education centre and WDC	
Current best practice to be used	
Patient Safety	**18%**
Clinical Governance	18%
Improves accountability arrangements	
Encourages sharing of best practice	
Improves clinical governance arrangements	

Common clinical protocols & procedures	
Value for Money	**12%**
Use of Resources	4%
Enables services to be shared (e.g. finance, HR, etc)	
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients	
Increase in purchasing power	
Makes better use of assets including IT resources	
Potential for Efficiency Savings	4%
Savings in Board costs (e.g. exec, non-exec, executive benefits)	
Savings in Management Team costs	
Early retirement costs & costs of management change	
Savings in cost of procurement (revenue & capital)	
Savings in Audit fees	
Potential for shared service arrangements	
Savings in Operational Costs	4%
Savings in HQ Estate costs (depreciation, rate of return, rent, repairs)	
Fleet maintenance costs	
Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)	
Total	**100%**
Transitional Issues	**100%**
Ease of transition to new organisation	
Costs of transition	
Additional investment required	
Time taken to recover costs	
Risk of transition	

5.2 Patient benefit – now

The criteria group 'Patient Benefit – Now' is divided into three sub-criteria groups:

- Operational performance
- Access to service
- Organisational efficiency

These sub-criteria reflect important areas to consider regarding the efficiency and effectiveness of Ambulance Trusts in the AGW area. The group 'Patient Benefit – Now' was allocated the highest percentage weighting of 45% so that it represented the most important area for us to consider in this review.

Operational performance

This includes the following criteria:

- Ability to achieve service improvements; and
- Capacity and capability to achieve performance targets.

5.2.1 Ability to achieve service improvements

To achieve service improvements, Ambulance Trusts must manage demand and improve service responsiveness, achieve national response time targets, improve clinical intervention procedures, increase healthcare outcomes, have greater co-ordination of effort and have the ability to review and allocate resources to areas of greatest need.

R	**Option 1** Without significant change and a reorganisation of management resources, capacity and capability within the organisations to continue the momentum of improving services will remain limited. To achieve further service improvements, the trusts will need significant investment which is not readily available from the PCTs. Given the continuing pace of change within the NHS, it is unlikely that this option will enable sustained service improvements.
Y	**Option 2** Limited improvements can be achieved due to time and resources being directed towards meeting the agendas of three different Boards with different visions on how services can be improved. The advantage of this option over Option 1 lies within the creation of a single Management Team to coordinate effort. This is countered by duplication of effort for managing each Trust Board.
G	**Option 3** There would be more flexibility within a larger organisation to direct resources to the most appropriate functions for development. A larger organisation should also be able to generate more ideas for improvements and have greater potential to implement them. There will be potential for 24/7 management supervision.

5.2.2 Capacity and capability to achieve performance targets

The ability of Ambulance Trusts to:

- Allocate resources to achieve their performance targets, for instance staff time devoted to mobilisation and dispatch;
- Take advantage of future improvements in control room technology and management of information; and
- Take strategic decisions that will influence the achievement of performance targets.

R 	**Option 1** All three trusts are experiencing pressures in achieving the performance targets and they do not have the resources, including IT, needed to support the service improvements to address current and future performance targets.
Y	**Option 2** By having a shared Management Team there is the potential to make improvements in performance. However, if the Boards are divergent in their views this will present difficulties for the Management Team to share resources to meet the targets. Also, the three services could potentially operate in 'silos' thus limiting opportunities for sharing resources and best practice to achieve targets.
G 	**Option 3** A larger organisation will have the benefits of critical mass, shared learning and greater flexibility for resource deployment to meet performance targets. In the long term this model will improve performance, but during the transitional stage performance may be affected due to the typical dip in performance of an organisation going through change. To mitigate this, a dedicated team focusing solely on performance targets should be created so that the focus is not lost.

Access to service

This includes the following criteria:

- Improves integration with primary and secondary care services;
- Enables a seamless service to be developed with common protocols;
- Coverage of Trust area, staff per '000 population; and
- Generates equity between communities.

5.2.3 Improves integration with primary and secondary care services

Improving integration with primary and secondary care will demand more staff resources to be devoted to liaising with other healthcare partners to improve service integration. Potential will need to be demonstrated by each option for closer coordination of Patient Transport Services (PTS), Out-of-Hours (OoHs) services and Accident and Emergency (A&E) services.

R 	**Option 1** All three trusts are experiencing pressure within their management teams to achieve the Category A and B targets, therefore leaving little staffing resource to concentrate on integrating ambulance service with OoHs, A&E etc. There are some examples in each trust of integrated working, however our overall conclusion is that the current configuration of management resource does not enable services to realise their full potential.

Y	**Option 2** The structure will not readily free management resource to look at further opportunities for integration of services. The structure is more difficult to navigate, with more blurred lines of accountability and communication which will make liaison with PCTs, acute trusts etc. more complex. The advantage of this arrangement is that it provides a catalyst for change and could enable management to introduce more consistent policies and procedures, however working to three Trust Boards will lessen the benefits of having one management team.
G	**Option 3** This option will: • Encourage more formalised relationships to develop with other healthcare partners to promote integration of primary and secondary care services; • Free up more time for strategic thinking to look at and implement new models of service delivery e.g. developing and extending the roles of ECPs; • Provide capacity for the development of robust business plans that capture the local demands and needs of each community in a whole system way of thinking; and • Allow more flexibility in resources to create a specific post to liaise with partner organisations on a full time basis.

5.2.4 Enables a seamless service to be developed with common protocols

The development of a seamless service has been in favour for many years. Whilst valiant attempts have been made, the drive and energy needed to make this happen requires a clear and robust partnership approach across the whole health economy. The development of common protocols, use of best practice and ability to share learning across all health and social care sectors will require staff resources to be effectively deployed. The management capability and capacity to implement a seamless service is also a key consideration.

R	**Option 1** This option does not provide the impetus to develop common protocols which can be shared with other trusts. From our work to date, we believe that there is not any real desire to collaborate effectively between the three trusts. There is little evidence to suggest that remaining as they are things will change. Each trust has clinicians on their management teams, however they are all part-time. This limits the opportunity for the clinicians to focus their time on protocols and to communicate these to the wider healthcare community to gain agreement on common approaches.
Y	**Option 2** The key advantage of Option 2 over Option 1 is that there will be a united single management team that can drive change, therefore there is also greater potential to encourage sharing and joined up thinking. But the difficulty of communicating with three boards will lessen the impact of the development of a seamless service and common protocols.
G	**Option 3** The drive and strategic direction provided by one Trust Board will enable a clear strategic plan for the future of ambulance services to 2 million people to be developed in partnership with PCTs, SHA, healthcare trusts, Patient and Public Involvement (PPIs) Forums and other local agencies. Greater critical mass will provide more clinical input into decision making within the organisation. With one full time person tasked with leading the progression of clinical protocols, this will allow a more co-ordinated approach to their development. One Medical Director will also simplify the communication between the Ambulance Trusts and PCTs, acute trusts etc.

5.2.5 Coverage of trust area, staff per '000 population

The equity in the configuration of ambulance resources in terms of number of front line staff (technicians, paramedics, emergency care practitioners) per head of population, number of front line staff available per sq km and number of vehicles per sq km. Each county has different needs, therefore an homogenous approach to staff coverage cannot be applied. Also, PCTs will wish to commission on a per county basis to ensure resourcing matches need.

R 	**Option 1** There are differences in the distribution of staff in the Ambulance Trusts across AGW. This is historic and reflects different level of investment in the three trusts. Gloucestershire has the highest number of staff per head of population and the highest number of staff per 1,000 patient journeys. Avon has the lowest number of staff per head of population and has a similar level to Wiltshire of staff per 1,000 patient journeys (see Appendix 8 and table below). There is little potential within the status quo to tackle the inequity of staff resourcing.
Y	**Option 2** There is some potential to address the inequity of staffing given the more integrated management structure across the three counties, however partial integration will limit the opportunities to pool staff resources.
G 	**Option 3** Full integration with one board and management team will provide greatest flexibility of resourcing across the counties allowing opportunities to bring a more equitable distribution of staffing. This is supported by views from other similar sized Ambulance Trusts we spoke to. PCTs will still maintain the ability to commission ambulance services specific to the needs of their area, the implications of commissioning are discussed later in this report.

The table below shows the current variation in ambulance staff expenditure per head of population.

	AAST	GAST	WAST
Population(million)	1.0	0.57	0.6
Ambulance staff salary costs (£000)	£9,014	£6,648	£4,996
Cost per head of population	£9	£11.66	£8.33

5.2.6 Generates greater equity between communities

Equity means delivering services which respond appropriately to local need, not homogeneity. Local communities generally have strong views about ambulance services, particularly in relation to the location of control rooms, stations and the preservation of a local identity in the naming of services. Local accountability and representation are also important. A positive impact and equity between communities can be achieved through better response times and improved quality of services.

R	**Option 1** Comparative data in Appendix 8 shows that there is a difference between the trusts' response time performances and within these figures there are differences between urban and rural performances which reflects the national targets. There is a need to build more capacity within the rural communities and to structure a service which can respond to the differences within and between the counties.
R	**Option 2** Each trust is working very hard to achieve the national targets for their Category A and Category B calls, but equity of provision demands more than meeting performance targets and without a more integrated structure, the significant resources required and the potential new ways of working will not be available. The structure for Option 2 will still not have the necessary power, authority and influence to generate the much needed change in ambulance services in AGW.
G	**Option 3** This option enables a strategic view to be taken of the delivery of ambulance services across all of the AGW region. Equity across AGW can be achieved by looking at the utilisation of resources over this area rather than on an individual county basis and more flexibility will be introduced to deploy resources according to local needs. Retaining a local focus through a distinct divisional structure should enable local pride in services to grow and not diminish.

Organisational efficiency

This includes the following criteria:

- Ability to deploy resources across the trusts in a flexible manner in order to match demand;
- Ability to be a financially and organisationally viable organisation in the long run; and
- Provides a critical mass to cope with future changes and has capacity and capability to grow.

5.2.7 Ability to deploy resources across trusts in a flexible manner in order to match demand

This criterion concerns the need for flexibility in the movement of personnel, vehicles and equipment throughout AGW and the necessity to demonstrate that the trusts can allocate resources to match demand.

R	**Option 1** The Ambulance Trusts in AGW do deploy their resources effectively to try to meet the demands of local communities; however they are constrained by their limited resources which is most apparent in the rural areas. There is limited evidence to suggest that the trusts are working effectively across their county borders and this disadvantages patients living close to the county boundaries.
R	**Option 2** Individual trusts would be very protective of their budgets and this restricts flexibility. PCTs would want funds earmarked for their area, income could even be hypothecated. There would be opportunity for the development of a common approach to managing resources, but by maintaining the three distinct organisations this will inhibit the progression of cross county deployment of resources.

G ●	**Option 3** This structure will have the potential for developing policies and procedures to flexibly deliver services across the AGW region.

5.2.8 Ability to be a financially and operationally viable organisation in the long run

Financial risk should be considered in both the short and long term. There needs to be critical mass in the finance function with good financial capability, sound financial systems and good internal control. Without financial stability the organisation cannot be operationally viable. Options 1 and 2 will have separate budgets and Option 3 will have a single budget.

R ●	**Option 1** All three Trusts have a track record of achieving financial targets; however, with increasing financial constraints from PCT commissioners there will be less resource available for the service and there will be a greater expectation from the services to achieve efficiency savings. Smaller organisations will find it more difficult to identify efficiency savings.
R ●	**Option 2** It would be easier to share good practice in the finance function. However it could potentially be difficult to resolve cross-funding issues and tensions created from working to three boards and reconciling three different sets of accounts. Investments in maintaining an operational organisation will be focused on each of the three services and may not be used equitably across the whole of AGW. This option is viewed by some stakeholders as an interim solution, a 'staging post' towards implementing Option 3, and therefore does not have a long term future.
G ●	**Option 3** This provides the greatest long term viability for the ambulance service. A larger organisation will have greater economies of scale, hence lower reference costs and wider opportunities to manage resources ensuring the operational viability of the organisation. With a single budget of circa £50 million[5], it will be easier to identify potential savings and there will be greater flexibility to make investments for the long term future. This single budget will not prevent PCTs investing in services specific to their own areas of identified need.

5.2.9 Provides critical mass to cope with future changes and has capacity and capability to grow

This criterion considers the arrangements and the different options to deploy staff on planning, project management and change management activities and the opportunity for wider access to resources. There is a need for an appropriate balance of staff in the organisations in terms of administrative and management functions and frontline staffing.

R ●	**Option 1** The existing organisations are very lean and have limited capacity to deal with future changes unless additional resource can be made available. It is unlikely that more income streams will become apparent with this option.

[5] based on 2005/06 incomes.

Y	**Option 2** Divisional structures would constrain staff, restrict the critical mass and promote a 'silo' working mentality. There isn't the fluid transfer between the three counties and opportunity available for transfer of resources would be difficult to realise.
G	**Option 3** Critical mass will be realised, a bigger organisation will be created with the ability to think more strategically. Creating a larger organisation will enable it to have a greater influence on future direction and become a leading voice in the future organisation of planned and emergency care across the health agenda. Comparative data in Appendix 8 indicates that income-wise, the single trust would join the top third of Ambulance Trusts in the UK.

5.2.10 Improves corporate governance arrangements

Good corporate governance arrangements will require trusts to have good risk management; health and safety; controls assurance and statement of internal control. The NHS places great importance on governance in trusts. The table below displays the rating each trust achieved in the 2004 performance rating. In 2004 GAST achieved two stars whereas neither AAST or WAST achieved any stars and all three trusts achieved the required standard in financial management, however their ability to meet the performance targets affected their overall rating and in the case of WAST, their ability to achieve the required standard for Improving Working Lives. The 2005 performance ratings are due to be published in July, and it is anticipated that GAST will lose a star and AAST will achieve one star.

Org Name	2004 Rating	Key targets				Key targets	Clinical focus	Patient focus	Capacity and capability focus	CGR
		Category A calls meeting 14/19 minute target	Category A calls meeting 8 minute target	Financial mgt	Improving Working Lives					Clinical governance review
AAST		×	-	✓	✓	Fail	High	Low	High	-
GAST	**	✓	-	✓	✓	Border line	Medium	High	High	-
WAST		-	×	✓	×	Fail	Low	Medium	Low	×

(Source: 2004 CHI)

R	**Option 1** Considering corporate governance in its widest context there are likely to be no improvements under the existing organisational arrangements. As above, none of the Ambulance Trusts in AGW have a three star rating and AAST and WAST currently have no stars. Work is being carried out by each trust to increase their rating but it is proving very challenging, particularly for small organisations.
Y	**Option 2** There may be some improvements depending on whether risk management, complaints and health and safety responsibilities are within the shared management team or within the three divisions.
G	**Option 3** This will provide the most significant improvements since this structure will have the resources to give corporate governance due attention. This option also provides the opportunity to make improvements as good practice can be shared and resources pooled.

5.2.11 Conclusion

Of the three options, the single trust (Option 3) provides the greatest benefit to patients. Option 3 will enable the ambulance trusts to implement best practice across AGW in all patient facing activities:

- Patient protocols;
- Equipment and supplies;
- Deployment of vehicles;
- Triage; and
- Dispatch procedures.

Option 3 will provide the critical mass to attract good quality senior management to provide direction and there will be sufficient resources to focus on the core issues. Good practice can be readily shared between the existing three services and the single trust can provide greater opportunity to use resources flexibly. There would also be capacity to achieve significant service improvements which post transition would be reflected in the new performance classification.

Patient Benefit - Now	**Option 1**	**Option 2**	**Option 3**
Ability to achieve service improvements	R 🔴	Y 🟡	G 🟢
Capacity and capability to achieve performance targets	R 🔴	Y 🟡	G 🟢
Improves integration with primary and secondary care services	R 🔴	Y 🟡	G 🟢
Enables seamless service to be developed with common protocols	R 🔴	Y 🟡	G 🟢
Coverage of trust area, staff per ‘000 population	R 🔴	Y 🟡	G 🟢
Generates equity between communities	R 🔴	R 🔴	G 🟢
Ability to deploy resources across the Trusts in a flexible manner in order to match demand	R 🔴	R 🔴	G 🟢
Ability to be a financially viable organisation in the long run	R 🔴	R 🔴	G 🟢
Provides a critical mass to cope with future changes and has capacity & capability to grow	R 🔴	Y 🟡	G 🟢
Improves corporate governance arrangements	R 🔴	Y 🟡	G 🟢

5.3 Patient benefit - future

The criteria used for the evaluation in this section are:

- Strategic issues
- Education, training and people development.

These two criteria were linked because it was felt that these are more focused on the longer term improvement of ambulance trusts. It is also important to reflect the benefits for staff. Training and development criteria were therefore broadened to cover education and people issues, and relevant links with tertiary education institutions.

The modernisation of the NHS will require Ambulance Trusts to be more responsive to their commissioners and to have a better understanding of their role in providing a good quality health service to the population. To do this, the service needs to have an understanding of the future direction for the Ambulance Trust and the potential contribution that it can make to healthcare. Opportunities exist for releasing efficiency gains for reinvestment in frontline services. Examples include adopting national and international best practice rather than investing in bricks and mortar.

There will also be a need to ensure that all staff of the Ambulance Trusts are suitably equipped to deliver the new service. This will include clinical skills to provide a better service in the community as well as management and leadership skills to ensure that the modernisation agenda can be delivered.

In terms of weighting this grouping, it was agreed by the Steering Group on 6 May that these should be given the second highest weighting. We have applied a 25% weighting (strategic issues 15%; education, training and people development 10%).

Strategic issues

This includes the following criteria:

- Consistency with national and local ambulance/NHS strategies;
- Addresses local issues;
- Capacity and capability to respond to new market opportunities; and
- Improved response to commissioning.

5.3.1 Consistency with national and local ambulance/NHS strategies

This criterion considers which organisational arrangement will best ensure that national and local strategies can be achieved. As mentioned in the section 'Setting the National Context', Peter Bradley is conducting a national review of ambulance services on behalf of the Department of Health concentrating on areas such as: improving integration with the wider NHS; the future role of Ambulance Trust personnel and clinical indicators and outcome measures. The document *Driving Change* published in 2004 also highlights the policy direction for Ambulance Trusts, focusing on a whole systems approach to service delivery and promoting localised initiatives in delivering healthcare.

In terms of local strategies we have included in our assessment how the options can respond to future commissioning arrangements and the service delivery framework as outlined in the final report of June 2004 regarding the integration of unscheduled care. The earlier work conducted by Adrian Lucas has also helped us in our evaluation of this criterion.

Y	**Option 1** The Ambulance Trusts are starting to have better links and relationships with PCTs and the acute sector, for example GAST provides the OoHs service and AAST have good links with NHS Direct. The three Ambulance Trusts are working with their local ECNs (Emergency Care Networks), however they are not necessarily pro-actively taking the lead which would be expected of them although the Chief Executive of AAST does chair the Bristol ECN. More work needs to be done in all three trusts to improve performance locally and nationally.

Y	**Option 2** There would be an opportunity to appoint a high calibre senior executive team which could implement the national agenda at a local level. This would be dependent upon the three trust boards co-operating and agreeing on these senior appointments and having a single vision for the ambulance community. This could also represent a major barrier to achievement of longer term change. The key advantage of this option is that it represents a step in the direction of larger change.
G	**Option 3** This option will have greater capacity and capability to define strategy and position itself as a high profile organisation that influences and directs strategy within the AGW area. The added strength over Option 2 is that it will provide a new platform for changes and is most likely to represent a viable organisational structure from which it can determine how best to deliver national and local agendas. Option 3 will be able to build on the good practice that exists and implement the best of the best.

5.3.2 Addresses local issues

This criterion focuses on which option will provide the most appropriate arrangements for addressing local issues, such as: geography, transport, infrastructure, local protocols, working arrangements with other transport providers, demographics etc. To address local issues, Ambulance Trusts should have good links with local communities and be engaging in partnerships with groups such as PPI representatives; PCTs; Local Authorities; Emergency Care Networks and Overview and Scrutiny Committees.

For Option 2 and 3, there was a concern that resources would not be allocated equitably across AGW. Some interviewees felt that resources would be diverted to Bristol and others felt that resources would be diverted out of Bristol into the rural areas. There needs to be an understanding of the communities that the Ambulance Trusts serve in order to deploy resources effectively.

Y	**Option 1** The existing Ambulance Trusts are aware of and are trying to respond to local issues. However, they are constrained by the limited resources available to them to address these issues. There is evidence that they are developing better partnerships but don't have the resources to act on their ideas. For example they have introduced a number of initiatives to improve performance such as community responders, rapid response vehicles and motorcycles. We are aware that the Ambulance Trusts have examples of good practice working with other emergency services for example Tri-Service centres in Gloucestershire and Wiltshire. There are still opportunities to develop these further if Option 1 is selected. Pressure on the Fire Service to develop 9 Regional Control Centres may also increase pressure on the existing Tri-Service arrangement. Currently there seems to be few links with local authorities for making effective use of resources.
Y	**Option 2** There would still be three Boards providing some opportunities to address local issues. However, this option is unlikely to provide sufficient management capacity to address the local agenda adequately. There is a perception that local communities (local press, MPs) would support a locally identified Ambulance Trust but this was not articulated by the various PPI representatives from across AGW.

G	**Option 3** This option would provide an opportunity to implement a structure that can retain a focus on local issues without losing local identity. This could be achieved through strong divisional leadership supported by strong executive leadership. This should provide a greater focus on local communities and lead to the establishment of good effective working relationship with key partners. A single trust would also be able to present itself to the 2 million people it serves in a credible way that can demonstrate cohesive thinking and strategic planning.

5.3.3 Capacity and capability to respond to new market opportunities

This criterion considers which management arrangements would have the greatest potential to develop new ways of working and new services that could be delivered by the Ambulance Trusts. These could be identified from the national agenda or from commissioning or ECN discussions and include expansion of training opportunities; development of community paramedics; development of mobile surgeries; switch from transportation to diagnostics and treatment services etc.

Y	**Option 1** Despite pockets of good practice we have concluded that the existing organisations have difficulty in addressing new market opportunities in a planned and proactive way. Currently, there is more focus on meeting the national performance targets than being innovative in developing new business opportunities. The existing management structures in the Ambulance Trusts are fairly lean and most Executive Directors have two or three areas of responsibility as a minimum. There is a risk if the status quo is maintained some of the good managers would be leaving their current posts to go to larger organisations which are addressing the national agenda.
R	**Option 2** There may be opportunities for expansion into new markets but would need consensus to progress these across the three organisations. This is seen as a major blocker to progress.
G	**Option 3** A larger organisation is more likely to represent an attractive, progressive organisation for new recruits and it is also likely to retain good senior mangers. The future NHS is increasingly becoming more commercial and the need to be able to respond to plurality issues and changes in commissioning arrangements will be critical. Creating a circa £50 million organisation will provide a single trust with a viable platform from which they can develop strategy regarding the achievement of Foundation Trust status. This option would provide significant potential provided there is adequate investment in leadership, IT, clinical effectiveness and a clear plan for the next 3-5 years. Option 3 would also have only one Board driving the agenda rather than three as per Options 1 and 2.

5.3.4 Improved response to commissioning

This criterion addresses the issue of which option would provide the most effective commissioning arrangements and enable the Ambulance Trusts to take a pro-active role in the process.

Y	**Option 1** There are variations in the quality of engagement in the commissioning process across the three Ambulance Trusts. Even those Ambulance Trusts and PCTs who consider themselves more adept at commissioning recognise that more potential could be made of the commissioning arrangements. Each of the Ambulance Trusts need more resources to make a pro-active contribution to the commissioning debate and engage commissioners in buying into these. There are pockets of good examples, and there is some evidence in the Ambulance Trust Local Delivery Plans that commissioning discussions are improving, but a lot of work needs to be done and Option 1 does not represent the best option which will enable progress in this area.
Y	**Option 2** This option would potentially improve the Ambulance Trust's response to commissioning because you would expect to see a dedicated focus on this area of work. With strengthening at a local level you could envisage a situation whereby a lead commissioner for each trust is in place. However it is unclear where responsibility for commissioning on the integrated Management Team would rest or whether it would remain within the three trusts.
G	**Option 3** This option provides the greatest opportunity for constructing a commissioning function that can respond effectively to PCTs. This option also has the greatest potential to respond to the envisaged changes in PCTs (these are likely to amalgamate to create fewer, but larger PCTs) and any revised commissioning arrangements. Having a single trust would be sensible in this respect so that the commissioning process can be developed strategically and in partnership with other agencies. By bringing a strong management team with a clear management structure to take ownership of commissioning, it would become a positive and innovative process. Divisional management with adequate support should be able to engage with local commissioners more effectively and commissioners should benefit more from the contribution that ambulance trusts can play within the whole system of care. Though, it is envisaged that the commissioning process will be more complex and there would need to be a review of the existing commissioning arrangements to determine how commissioning should be conducted across three counties. (In London we understand that it took seven years to resolve the commissioning arrangements). This would need to coincide with any plans to consider the organisational structures of PCTs in the AGW area.

Education, training and people development

This criterion includes the following:

- Enables a better equipped workforce;
- Increased liaison with tertiary education centres and WDC; and
- Enables current best practice to be used.

5.3.5 Enables a better equipped workforce

The key issues to be considered for this criterion are which option would provide the greatest opportunity to develop arrangements for identifying the skills and expertise required to deliver the service and ensuring that individuals within the service are able to develop new roles and responsibilities. It will also be necessary to consider what the future role of the service would be like as it addresses the NHS modernisation agenda.

R	**Option 1** The CHI Clinical Governance reviews undertaken at the three Ambulance Trusts in 2003/04 noted the training provided did not fall within an overarching strategic plan. A common weakness identified in these reviews concerned the limited training provided for managers. This option does not provide the strategic vision for ensuring that there is better equipped workforce in place to provide a service. Obviously the existing trusts do provide training for the staff and there are examples of new training programmes being developed so that ambulance staff will be able to provide new pathways of care such as staff becoming Emergency Care Practitioners attending patients at home to ascertain whether they can be supported at home by a joint healthcare/social package rather than being admitted to hospital. The management staff of the three trusts take on a number of roles within their job titles, for instance the Director of Finance taking on the IM&T function within a trust, although this is not uncommon in the NHS, there is a lack of infrastructure below them to provide support.
R	**Option 2** It is unclear whether the Medical Directors would have sufficient authority to move forward the training agenda. It is also unlikely that there would be any additional funding for training. There is a concern that the complexity of the structure in option will discourage applicants for the senior management posts, therefore questioning the ability to recruit the calibre of staff needed.
G	**Option 3** There should be an opportunity to produce a training strategy to address development of management and front line staff and to invest more resources into training. It would also be easier to work closer with the Workforce Development Confederation (WDC). Option 3 would provide the greatest opportunity to move this agenda forward because the management capacity and capability will provide the direction and coordination required. It will also be able to develop comprehensive strategic training plans that address long term changes in the ambulance service. The organisation would be sufficiently large enough to be able to deliver this training programme or be able to enter into appropriate negotiations with other training providers. Option 2 might go someway to achieving this criterion but there is a risk that the individual trust boards may have different views and want different approaches to reflect 'local' needs and this could divert management attention. There are some health community wide arrangements already in place and it will be necessary to consider how one single trust will relate to them.

5.3.6 Increased liaison with tertiary education centres and WDC

This criterion concerns the availability of staff to develop links with universities and colleges.

R 	**Option 1** Overall there is limited progress made to date in this area with the exception of AAST who have received funding from the WDC for the development of the ECP role.
Y	**Option 2** There will be an HR Director in the Management Team and they may have the opportunity to link more effectively with the WDC than the existing Ambulance Trusts are able to.
G 	**Option 3** One organisation will make human resource issues more cohesive and importantly redirect its focus to that of organisational development. To achieve this it will be necessary for the single trust to appoint a high calibre executive who has the breadth of experience in taking a new organisation forward and turning it into a learning organisation. There would be the potential for the Ambulance Trust to develop a better relationship with the WDC and tertiary education centres. The creation of a single trust would provide the most cohesive vehicle from which it can achieve its potential regarding workforce development and making it a great place to work.

5.3.7 Enables current best practice to be used

The key issues to be considered are whether good practice between ambulance trusts in respect of education, training and people development can be shared across AGW.

R 	**Option 1** Training is provided by the three Ambulance Trusts but it is currently focused on operational issues and although there is some sharing of resources they largely work in isolation. WAST have the Southern Ambulance Trust College which staff from the other services do use, but there is limited if any collaboration between the services or the sharing of good practice in respect of training. Training and development are constrained by the limited resources available for the individual organisations. There was no evidence that, for example, shared learning from clinical audit programmes takes place.
R 	**Option 2** The structure should support communication of best practice through each of the organisation's locality managers; however there would be challenges in ensuring that the individual trusts would adopt the good practice.
G 	**Option 3** By pooling resources, sharing good practice would definitely be achievable with this option. One organisation would have one culture which would enable good practice to be implemented, because there would no longer be an issue of “not invented here” excuse for not implementing new procedures.

5.3.8 Conclusion

Retaining the existing organisation would not provide the patient benefits that are offered by Options 2 and 3.

The three trusts are endeavouring to address the strategic issues facing the Ambulance Trusts but as some have difficulties in meeting the national performance targets, management attention is focussed on this area rather than the 'bigger picture'. Training and development opportunities exist in the current organisations but there would be scope to improve the arrangements if the strategic issues could be more effectively addressed if either Option 2 or 3 were selected.

Options 2 and 3 provide the greater potential increase in patient benefit as the ambulance service would be able to provide a more appropriate healthcare service and ensure that patients were being treated by the right people, at the right time and in the setting for the whole population of AGW rather than specific areas.

Patient Benefit – Future	**Option 1**	**Option 2**	**Option 3**
Consistency with national and local ambulance/NHS strategies	**Y**	**Y**	**G**
Addresses local issues	**Y**	**Y**	**G**
Capacity and capability to respond to new market opportunities	**Y**	**R**	**G**
Improved response to commissioning	**Y**	**Y**	**G**
Enables a better equipped workforce	**R**	**R**	**G**
Increased liaison with tertiary education centres and WDC	**R**	**Y**	**G**
Enables current best practice to be used	**R**	**R**	**G**

5.4 Patient safety

NHS organisations need to deliver safe and effective services. Clinical governance provides a framework within which services are developed and monitored. This includes sharing clinical good practices, improving clinical governance arrangements, and developing common clinical protocols and procedures. The criteria in this group were given a weighting of 18%, which was the second highest weighting of any specific criteria, i.e. less than access to service (20%) but had a greater weighting than strategic issues and operational performance (15% each).

Clinical governance

This includes the following criteria:

- Improves accountability arrangements;
- Encourages sharing of best practice;
- Improves clinical governance arrangements; and
- Common clinical protocols and procedures.

5.4.1 Improves accountability arrangements

This criterion considers which option is likely to provide the greatest focus on clinical governance and that there will be clear, transparent reporting mechanisms.

R	**Option 1** In this option the management structure is such that the avenues of accountability are very clear to those involved in delivering the service. Also, given the size of the organisations, there is an opportunity for the involvement of the local PPI representatives and the local Non-Executive Directors. Concern has been raised that the Non-Executive Directors do not have the ability to drive forward issues within the trusts and that this may be attributable to them not having a grasp of the relevant issues.
R	**Option 2** This option poses concern in respect to accountability. With the presence of three Boards yet only one Chief Executive, the lines of accountability may become blurred. It has been described as a democratically deficient model which leaves a lot of power in the hands of the Executives leaving the Non-Executives roles vague. Also, the PPI representatives presence within the structure is more distant therefore lessening their strength and influence.
Y	**Option 3** This option provides a clear structure of accountability and with a strong Management Team in place, will provide opportunity for more strategic focus on issues of risk within the organisation. However, the central management structure with divisions will mean that there will be less representation from the local areas at the Non-Executive level and from PPI representatives.

5.4.2 Encourages sharing of best practice

The key issues to be considered for this criterion are which option:

- Provides the ability to identify, share and implement best practice (both clinical and business processes, risk management etc.) across all three organisations;
- Ensures that the sharing of best practice would be of direct benefit to patients; and
- Needs to invest in specific services.

R	**Option 1** We concluded that current communication mechanisms are at best ineffective. The three trusts should be working better together but there is no incentive to do so. During the review there was evidence that WAST and GAST were starting to share ideas and approaches as a precursor to sharing a Chief Executive from June 2005.
Y	**Option 2** The management structure in Option 2 would formalise communication between the three trusts, however under this option the link between the trusts could still be viewed as somewhat tenuous. The three Boards would still decide local policy which may inhibit or restrict the sharing of best practice.
G	**Option 3** This option would encourage more sharing of best practice. The links between the three divisions would be more defined. There would be more ability to divert resources to Research and Development.

5.4.3 Improves clinical governance arrangements

Clinical governance risk arises where there are limited safeguards, controls and agreed procedures and protocols in the provision of healthcare. Improved training of healthcare professionals and agreed protocols between Ambulance Trusts and A&E departments and clinicians can reduce clinical governance risk. Local Medical Committees play a key role in ensuring effective Clinical Governance. Two key critical success factors in this criterion would be to have:

- The ability to invest more resources in the post of medical director either through creating a full time post or increase the total level of support provided; and
- A clinical audit programme which is linked in to secondary care.

R	**Option 1** Currently there is limited clinical leadership and limited clinical audit. All three Ambulance Trusts each have clinical input on their management teams, however each of these clinicians are employed on a part-time basis. This review found that each service perceived themselves as struggling with the clinical governance agenda. Remaining with the status quo under Option 1, there would not be the investment needed to increase senior level input in each of the trusts.
Y	**Option 2** The proposed structure would be have little impact on the structure in respect of the part time Medical Directors, as this option provides a similar structure. However there might be more opportunities for collaborative working, having more standard approaches, and introducing common audits to benchmark themselves against. There would be a question mark over whether there would be the capacity to carry it through to any significant extent.
G	**Option 3** This option would provide a structure which would more fully enable collaborative working between the services. Also it would provide more opportunity to appoint a full time Clinical Governance lead who can project manage initiatives as such as PGDs across AGW. The importance of clinical governance and the national requirements for this agenda increasingly mean that only large organisations have the ability to tackle issues such as: Clinical Audit, Training and Development more effectively.

5.4.4 Common clinical protocols and procedures

The key issues to be considered are the ability and willingness to identify, share, develop and implement common clinical protocols across the trusts.

R	**Option 1** This option currently restricts the ability to deliver common clinical protocols across all three existing trusts due to the senior clinicians in these trusts only being employed on a part time basis. Also the current structure prevents effective communication between the trusts.
Y	**Option 2** There is more opportunity for collaboration between the three counties due to the integrated management structure which will enable the development of common clinical protocols and procedures.
G	**Option 3** Clinical input has the potential to be greater because the structure will enable more opportunity for strategic thinking. There could be the potential for more medical input at Board level and more opportunities for clinical input to be used more strategically.

5.4.5 Conclusion

Each Ambulance Trust is improving its clinical governance arrangements. However each felt that they would benefit from more clinical input to improve these arrangements. Option 3 has the greatest potential to improve clinical governance. There would be a less fragmented approach to clinical leadership with one Medical Director across AGW which would subsequently bring about clearer lines of accountability. This Medical Director post would have the opportunity to liaise with the three county divisions and promote good practice within the one merged organisation. The one Medical Director would also be one point of contact liaising with other healthcare organisations within AGW promoting common protocols such as Patient Group Directives (PGDs).

Patient Safety	**Option 1**	**Option 2**	**Option 3**
Improves accountability arrangements	**R**	**R**	**Y**
Encourages sharing of best practice	**R**	**Y**	**G**
Improves clinical governance arrangements	**R**	**Y**	**G**
Common clinical protocols and procedures	**R**	**Y**	**G**

5.5 Value for money

5.5.1 Financial context

When looking at the financial implication of possible reconfiguration of ambulance trusts in AGW, it is important to understand the cost base of the three existing Ambulance Trusts. The table below is an extract from the audited financial accounts for 2003/04 for each of the trusts. The main items of revenue expenditure are payroll costs which accounts for approximately two thirds of the total expenditure. The next largest expenditure item is the establishment and transport expenses of which the majority are transportation costs. Other costs included under establishment are printing, telephones and travel and subsistence expenditure.

The next largest cost to the trusts is the premises and plant expenditure which incorporates the utility costs of running the estates (water, lighting, heating) and other costs such as rent and rates and any building and engineering work to the current estate. The other large area of single expenditure is the costs of depreciation on the fixed assets.

The gross capital expenditure for each of the trusts in 2003/04 was £801k, £2,660k, and £454k for Avon, Gloucestershire and Wiltshire respectively. Capital expenditure relates to major investment including estates, plant, equipment and IT.

The table below highlights the areas where there are further opportunities to look at the redeployment of resources. We have not concentrated on the detailed operational areas, as it is the trusts decision as to what areas to focus on.

	AAST		GAST		WAST		Total	
	£000	%	£000	%	£000	%	£	%
Salaries & Wages	15,559	69	7,811	70	7,369	61	30,739	67
Clinical supplies & services	575	2.5	209	2	311	3	1,095	2
General supplies & services	120	0.5	96	1	420	3	636	1
Establishment and Transport	3,674	16	1,538	14	2,028	17	7,240	16
Premises & fixed plant	952	4	340	3	906	8	2,198	5
Depreciation	1,119	5	535	5	646	5	2,300	5
Fixed Asset impairment			211	2			211	-
Miscellaneous	272	1	197	1	243	2	712	2
Service from other NHS bodies	386	2	260	2	107	1	753	2
Total	22,657	100	11,197	100	12,030	100	45,884	100

The table below is a breakdown summary of expenditure on salaries and wages:

	AAST		GAST		WAST		Total	
	£'000	%	£'000	%	£'000	%	£'000	%
Ambulance staff	9,014	57.9%	6,648	85.1%	4,996	67.8%	20,658	67.2%
Nursing & Midwifery	2,004	12.9%					2,004	6.5%
Healthcare Assistants and other support staff					26	0.4%	26	0.1%
Chairman & Non Exec Directors	41	0.3%	39	0.5%	41	0.6%	121	0.4%
Senior managers and managers	992	6.4%	269	3.4%	737	10.0%	1,998	6.5%
Administrative & Clerical	3,279	21.1%	736	9.4%	1,205	16.4%	5,220	17.0%
Maintenance Staff	58	0.4%	105	1.3%	128	1.7%	291	0.9%
Administrative & Clerical (Non NHS)	166	1.1%	15	0.2%	237	3.2%	418	1.4%
Maintenance Staff (Non NHS)	5						5	
Total	**15,559**		**7,812**		**7,370**		**30,741**	

(Source: 2003/04 TFR)

Please note that the figures shown above are based on 2003/04 trust's financial returns. AAST at the time was hosting NHS Direct in AGW, hence the salaries and wages of staff employed by NHS Direct were also included in the calculation. As shown in this table, the majority of the staff cost is for ambulance staff.

We have undertaken a high level strategic evaluation of possible costs and efficiencies of the three options under consideration. There is a general recognition that any re-organisation of Ambulance trusts should be focused on achieving benefits to patients and that any potential opportunities to release efficiency savings for reinvestment in patient care are important. This section is designed to allow the financial consequences of the various options to be assessed alongside the other categories of the evaluation criteria. The weighting for this section was set at 12%, the lowest weighting being applied throughout all of the evaluation criteria. The low weighting given to the financial criteria reflects that the review is not a cost reduction exercise but is focused on improving patient benefits.

Use of resources

This includes the following criteria:

- Enables services to be shared (eg. Finance and HR);
- Abilities to release resource that can be deployed in areas that will have direct and indirect benefit to patients;
- Increase in purchasing power;
- Makes better use of assets including IT resources.

5.5.2 Enables services to be shared (e.g. finance and HR)

The key issues to be considered are the ability to develop a critical mass in key business areas to deliver an improved level of service (IT, HR, Finance, Procurement, Business Planning etc). This considers the level of resources involved in delivering managerial and administrative tasks. In 2003/04, Avon, Gloucestershire and Wiltshire spent £3.4m, £0.75m and £1.4m respectively on administration and clerical staff both substantive and temporary. This covers all areas even those that may not be the most obvious for services to be shared. This will provide opportunities to redeploy resources in the most effective way.

R 	**Option 1** We are aware that there are informal arrangements between the three services where they do meet to discuss new operational systems, for example, a potential new PTS system. However, there are no formal arrangements in place to take this forward. We understand that the potential for sharing of services has been discussed for sometime, however, very little action has come from these discussions. We are also aware that currently AAST has a contract with United Bristol Hospitals NHS Trust to provide administrative support on a shared services basis and that GAST shares vehicle maintenance services to a certain extent with its tri-service partners. The Ambulance Trusts' ability to share support services is restricted due to the organisational boundaries, and there is neither the incentive nor the communication channels to encourage sharing of services.
Y	**Option 2** There is likely to be some sharing of resources and services, but to some extent it would depend on how the management team were proposing to work and how much would be managed at the centre and how much would be devolved. For example having one Director of Finance and one Director of HR, would encourage sharing of some services such as: recruitment, Improving Working Lives, diversity, and accounts could be centralised.

G	**Option 3** In this option support services would be shared. There will be some debate about whether command and control functions should be shared. The Trust will be able to afford more specialist staff who can be dedicated to a particular function than would be possible in a smaller service providing service improvement as a result of the focus on the key issues.

5.5.3 Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients

The key issues to be considered are which option would provide the greatest opportunities to use resources in a more effective way which would have benefits to patients.

R	**Option 1** The existing arrangements provide few opportunities to release resources and the savings made to date have been generated from schemes that were initiated some time ago, for example the estate rationalisation in GAST. The cash releasing efficiency saving target (CRES) is increasing from 1% to 1.7% in 2005/06, which presents a further challenge to the Ambulance Trusts to make savings when it was already proving difficult to achieve 1% of savings. The Ambulance Trusts are now identifying and implementing schemes that could prevent admissions to hospital and this should release funds from the acute sector which could be re-directed to patient care provided either by primary care or the ambulance services. Ambulance trusts have recognised this and are starting to become more involved in this area, but it is unclear whether they are receiving the funding for this.
R	**Option 2** There would still be three different and distinct organisations under this option, being led by an integrated Management Team. The potential to release resources under this option is minimal as the organisations will continue to operate as they currently do. There will still be three HQs and control rooms, and the trusts will still continue to operate their own finance, human resources, procurement and IT functions. There will be limited opportunity to release resources which will deliver a benefit to patients.
G	**Option 3** As a single organisation there will be opportunities to eliminate the duplication that exists under the current structure. There will be opportunities to employ resources more efficiently when the areas of duplication are eliminated. There will be the opportunity to be more proactive about the use of staff, and use individuals flexibly to suit the organisations strategy and respond to the need to provide a service which reduces the need for admissions to secondary care. There is greater potential under this option for one organisation to use the resources at its disposal in a more creative way which will deliver patient benefits that were not previously possible. Within the financial summary, we have highlighted potential areas for investment through resources released in the following areas: • New vehicles (ambulance, car, motorcycle) • Additional Emergency Care Practitioners, Paramedics, Ambulance Technicians • Support staff • Equipment • Drugs and medical supplies • Training and management development

5.5.4 Increase in purchasing power

The key issues to be considered are whether there will be an increased leverage in the power that the Trusts can exert on suppliers under Options 2 and 3. Option 1 will not see an increase in the purchasing power as the three trusts will continue to operate under the same configuration as before. The benefits from Option 3 will come to fruition in the long term when the foundations of strategic procurement have been laid. The single trust will have the expertise to look at the whole supply chain from how it procures (including economic ordering) including using new technology such as e-procurement. Additionally, the trust can focus on logistics as well as stores management. By examining the whole supply chain, there will be efficiency gains.

R 	**Option 1** The existing trusts do not employ individuals who have the appropriate expertise in procurement. This activity is undertaken by individuals who undertake procurement in addition to their other responsibilities. The trusts use the national contracts through the NHS Purchasing and Supply Agency (PASA) to achieve value for money on their contracts where possible. By using PASA means that the trusts endeavour to buy into the most cost effective deals using nationally negotiated terms and conditions.
R 	**Option 2** Under this option, there may be the possibility of the trusts working together to achieve greater value for money on other contracts which are not negotiated by PASA. However, the arrangements within individual trusts are unlikely to change significantly to lead to a real increase in purchasing power.
G 	**Option 3** This option offers the potential to bring procurement expertise in to the organisation and employ resources which are dedicated to procurement. This could deliver a procurement strategy and with it the potential to negotiate better contracts. There would also be additional benefits such as streamlining the procurement process, improving supply chain management and even consider exploring options such as becoming part of a purchasing consortium. The combined Trust expenditure on procurement was £17m in 2003/04, and we believe that a saving of 2% on procurement is achievable. An analysis of the top 20 suppliers for each trust showed that there were ten suppliers on this list that were common to at least two of the trusts (accounting for approximately £2m of expenditure). If all trusts were to use the same supplier for their purchases, there would be the potential to achieve further efficiencies in the procurement process. The other added benefits are ensuring that the changing requirements of the trust are identified and that this drives purchasing and supply activity, undertake performance monitoring, benchmark themselves against other organisations to determine the performance of the trust with regard to purchasing and supply. For the purpose of the financial summary, we have assumed that a saving between £50k and £150k representing between 0.3% and 0.9% of total procured spend could be easily achieved.

5.5.5 Makes better use of assets including IT resources

One of the main concerns for the financial viability of Ambulance Trusts has been the ability to finance major capital investments. The value in Option 2 and 3 is not just about the recurring efficiencies and reductions in management costs, but also about the ability to make the most appropriate capital investments in the future in terms of value for money.

There is the potential for the trusts to share and adopt the same technology and share the costs of investing in the latest information and communication equipment and the opportunity to achieve greater capital procurement advantage in the market place. This could be quite timely with the forthcoming implementation of digital radios for Ambulance Trusts in the next two years. There is also the potential for the improved utilisation of the existing asset base of the trusts (buildings, equipment and vehicles).

Capital investment will be required to make any reconfiguration of ambulance trusts work, such as the harmonisation to common command and control and communications IT. It is anticipated that there will also be estate efficiencies from shared HQ and control centre. We feel that there will be a need for divisional offices when the three trusts move to a central HQ building. A single trust will also facilitate the better use of vehicles through reduction of current cross boundary patient flows. The issue of more efficient use of training facilities and vehicle maintenance needs to be considered going forward.

R 	**Option 1** This option has limited potential for making better use of assets. The three existing trusts have different systems for command and control systems, and finance etc. They also have their own approach to asset management and different replacement cycles which has suited their organisation to date in light of the limited funding available for investment.
R 	**Option 2** This option also has limited potential for the better use of assets. There will still be three organisations with different needs but there will be a Director of Information Technology who can attempt to harmonise the three Trusts and create a strategy which encompasses the better use of IT. It is not obvious where the combined strategy for the better use of other assets will lie.
G 	**Option 3** Under this option, there could be a Director of Information Technology who could lead to the better use of IT. Considerations could be given the centralisation of the three existing control rooms. This would necessitate a harmonisation of the command and control and communications IT in addition to other technology. This would be welcomed where investment in IT has been limited, and would enable the technology to be brought up to date. It may also be possible to consider the estates of the organisation and review the current buildings and whether there would be the potential for the rationalisation of any of the estate. This option would also offer the potential for the fleet and other assets to be used more responsively across the three distinct geographic areas.

Potential for efficiency savings

This includes the following criteria:

- Savings in Board costs (e.g. exec, non-exec, executive benefits);
- Savings in Management costs;
- Early retirement costs and costs of management change;
- Savings in cost of procurement (revenue & capital);
- Savings and audit fees;
- Potential for shared service arrangements.

The financial evaluation has concentrated on the key estates and organisational support management areas, for example: focussing on HQ and control room efficiencies arising from the merger options and savings in management costs. Additionally, the one-off cost of redundancies and early retirements have been estimated, along with the recurring costs of moving towards the harmonisation of the pay and conditions of staff under Agenda for Change.

After considering the efficiency savings possible, we have tried to identify where the opportunities are in the short term (one year) and medium term (2-5 years). These areas are explained more fully in this section of the report.

1 year	2-5 years
Board Costs	Estates
Management Costs	Information Technology
Audit Fees	Procurement
	Fleet replacement/reconfiguration
	Control room

5.5.6 Savings in Board costs (e.g. exec, non exec, executive benefits)

This review has considered the likely financial impact of the different options under consideration. The scope of this assessment has been limited to the most senior levels of management within the three Ambulance Trusts. We have not considered the impact of the three options on operational staff.

The approach adopted has considered what the structure of the organisation will look like at the most senior level under the three different options. Option 1 has reflected what the organisations currently look like. Option 2 has considered the structure under an integrated management team and finally Option 3 looks at what the structure might look like under a single Ambulance Trust.

The net savings under each of the options are due to:

- a reduction in the number of Executive Directors and Non-Executive Directors after reinvestment in the organisational structure for any required strengthening;
- saving in salary and expenses due to structural changes; and
- increases in the pay for Directors under Option 3 to reflect the increase in responsibility and to attract a high calibre of individuals into the new corporate structure.

Our approach to estimating Board savings has been to:

- identify the current cost of Executives and Non-Executives at each Trust using a combination of information provided in the 2003/04 annual report and accounts uplifted for inflation and current information provided by the trusts;
- benchmark the costs provided in the annual report and accounts of larger Ambulance Trusts around the country which will be comparable should Option 3 be considered, including West Country Ambulance Trust, East Midlands Ambulance Trust, North East Ambulance Trust and Tees, East and North Yorkshire Ambulance Trust;
- use a reasonable average from larger trusts as a proxy for new Board costs, except where existing Board costs are already higher; and
- incorporate a Divisional Director of Operations for each current trust – although it is not envisaged that these would operate as a Board Executive.

The table below highlights the board costs under the three options:

	Non-Executive Costs	Executive Costs	Total	Savings on Option 1
Option 1	£124,545	£974,552	£1,099,097	-
Option 2	£124,545	£743,331	£867,877	£231,221
Option 3	£51,092	£603,900	£654,992	£444,106

Further work in this area indicated that if Option 3 is selected there would be the potential to release resources of £528k. (Currently, there are 14 Directors in posts across the three Trusts and we propose six in the new organisation and appropriate levels of PA support.)

R	**Option 1** This option will not generate any savings in Board costs. The three Ambulance Trusts will remain as they are. The structures will remain unaltered, and there will be no potential to generate savings in Board costs. The current costs of the Boards are £370k, £392k and £338k for AAST, GAST and WAST respectively.
Y	**Option 2** This option will generate some savings in Board costs. There will be the cost of the integrated management team working across the three trusts and the investment in the organisation structure to support the Board to monitor the performance of the trusts on a day to day basis. The directors at each of the trusts are not a feature of the organisational structure under Option 2 which will generate the opportunity to release and redeploy resources. Under this option, there will be no reduction in the costs of non-executive directors on the Boards.
G	**Option 3** This option has generated the most potential for savings. There will fewer executives, chairs and non-executive directors. However, we have recognised that there is a need to reinvest in the layer of the organisation structure to support the Executives. There will be transitional costs of early retirement or redundancy under this option, but in the long term this offers the greatest potential in real savings.

5.5.7 Savings in management costs

As previously mentioned we have not attempted to estimate efficiencies possible from operational management. However, trust support and corporate services have been reviewed. Our approach has been to select the core functions from which efficiencies can be expected to be driven with a merged trust. This includes services such as Finance, Human Resources and Information and IT. We have not attempted to devise new operational management structures for the short-listed options below management team level.

Our approach has been to use the staffing information provided by the three Ambulance Trusts and apply proportions of savings possible under the merger configuration to the total staff employed for these services. We have then used the average pay to identify what resources could be released for reinvestment. Our assumption is that the three trusts merging will bring about the opportunity to reduce the staff base in the areas outlined above by 25%. This assumption recognises that in smaller trusts the management cost pressures have been relatively higher than for larger trusts. As such it becomes difficult to structure management to allow the thorough development of expertise. If these smaller trusts combine we have assumed that 75% of the current cost base will need to be retained to provide the new trust with the maximum potential to develop expertise and functional management roles.

R	**Option 1** This option will not generate any savings in trust support and corporate services. The three Ambulance Trusts will remain as they are and the structures will remain unaltered, and there will be no potential to generate savings in this area.
Y	**Option 2** This option will generate the opportunity for some savings in trust support and corporate services. The three Ambulance Trusts will structures will largely remain unaltered, but there is limited potential to generate savings in this area.
G	**Option 3** Under this option we assume that there is the possibility for support staff within any new organisation to be scaled back to 75% for the functions of finance, HR, information and IT. This equates to a saving of approximately £208k. These are detailed in Appendix 9. However we are aware that there are total administration and clerical costs for the 3 trusts of £5m so we have conservatively estimated that for the purpose of the financial analysis that savings of between £500k and £208k could be achieved. This option has therefore been rated with some potential for efficiency savings as we recognise that there still needs to be a critical mass of staff to operate these services. Our review has focussed on Board costs and corporate services. The lower estimate has intentionally excluded operational services and other support services including communications, control, supplies and fleet management, although we recognise that there are efficiencies that will arise out of these areas on a trust merger. We also calculated that savings of £90k could be achieved from the PA support provided to the Executive Directors.

5.5.8 Early retirement costs and costs of management of change

Our methodology used in estimating savings in Board members, other management and control room has identified the number of WTE affected by the savings generated. Using these numbers and by assuming an average person profile we have estimated the one-off cost of voluntary redundancy/early retirement necessary to achieve the recurring cost efficiencies. However without detailed knowledge of the actual individuals involved, it is not possible to accurately calculate redundancy or early retirement packages.

Under Options 2 and 3, the trusts will be making decisions about the way it wishes to operate. A new structure will emerge and some posts may not be necessary under this new structure. It is not possible for us to predict what this new structure will look like, and therefore what posts may be affected. We anticipate that there may be a mixture of redundancies and voluntary/early retirement. For the purposes of this exercise we have made some assumptions of a non-specific nature to provide an indication of the likely costs.

Early retirement

For early retirement, we have assumed that any individual over the age of 50 would be eligible for early retirement. We have estimated the cost of early retirement for an individual who is in a post that is considered to be surplus to operational requirements, aged 55 with 20 years service in the NHS on a salary of £50k is £117k. The costs could be significant in the short term but this will be outweighed in the medium to long term as the payback period for this individual will be two years. After the two year period has elapsed the recurrent savings can be released and redeployed in other areas of the service.

Voluntary Redundancy

For the purpose of developing a financial summary, we have assumed that staff who are less than 50 years of age and whose post is deemed to be surplus to operational requirement will be considered for voluntary redundancy. We have estimated that the cost of redundancy for an individual who is aged between 41 and 49 and has 20 years service with an average salary of £35k will cost £37,688. Similarly to early retirement, there will be a short term cost, but the costs of redundancy are significantly less than early retirement. The

payback period in most cases will be one year. As the organisational changes will take place over time, there may be some natural wastage in certain posts which will reduce the costs of transition.

If under Option 3 the decision is taken to move to a central HQ building, we have assumed that removal expenses/relocation expenses would be paid for a limited period of time. Whether excess travelling allowance or removal expenses are paid will depend on the distance involved and whether this is reasonable to travel to and from work. If it is not reasonable to travel on a daily basis then consideration will have to be given as to whether and what level of removal expenses/relocation expenses would be paid. This can either be paid as a one-off lump sum up front or can be paid over a specified period of time.

G 	**Option 1** As this option maintains the status quo, there will be no cost associated with early retirement/redundancy and change management.
Y	**Option 2** Under this option, there will be some costs associated with changing the organisational structure and instigating a programme of change management, but the change is less than that under Option 3, and so is the cost of this change.
R 	**Option 3** This option will involve the most change as three trusts become one. This will involve change to the composition of the Trust Board and the supporting Management Teams. There will be a need for fewer Directors across the trust which will result in voluntary redundancy/early retirement costs in addition to the cost of change management that will be necessary such as communications, marketing, and the re-badging of the new organisation. This option has the highest cost associated with the transition from the current structure. We have estimated that this would be £ 1.215m.

5.5.9 Savings in cost of procurement (revenue & capital)

Aggregations of existing trusts present the possibility of achieving greater economies of scale in capital procurement. For Ambulance Trusts, this largely relates to the purchase of vehicles. There appears to be a degree of scepticism about how much can actually be achieved through bulk purchase. In general terms if efficiencies can be gained, these should be greater the number of vehicles procured.

We understand the need to avoid double counting potential efficiencies that can be obtained. Of the total procurement spend, some of the costs will relate to premises which will be discussed later in the report. What we want to highlight are indicative figures for the purposes of this exercise.

The same logic applies to this criterion as it did for the earlier criterion on increasing purchasing power.

R 	**Option 1** The trusts do not employ individuals who have the appropriate expertise in procurement. This activity is undertaken by individuals who undertake procurement in addition to their other responsibilities. The trusts use the national contracts through the NHS Purchasing and Supply Agency (PASA) to achieve value for money on their contracts where possible, which involves the procurement of vehicles, however, this does not extend to ambulance conversions.
R 	**Option 2** Under this option, there may be the possibility of the three trusts working together to achieve greater value for money on other contracts which are not negotiated by PASA. In order to achieve greater value for money, the Trusts may need to agree on a common specification, which may be problematic. The arrangements within individual trusts are unlikely to change significantly to lead to a real increase in savings in the cost of procurement.

G	**Option 3** This option offers the potential to bring procurement expertise in to the organisation and employ resources which are dedicated to procurement. This could deliver a procurement strategy and the potential to negotiate better contracts. A common specification in goods other than just vehicles should offer the potential to secure other revenue and capital procurement gains. The potential to achieve real savings for both capital and revenue expenditure is much more feasible under this option.

5.5.10 Savings in audit fees

We have assessed the savings which could be achieved from external and internal audit. Under Option 1 and 2, there is no scope for savings as nothing essentially will change from the current position. However, under Option 3 there will be savings from external audit as there will only be the need to audit one organisation rather than three. The external audit fee will be reduced to take account of this.

Similarly, the internal audit fee will reduce under Option 3. For an organisation this size we estimate that the number of days required would be approximately 100, which would cost in the region of £30k. We have looked at the cost of audit fees for comparable Ambulance Trusts under Option 3 and the estimated saving of £80,000 appears to be prudent.

	Option 1	Option 2	Option 3	Saving for Option 3
External Audit	£134,000	£134,000	£70,000	64,000
Internal Audit	£46,000	£46,000	£30,000	16,000
				80,000

The above table excludes efficiency savings from the Local Counter Fraud Services.

R	**Option 1** The trusts will be distinct entities in their own right which will leave the audit arrangements unchanged and therefore the possibility of achieving any savings.
R	**Option 2** Under this option again the trusts will be distinct entities in their own right which will not alter the audit arrangements and therefore the possibility of achieving any savings is very limited.
G	**Option 3** Under Option 3, there will be one organisation which will bring with it the opportunity for savings on both the internal and external audit fee. More importantly the audit resource can be targeted at a wider resource base, and provide better value.

5.5.11 Potential for shared service arrangements

This is based on the ability to develop a shared service approach to the provision of business support services: HR, Finance, Estates, Procurement and Training. Under Option 1 and 2 the potential to have shared service arrangements is limited. Option 3 and one organisation will necessitate the need to merge the above functions which will mean that areas of good practice from each of the organisations can be harnessed. Equally, it means that experts can be employed who have the necessary knowledge and skills in their area of expertise and their focus will be trained on this one area rather than undertaking their role in addition to the other 'hats' they wear.

The three Ambulance Trusts currently have their own training functions. There are potential savings that could be made by Option 2 and 3 to co-ordinate training more effectively and economically due to the larger workforce. Whilst, in general terms the larger the service, the greater the saving. However, this must be counter balanced with the necessity of residential stays and higher travel expenses with the location of a

shared training centre. Therefore, whilst accepting that savings are a real possibility in this area, we have not attempted to cost them.

R	**Option 1** We are aware that there are informal arrangements between the three services where they do meet to discuss new operational systems, for example, a potential new PTS system. However, there are no formal arrangements in place to take this forward. We understand that the potential for sharing of services has been discussed for some time, however very little action has come from these discussions. The ability to share is restricted due to the organisational boundaries, and there is neither the incentive nor the communication pathway to encourage sharing of services.
R	**Option 2** There is likely to be some sharing of resources and services, and to some extent it would depend on how the management team were proposing to work and how much would be managed at the centre and how much would be devolved. For example having one Director of Finance and one Director of HR, would encourage sharing of some services such as: recruitment, IWL, diversity, and accounts could be centralised.
G	**Option 3** In this option services would be shared, although there might be some debate about the command and control functions and there would some difficulty in getting agreement on the most appropriate system. The trust will be able to afford more specialist staff who can be dedicated to a particular function than would be possible in a smaller service providing service Improvement as a result of the focus on the key issues.

Savings in operational costs

This includes the following criteria:

- Savings in HQ estates costs (depreciation, rate of return, rent, repairs);
- Fleet maintenance and EMDC costs;
- Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans).

5.5.12 Savings in HQ estates costs (depreciation, rate of return, rent, repairs)

The majority of savings in estates costs relate to the possible merger of HQ functions. Other opportunities exist for training facilities and vehicle maintenance workshops, but as these are operational issues we have not considered these areas in detail.

Our estimate on the savings achievable assumes that the organisations will eventually move to a single HQ building. The areas that savings can be achieved relate to rent, rates, heat, light and power. It has not been possible to accurately isolate the cost of HQ across the three Ambulance Trusts. The information we have on estates covers areas such as workshops, ambulance stations, training centres and control rooms.

The accurate costing is also not possible without detailed specification such as the location of the new HQ, the size of the building and the number of staff that need to be accommodated and the design requirements. These areas are operational decisions which are not in the scope of this review. However, should a detailed analysis be undertaken, we believe that there will be opportunities to rationalise the costs of the estates which will release resources for re-investment. As an estimate, we believe that the savings should approximate to 10% of the total premises costs of the three trusts which equates to £220k.

R	**Option 1** Under this option, the organisations will continue to operate from three HQ and control centres. There will be no opportunity to achieve savings in HQ estates costs.
R	**Option 2** Under this option the trusts will retain their own HQ, and are likely to retain the same arrangements for their control centres. Therefore, the savings in HQ costs will not be realised under this option.
G	**Option 3** This option will achieve savings in the long term. There will be real savings in rent and utilities costs under this option as the organisations HQ are housed in one building. However, none of the current HQ can accommodate the number of staff that would exist under one organisation. In the short term, there will be transition costs in renting or purchasing a building big enough to accommodate all staff, and be in a prime location for ease of access to all three geographic areas. There will also be the cost of rebranding under this option.

5.5.13 Fleet maintenance and EMDC costs

We recognise that even if the same number of centres is supported in totally new trust configurations there would be at least savings in management and supervisory costs. The efficiencies that can be driven from rationalising vehicle maintenance workshops are however complex to determine as savings in central organisation may be lost in longer vehicle down times in travelling and additional lease payments (incurring higher mileage). There may also be a need for a greater number of vehicles in the fleet to compensate for the amount of down time.

A review was undertaken approximately three years ago between AAST and GAST, which came to the conclusion that it did not make sense to centralise workshops for the very reasons outlined above. Additionally, GAST have tri-service arrangements for their fleet maintenance with the other emergency services.

This area would need a detailed review in its own right, recognising that a larger centre could also operate 24 hours and carry out servicing during the night at greater convenience to crews and the overall service.

Each of the Ambulance Trusts is renting their control centre from relatively new accommodation. In terms of AAST, they are based in a control centre which opened in July 2001 and houses their control operations and NHS Direct. There is a need for additional accommodation as the operation expands. This building is rented and there are two lease agreements as the building is split into two units. The lease is rolling and has clear break points. We have been advised that 9 months notice must be given to the landlord.

Gloucestershire moved into a new HQ and control centre which is a tri-service centre in 2003. The Trust is a tenant in this building and the lease is for 50 years and there is a 30 year break clause. WAST also share tri-service arrangements and moved into their building in 2003. This building is owned by the Police Authority and there is a long term agreement to share the costs. Again, this contract has a break clause.

The concern expressed to date is that there will be severe financial penalty clauses to release themselves from this agreement. The agreements do not quantify the financial penalties, and this would need to be investigated with the appropriate legal advice. However, we are aware that AGW SHA has commented that they can occupy some of this space, and this will need further discussions between the SHA and the Trusts. Additionally, in GAST and WAST where tri-service arrangements exists, the fire service will be looking to move from the tri-service centre at some point due to the regionalisation of the service. This would present an opportunity for a merger under one centre to be considered.

Other comments have been made on the investment in the communications infrastructure in these buildings, which means that housing the centre in one building would need to occur at an appropriate time. With the combination of three control centres, efficiencies can be difficult to achieve as adding the activity of three services together will aggregate calls throughout the day. However, costs in the control centre are stepped in nature – effectively resulting in demand periodically driving the need for an extra operator on duty. A larger control centre therefore has the ability to manage stepped costs more appropriately throughout the day, not just during the quiet hours of the night and the early morning.

For the purposes of the financial summary we have assumed that there could be opportunities to redeploy resources of £50k in terms of the costs of the control room and £150k in respect of staff costs should a new Trust wish to consider this option at some point in the future. At present, approximately £2m is incurred across the three Trusts on control room functions.

R	**Option 1** Under this option the three trusts will continue to act as separate entities with their own approaches to fleet maintenance and their control centre. This will not facilitate operational savings in the areas outlined above.
Y	**Option 2** There may be some potential to achieve operational savings if these areas are co-ordinated strategically. There are incompatibilities in command and control communications which would mean the replacement with a common system at a more appropriate point in the future. In the short term the three controls would have to operate separately, but when a new system is required, investment in a common system could take place.
Y	**Option 3** In the short term, the three control rooms would have to operate separately. We have not costed the future investment required to unite controls. We assume that the separate controls will continue to operate until the next stage of major investment when a common system can be considered, and an appropriate building has been chosen to unite the control rooms. The savings in operational costs will not crystallise until the necessary investment has been taken to harmonise the organisations. However, there is clear potential for savings in this area with revenue efficiencies from control staff and estates and the approach to fleet maintenance. There will be no capital receipt generated when the trusts combine to a single control centre as the organisations rent their current sites.

5.5.14 Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)

One of the main concerns for the financial viability of ambulance Trusts has been the ability to finance major capital investments. The value under option 3 more so than the other two options is the potential for recurring efficiencies and reductions in management costs but also the ability to avoid capital cost investments in the future on stations, vehicles, control room, equipment as a consequence of reconfiguration of services or the identification of alternative solutions to operational issues.

Capital cost avoidance relates to the opportunity to eliminates capital expenditure on premises, fixed plant, equipment and vehicles, by the removal of potential duplicate expenditure on similar facilities.

R 	**Option 1** This option does not give rise to economies of scale with regards to capital schemes. The amount of funding available is unlikely to increase and capital schemes will continue to be undertaken on a small scale. The Trusts have suffered from a lack of funding which has hampered their ability to make the necessary investment to improve the operation of the organisation.

R 	**Option 2** The organisation of resources under this option will not necessarily give rise to capital cost avoidance. There will not be significant enough change under this option to yield savings through capital cost avoidance.
G 	**Option 3** Capital investment will be necessary under Option 3 as under Option 1 and 2, the Trusts can continue with their current systems. Capital investment generally relates to command and control and communications IT. A new Trust may wish to explore the possibility of moving to new headquarter and control centre. In the long term, the Trust will have a larger capital base to invest in their infrastructure and make strategic service issues which can draw on a larger pool of existing capital resources. Also, if there is a need to invest, the duplication is avoided and cost avoidance will occur.

Financial Summary

Introduction

Within this section we provide a high level overview of the potential costs and opportunities to release and redeploy resources over the next 10 years under Option 3. The financial summary is intended to provide an assessment of whether the creation of a single integrated ambulance service serving the whole of AGW is capable of releasing resources that can be reinvested to create additional benefits for patients.

We have not undertaken a detailed cost benefit analysis in accordance with Treasury guidelines of the three options that we were asked to consider. This was acknowledged by the Steering Group as being outside the scope of the review. As a result we have not considered in detail issues such as the opportunity costs of investing resources in alternative operational areas or the identification of intangible benefits.

With regard to the potential opportunities to redeploy resources we have merely identified the areas where additional investment could be made. It is for the Board and Management Team of any new Trust that may be created in the future to agree on investment priorities based on the many competing demands for limited financial resources and the needs of the communities served by the Trust.

In addition we have not examined opportunities to reconfigure services at an operational level (either A&E, PTS, High Dependency Transport, NHS Direct, Out of Hours Services, Training facilities etc) as this was outside the scope of the review and would be the responsibility of any new Management Team in consultation with the Trust Board.

In preparing the financial summary we have also made assumptions regarding the timing of when certain costs could be incurred and when resources could be released for redeployment. In making these assumptions we have drawn on our experience of other similar projects.

High level assumptions

In projecting ahead we recognise that there are a large number of issues, policies, procedures and points of detail that have yet to be determined that could materially affect the overall level of costs to be incurred and also the scale of the opportunity to redeploy resources. In order to develop this financial summary we have had to make a number of assumptions based on our experience of similar projects elsewhere. In order to assess the potential impact of our assumptions we have undertaken a sensitivity analysis to indicate the materiality of our assumptions on the overall financial viability of Option 3.

For certain areas of expenditure such as the internal and external audit fees, cost on Non- Executive Directors and Management Team costs we can be relatively precise as to the overall opportunity to release and redeploy resources. We have comparable information on which to base our estimates.

For other items of expenditure the level of uncertainty makes it difficult to be precise as to the extent of potential costs and opportunities to release and redeploy resources. Where this is the case we have provided only a broad range of potential costs and opportunities to redeploy resources.

Where we have estimated the costs of creating additional management posts to provide additional capacity in key areas we have used information from similar sized Trusts as a benchmark of salaries.

We have sought to eliminate as far as possible any double counting of the potential opportunities to release and redeploy resources particularly in relation to savings in procurement costs where we have also raised the opportunity to reduce expenditure on premises costs.

In examining the high level costs and opportunities to release resources in the future we recognise that some costs will be incurred within a relatively short period of time (e.g transition costs) whereas other costs and potential opportunities to release and redeploy resources will occur at some time in the future.

Detailed underlying assumptions

In developing the high level financial summary of the potential financial implications of reconfiguring the ambulance trusts within AGW we have made the following assumptions:

- We have not taken into account any change in demand for the services in terms of increased activity or new areas of responsibility;
- We have classified costs as being either transitional in nature, recurring or non-recurring;
- We have separated capital expenditure (and any possible avoidance of capital costs) from annual or 'revenue' expenditure. We do however recognise the link between capital expenditure and the revenue implications arising from that expenditure (maintenance costs, depreciation etc).
- That there will be cash flow implications for the three Ambulance Trusts should Option 3 be accepted as the preferred way forward. This will need to be discussed in detail with AGW SHA to find the most appropriate way forward to fund the programme;
- We have assumed that in the fullness of time a new Trust may wish to develop new headquarters and that it would take at least two and a half years from the formation of the Trust before moving to a new headquarters building. We have not estimated the capital cost of any new headquarters building as this will be dependent upon its design, method of construction, location, number of staff to be accommodated, agreed space utilisation standards etc;
- We have considered the possibility of raising capital receipts from the disposal of existing headquarters buildings that may be classified as being surplus to operational requirements at some point in the future. We recognise that AAST's headquarters incorporate an ambulance station and this would need to be replaced should any decision be taken in the future to vacate the existing site;
- We also recognise and that GAST occupy a Tri-Service Centre which would mean that either a new tenant would have to be found (possibly AGW SHA) or the existing contract renegotiated. We consider that the capital cost of reconfiguring headquarters and creating small divisional offices could be met by the generation of capital receipts from the disposal of existing headquarters;
- Similarly we have assumed that it could take up to 3 years before a new strategy with regard to ambulance control rooms within AGW is developed and implemented. We recognise that a new Trust may wish to review the need to maintain three separate control rooms for A&E services. For the purpose of developing a financial summary we have assumed that a single control room could be established within three years from formation of a new Trust if not earlier;
- We have also assumed that it will take a new Trust approximately 18 months before support services (e.g. finance, IT, HR) are fully integrated and opportunities to redeploy are realised. This timetable recognises the need to agree the information systems to be adopted, determine new organisation structures, roles and responsibilities and appoint staff to the new positions. We recognise that AAST already has a contract with United Bristol Hospitals NHS Trust (UBHT) to provide administrative support on a shared services basis and that GAST shares vehicle maintenance service to a certain extent with its tri-service partners. There will be restructuring costs associated with the move to a single HQ and these have been taken into account in the financial summary.

Transitional costs

These relate to expenditure incurred in moving from the existing organisational configuration of ambulance trusts within AGW to a new structure under either Option 2 or Option 3. We have assumed that the period of transition could be up to three years from the formation of a new Trust.

The items of expenditure that could be classified as transitional will include:

- Any external support required in relation to project management and change management. In the short term we recognise that the three existing Trusts may have limited capacity in certain specialist areas. External support can often help support and drive the change process and provide specialist resources that may be required for a limited period of time. We have assumed a figure of £200k over a three year period to cover any external support that may be required;
- Costs of any communication programme with stakeholders and we have assumed a cost of £15k to cover this item of expenditure;
- The cost of organisational restructuring. Under this heading we have included the costs of any early retirements and voluntary redundancies where certain posts on the management team are no longer required and are declared as being surplus to operational requirements. This is an extremely sensitive topic and it will be for the Board of any new Trust that may emerge to decide its policy in this area and to agree the structure of the new organisation. Our figures at this stage are merely indicative;
- This will include costs of reducing administrative posts in support functions where opportunities exist to consolidate these in the future. This will also include the costs of any early retirement of voluntary severance schemes that may be considered in the future;
- The costs of changing signs, decals on existing vehicles, stationary, uniforms etc under Option 3. We have assumed a figure of £150k to cover this expenditure but identify this as an opportunity for investment;
- Should a new Trust wish to create a new headquarters there will be staff relocation costs that could either be paid a single 'lump sum' or be paid over a period of time. We have included an estimate of £100k to cover relocation costs and assumed that these are incurred in the third year following formation of a new Trust;
- Should a new Trust wish to develop a single control room for A&E services we would classify these costs as being transitional. As with the creation of a new headquarters there may be relocation costs for staff.

Ongoing costs

These relate to areas of expenditure where the cost base of the organisation has increased year-on-year. This will include the creation of new posts to provide additional management capacity in key functional areas.

Should Option 3 emerge as the preferred way forward then opportunities will exist at some time in the future to review the property portfolio of the new organisation. For the purposes of developing a financial summary we have assumed that in the fullness of time there would be one headquarters building (at a location yet to be determined) and that there would be a need for limited office accommodation at a divisional level though not at the same level as the existing headquarters of each of the three trusts.

Consideration will also need to be given to the arguments for and against the rationalising the number of control rooms. These considerations and any final decision are for the Management Team and the Board of the new organisation to make, if that is the preferred way forward.

Capital costs

Capital costs relate to expenditure on assets that have a value to the organisation beyond the period of account (one year). Expenditure that is treated as capital will include construction of new buildings, major alterations or adaptations to property, equipment, acquisition of new vehicles, major items of equipment and investment in new ICT systems.

Should Option 3 be the preferred way forward the new Trust will wish to develop a new ICT strategy and consideration will need to be given to the most appropriate way to implement the new digital radio network and replacement of control room software and equipment (computer aided despatch, automatic vehicle location, mobile data etc). Similarly a new approach to the provision of the necessary IT business infrastructure (Finance, HR, Fleet Management, intranet, extranet etc) will need to be developed. Opportunities will exist to reduce IT infrastructure costs.

Summary of costs and potential opportunities to release resources under Option 3

The table overleaf provides details of the estimated transitional costs, ongoing costs and opportunities to release and redeploy resources. Given the assumptions listed above we estimate that over a ten year period the key financial aspects of a reconfiguration of ambulance trusts proposed under Option 3 would:

- Result in transition costs of approximately £1.215 million over a seven year period;
- Leads to opportunities available for service improvement of initially between £738k and £831k in 2006/07 rising to between £1.16 million and £1.6 million in 2009/10 and in subsequent years thereafter;
- Out of this total, we have included investment of £67k for Director of Information Management and £273k for Divisional Directors and PA support;
- Lead to investment of £150k per annum to provide extra management capacity at the corporate centre of a new Trust over and above the costs of providing a new Management Team;
- After the investment in additional posts at both a divisional level and at headquarters to provide additional capacity, generate opportunities in a full year (from 2009/10 onwards) to redeploy approximately between £819k and £1.2m per annum for investment in the service for the benefit of patients.

Opportunities to redeploy resources for the benefit of patients

Given the assumptions stated above the financial summary indicates that from 2009/10 onwards a range of a minimum of £1.6 million to a maximum of £1.55 million will be available for service improvement (approximately 2% of the existing budgets of the three Trusts combined). We consider this to be a very conservative and prudent estimate of the potential to release and redeploy resources as we have not explored the potential at an operational level as this is outside the scope of this review. Given that approximately £31million (67%) is currently spent on the salaries and wages of employees across the three trusts, we believe opportunities will exist to develop new roles and responsibilities at an operational level that will lead to improved patient care.

The decision as to where any resources that are released could be redeployed will be the responsibility of a new Board and Management Team. Possible areas of investment could include:

- New vehicles (ambulance, car, motorcycle)
- Additional Emergency Care Practitioners, Paramedics, Ambulance Technicians
- Additional support for community responders
- Support staff
- Equipment
- Drugs and medical supplies (current expenditure across three trust is in the region of £1.1m per annum)
- Training and management development

Statement of costs and potential opportunities to release resources (minimum level) under Option 3

	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Potential for recurrent investment										
Short - term										
Reduction in Management Team costs [3]		(528)	(528)	(528)	(528)	(528)	(528)	(528)	(528)	(528)
-Reduction in Board costs (Chair & Non Execs)		(73)	(73)	(73)	(73)	(73)	(73)	(73)	(73)	(73)
-Saving in External audit costs		(64)	(64)	(64)	(64)	(64)	(64)	(64)	(64)	(64)
-Savings in Internal audit costs		(16)	(16)	(16)	(16)	(16)	(16)	(16)	(16)	(16)
Sub-total of short-term potential opportunities		(681)	(681)	(681)	(681)	(681)	(681)	(681)	(681)	(681)
Medium -term										
-Estates costs (single HQ)				(110)	(220)	(220)	(220)	(220)	(220)	(220)
-Reduction in support staff costs			(104)	(156)	(208)	(208)	(208)	(208)	(208)	(208)
Savings in procurement costs		(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)
Sub-total of medium-term potential opportunities		(50)	(154)	(316)	(478)	(478)	(478)	(478)	(478)	(478)
Recurrent balance available for service improvement		(731)	(835)	(997)	(1159)	(1159)	(1159)	(1159)	(1159)	(1159)
Suggested investment strengthening service improvement										
- Additional post on the Management Team [5]		67	67	67	67	67	67	67	67	67
- Additional Divisional Director posts and PA support[6]		273	273	273	273	273	273	273	273	273
Total suggested investment strengthening service improvement		340	340	340	340	340	340	340	340	340
Balance available for service improvement		(391)	(495)	(657)	(819)	(819)	(819)	(819)	(819)	(819)

Non-recurring transitional costs								
Communication Plan [1]	**15**							
Restructuring costs-early retirement & voluntary severance [2]	**100**	**100**	**100**	**100**	**100**			
HQ restructuring costs-early retirement & voluntary severance				**100**	**100**	**100**	**100**	**100**
HQ staff relocation costs				**100**				
Total transitional costs	**115**	**100**	**100**	**300**	**200**	**100**	**100**	**100**

Statement of costs and potential opportunities to release resources (maximum level) under Option 3

	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Potential for recurrent investment										
Short -term										
Reduction in Management Team costs [3]		(528)	(528)	(528)	(528)	(528)	(528)	(528)	(528)	(528)
-Reduction in Board costs (Chair & Non Execs)		(73)	(73)	(73)	(73)	(73)	(73)	(73)	(73)	(73)
-Saving in External audit costs		(64)	(64)	(64)	(64)	(64)	(64)	(64)	(64)	(64)
-Savings in Internal audit costs		(16)	(16)	(16)	(16)	(16)	(16)	(16)	(16)	(16)
Sub-total of short-term potential opportunities		(681)	(681)	(681)	(681)	(681)	(681)	(681)	(681)	(681)
Medium -term										
-Estates costs (single HQ)				(110)	(220)	(220)	(220)	(220)	(220)	(220)
-Reduction in support staff costs			(250)	(375)	(500)	(500)	(500)	(500)	(500)	(500)
Savings in procurement costs		(150)	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(150)
Sub-total of medium-term potential opportunities		(150)	(400)	(635)	(870)	(870)	(870)	(870)	(870)	(870)
Recurrent balance available for service improvement		(831)	(1081)	(1316)	(1551)	(1551)	(1551)	(1551)	(1551)	(1551)
Suggested investment strengthening service improvement										
- Additional post on the Management Team [5]		67	67	67	67	67	67	67	67	67
- Additional Divisional Director posts and PA support [6]		273	273	273	273	273	273	273	273	273
Total suggested investment strengthening service improvement		340	340	340	340	340	340	340	340	340
Balance available for service improvement		(491)	(741)	(976)	(1211)	(1211)	(1211)	(1211)	(1211)	(1211)

Non-recurring transitional costs								
Communication Plan [1]	**15**							
Restructuring costs-early retirement & voluntary severance [2]	**100**	**100**	**100**	**100**	**100**			
HQ restructuring costs-early retirement & voluntary severance				**100**	**100**	**100**	**100**	**100**
HQ staff relocation costs				**100**				
Total transitional costs	**115**	**100**	**100**	**300**	**200**	**100**	**100**	**100**

Explanatory notes:

Transitional costs

1 For successful implementation there will need to be robust communication arrangements, these have been estimated at £15k.

2 There will be initial restructuring costs – these have been estimated as £500k for early retirement and it has been assumed that the pension costs will be impacting on revenue over 5 years rather than as an initial lump sum. However , these costs could be mitigated to some extent by the redeployment of staff in the new Trust or in the wider NHS.

Potential to redeploy resources

3 Reduction in Management Team costs – this is the difference in the costs of the three existing Management Teams compared to the cost of the new trust Management Team (Chief Executive; DoF; DoOps; DofHR, Director of Corporate Affairs, Medical Director). This also includes the reduction in PA support to the Management Team, for the three trusts there are currently 7.68 PAs supporting the 14 Directors, we have assumed that 4 PAs should be able to support the new Management Team releasing £90k for re-investment.

4 HQ rationalisation – could generate savings, but there are costs of relocation and restructuring, the same approach used for the transitional costs has also been applied here.

The rationale for the other opportunities to release resources are more fully described in the text to the report.

Opportunities for investment:

Discretionary recurring costs (these have been included in the table above)

5 The Management Team may wished to be strengthened with a Director for Information – we have estimated that this would cost £67k per annum.

6 There Divisional structure could be strengthened by appointing three Divisional Directors at an estimated cost of £201k per annum. Three PAs to support the Divisional Directors have been included at a total cost of £72k per annum.

Transitional costs (these have been excluded from the table above)

Project and change management costs have been excluded, estimated as £200k

Costs of changes to signs, vehicles etc estimated as £150k have been excluded.

Further potential opportunities to redeploy resources (these have been excluded from the table above)

Potential opportunities to release resources by integrating the three control rooms have been excluded. The three services currently spend approximately £2m on staff in the control rooms and the new Trust may wish to consider reconfiguration in the future which may provide further opportunities to release resources.

We have not included the capital costs of a new headquarters building or its fitting out. Neither have we taken into account the sale of the two existing HQ buildings.

Value for Money	Option 1	Option 2	Option 3
Enables services to be shared	R	Y	G
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients	R	R	G
Increase in purchasing power	R	R	G
Makes better use of assets	R	R	G
Savings in Board costs	R	Y	G
Savings in management costs	R	Y	G
Early retirement costs and costs of management change	G	Y	
Savings in cost of procurement	R	R	G
Savings in audit fees	R	R	G
Potential for shared services arrangements	R	R	G
Savings in HQ estates	R	R	G
Fleet maintenance, EMDC costs	R	Y	Y
Capital cost avoidance	R	R	G

5.6 Transitional issues

5.6.1 Introduction

Each option will face different transitional issues. The three options will also have transitional issues which will span different time frames. Option 1 would have short term transitional issues lasting for perhaps up to nine months. Option 2 would also probably have transitional issues for up to one year, whereas for Option 3 the transitional process could be for up to three years.

In order to address these we have assessed each option in its own right and formed an opinion based on five key areas:

- Ease of transition to a new organisation
- Costs of transition
- Additional investment required
- Time taken to recover costs of transition
- Risks of transition

The scoring for each of the above has also been adjusted to take into account the degree of complexity in the task involved. Each of these is described in turn under their respective section.

5.6.2 Ease of transition to a new organisation

In this section we have considered the transition from the status quo to whatever the new arrangements will be in the future. It has been necessary to take account of:

- Degree of difficulty in implementing a particular course of action;
- The timescale to achieve change;
- The complexity of task;
- The amount of staff time needed to be devoted to the particular initiative; and
- Ability to recruit executive directors and other senior management.

The issues regarding culture, political pressure, and willingness to change have also been taken into account mostly based on perception from what we have seen and heard to date. We have scored this by reviewing this on an "Easy (3 points) to Difficult (1 point)" scale (Appendix 7).

The option with most points should be regarded as being the most favourable regarding ease of transition to a new organisation issues.

Total score 14 points	**Option 1** Initially we thought that there would be no transitional issues for Option 1, however, there is a need for the existing organisations to improve on their current performance. They are already implementing their own change programme. For WAST and GAST, the ease of transition might be easier as they will shortly be sharing a Chief Executive. Work has been undertaken by Alan Murray (independent consultant and a member of the project's Technical Sub-Group) to move the agenda forward on achieving clinically effective response times. This has recognised the need to develop an improvement of culture. An advantage of Option 1 would be that staff would not be diverted to issues around a new organisation. However, the continued modernisation of Ambulance Trusts would require more management input and as discussed earlier there is an issue of whether the existing organisations have sufficient management capacity. The Trusts also have limited access to performance management information which makes it difficult for them to move the agenda forward. Of the three options, this would be the easiest to implement as no significant changes would be made.
Total score 11 points	**Option 2** It would be probably easier to achieve from the existing arrangements than Option 3 as there is likely to be 'political' buy in to this option. Local identity would be retained as would local accountability. However there would be issues concerning the implementation of the new structure, such as: • Where would the management team be based; • Which organisation would employ the management team; and • What would be shared and what would be retained within the three services. In conclusion there are some issues in the implementation of this option but there would probably be fewer objections than for Option 3.
Total score 13 points	**Option 3** It would be harder to implement than the other options as there would be more significant issues to address concerning the 'politics' of forming one single trust. All the options need to have project plans to take them forward, but this option would need more planning to take account of the issues raised for Option 2 and also to consider how to exploit the opportunities that this option would provide. In conclusion this would be the hardest option to implement as this would involve major change for the three Trusts.

5.6.3 Costs of transition

We have concluded that any transitional costs for Option 1 are minimal. Any move from Option 1 will involve transitional costs as the organisations move from their current configuration to the chosen structure. Some of these costs will be one-off costs in the short term, which will help the organisations become fit for purpose. Below is a list of the likely transitional costs:

- Project management of any change to the current structure. This will involve organisational redesign, communication and marketing costs, and costs of re-badging;
- Aligning administrative, IT, CAD systems;
- Organisational redesign which will involve the recruitment of new staff in to posts which exist, and those which do not. There will also be early retirement and voluntary redundancy as a possibility under options other than Option 1. For Option 2 or 3 there will possibly be early retirement and voluntary redundancy costs; and
- If the organisations are going to come under one structure there will be significant costs. There will be costs of removal from the current location, which may involve the payment of penalty clauses. There will also be relocation costs or excess travel costs which will be paid for a minimum amount of time depending on the location of the accommodation.

There will also be transitional costs associated with operational areas of the organisation, this was outside the scope of this review.

G ●	**Option 1** There would be few transitional costs in this option.
Y ●	**Option 2** There would be some transitional costs.
R ●	**Option 3** There would be significant costs if this option were selected.

5.6.4 Additional investment required (i.e. remodelling of HQ, divisions etc)

The key issues considered were based on a view of which option would have the most significant costs. If Option 3 is the proposed option then a number of key decisions need to be taken before a real estimate of the cost of transition can be developed by the respective Boards, Management Team and project team. This will include the need to consider the following areas:

- Size and shape of the new organisation;
- Terms and conditions for staff;
- Asset management strategy;
- ITC strategy;
- Service improvement plan; and
- HR strategy including training and development required.

G ●	**Option 1** There would be no additional investment required in this option.
G ●	**Option 2** There would be the need for minimal additional investment.
R ●	**Option 3** There would be significant additional investment if this option were selected.

5.6.5 Time Taken to Recover Transition Costs

These would be most significant for Option 3 but probably not that significant to recover for Option 2, and not an issue for Option 1.

G	**Option 1** There are effectively no costs with this option.
G	**Option 2** Some costs but recovery should still be short to mid-term
R	**Option 3** The costs of recovery could be longer term (1 to 2 years). For more detail see the financial summary.

5.6.6 Risk of Transition

- For this assessment we have made a judgement of the risks identified below by conducting an analysis of the Political, Economic, Social, and Technological (PEST) issues.

There would be risks associated with the transition for the Ambulance Trusts. This would include risks relating to political, social, economic and technological context. We have also taken into account the risks of transition identified by Adrian Lucas, Chief Executive of the Scottish Ambulance Trust:

- Operational risk – that operational performance fails to improve in each county;
- Clinical risk – that clinical care performance fails to improve in each county;
- Political risk – that change fails to attract and sustain support from key internal and external stakeholders;
- Financial risk – that change can increases rather than reduces cost of purchasing Ambulance Trusts;
- Human resources risk – that change generates 'management of change' issues and de-motivates managers and staff;
- Strategy risk – that new organisational set-up is incapable of achieving and sustaining performance across all performance 'domains'; and
- Legal risk – that change generates legal issues around new organisational entities, decoupling control agreements, property rights, employer's liability etc, etc.

G	**Option 1** There is a risk that if there is no change in management organisation that the services would not improve. There is also a risk that if no changes are made, that either the SHA or the DH may make the decision that the Trusts should be integrated. There is a risk that insufficient resources are available from the commissioners to ensure that the ambulance Trusts can improve their performance. This is not identified as a risk for the other options because they provide more opportunities for existing resources to be used more effectively. There is also the risk that the performance of the existing services does not improve or at worse deteriorates. There is also the risk that the trusts would not be able to invest in the new technology. The conclusion is that there are minimal risks for the service associated with the status quo although there may be a bigger risk for the health community in that the DH may become involved in the decision making process and determine a future structure for Ambulance Trusts if they continue to fail to meet performance targets.

Y 🟡	**Option 2** Risks for this option are: • Not having sound project management arrangements; • Complications dealing with the contractual arrangements, HR, estates and procurement; • Not having a robust communication strategy; • Managing a dip in performance as manager's focus on the new arrangements rather than service delivery; and • Impact on morale as some staff has concerns about the future. There are high risks around transition, although probably not as high as Option 3.
R 🔴	**Option 3** The risks of transition would be similar to Option 2 but there would probably be greater risks concerning the project management arrangements because there would be more issues to resolve regarding the dissolution of three trusts and the creation of a new trust.

5.6.7 Conclusion

Option 1 has the fewest transitional issues and both Options 2 and 3 have transitional risks that can only be considered if there is good project management and dedicated support. Option 3 has the greatest risk because of the major changes that would take place. Steps will need to be taken to mitigate risk, and we would advocate a structured approach to risk management during this period, where steps would be taken to assess the impact of risks and likelihood of ocurrence.

Whilst transitional issues are extremely important they need to be seen in the overall context of the benefits to be gained from the change process. Whilst Option 3 identifies significant transitional issues for the new trust we believe these are capable of being addressed through the use of good project management and should not deter the Trusts from pursuing Option 3.

Transitional Issues	Option 1	Option 2	Option 3
Ease of transition to a new organisation	*Total score 14* G 🟢	*Total score 11* R 🔴	*Total score 13* Y 🟡
Costs of transition	G 🟢	Y 🟡	R 🔴
Additional investment required	G 🟢	G 🟢	R 🔴
Time taken to recover transition costs	G 🟢	G 🟢	R 🔴
Risk of transition	G 🟢	Y 🟡	R 🔴

6 Preferred option

Each of the three options were analysed and scored across all the agreed criteria. The scoring of the options was conducted by the PricewaterhouseCoopers review team.

All the criteria and scores were discussed and debated by the Technical Sub-Group in relation to each option. A further sensitivity analysis of the scoring was undertaken by the PricewaterhouseCoopers review team to reflect the conclusive findings arising from the analysis. The overall scores and sensitivity analysis for each option is shown in the table below and indicates a clear pattern emerging favouring Option 3. The detailed analysis is at Appendix 6.

	Opt 1	Opt 2	Opt 3
Analysis 1 - Original weighting	4.32	6.03	10.62
Analysis 2 - Adjusted weighting	4.42	6.08	10.86
Analysis 3 - Equal weighting	4.46	6.04	10.88

To determine the preferred option we examined the key strengths and weaknesses in terms of:

- patient benefit;
- organisational benefit; and
- wider health community benefits.

6.1 Option 1

6.1.1 Patient benefits

When assessing Option 1, we were aware that each Ambulance Trust has examples of how they are modelling their services to benefit their respective patient populations. However there is limited capacity within each of the organisations to maintain this ability to improve services. Each trust is concentrating its management effort to improve response times which are the key performance indicators for Ambulance Trusts and this is putting considerable pressure on the teams. The trusts are either not achieving the key performance targets or are not achieving all of them consistently. With focus on these targets, there is little management time for innovative thinking to concentrate on other areas of service delivery which will benefit patients.

The three Trusts in AGW have differing demographics which require different service responses within and between each county. There are marked discrepancies between the three counties in response times, level of staff per head of population and number of staff per ‘000 patient journeys. Under Option 1, there is less opportunity to change this inequitable provision of services.

The configuration under Option 1 offers less opportunity than Options 2 and 3 for creating common protocols between each of the Ambulance Trusts and sharing these protocols. This would also be the case for training and sharing of facilities, as each trust conducts their own training programmes and currently do not share training facilities for staff. Training in each of the Trusts has been considered weak and not addressing issues of modernisation within the Ambulance Trusts.

6.1.2 Organisational benefits

Organisationally, the Ambulance Trusts in AGW have limited scope to develop in terms of moving the modernisation agenda forward. The small size and lean structure of the Trusts promotes short and clear lines of accountability to their patients and trust boards, however with small budgets and limited staffing there is less flexibility within the management teams. The Trusts within AGW do not have any formalised mechanism for communicating with each other. Currently there are few opportunities other than on an ad-hoc basis to share good practice or back room functions.

There is clinical leadership in each of the Trusts at board level, however all three Medical Directors/Advisors are employed on a part time basis and they do not communicate regularly with each other, therefore fragmenting their impact.

There was little evidence in each of the Trusts of skills and background in information technology which could be used to inform the direction of each of the organisations' strategies.

6.1.3 Wider health community benefits

The relationship between each of the Trusts and the wider health community was weak and this is reflected in the poorly developed commissioning relationships with the lead commissioning PCTs. Some trusts were stronger in commissioning than others, however as a whole there was potential for each organisation to further develop the relationship with their commissioning PCTs. Also, PCTs are not exercising their governance responsibilities and this is undermining their role within the commissioning process. The PCT should be making more use of information provided by the Ambulance Trusts in the commissioning process.

There was limited evidence of the trusts partnering with other organisations. GAST works closely with the PCTs in their county providing an OoHs service and AAST is working with NHS Direct, however more potential could be made of these relationships and with relationships with other organisations including Local Authorities.

In discussions with the Police and Fire service we were aware that the whole local community did benefit from the links and partnerships that have been established in Wiltshire and Gloucestershire. There are tri-service centres in both these counties which do provide some benefits in terms of delivering services to the local populations and the Audit Commission have reported on the good practice in place in these centres.

6.1.4 Transitional risks

Compared to the other options, this option has the fewest risks in respect of transition. Those risks that are apparent are because there is a need for some change to ensure that the services across AGW continue to improve. The progress made to date to improve services across the three trusts has been at different paces. In the last year there is some evidence indicating that AAST has made significant improvements in improving performance and in modernising its services. This organisation has therefore put forward a stronger case for retaining the status quo.

6.1.5 Conclusion

Option 1 offers neither the capacity and capability to address the current issues within the existing Ambulance Trusts, nor the potential for development and change needed to address the future of service delivery for the population of AGW.

6.2 Option 2

Option 2 has some strengths which are also present in Option 3, but its main difference is that there is still local accountability and local identity which are politically acceptable. This option does present some concerns with regard to governance arrangements and how three separate boards would be able to work with one management team.

6.2.1 Patient benefits

We have only identified a few benefits for patients in this option. There would be the potential for sharing of good practice between the three organisations, however there is a risk that the three trusts could continue to operate in 'silos'.

There is also a risk that only limited improvements can be achieved due to the time and resources being directed towards meeting the agendas of three different boards with different visions on how services can be improved.

6.2.2 Organisational benefits

This option would encourage more collaboration between the three trusts promoting sharing of limited resources. But the success of this will depend on the ability of the three boards to reach consensus and to communicate their decisions with each county division.

There are a number of challenges with this option regarding how the management team would work with three Trust Boards, for instance:

- If Boards are divergent in their views this will present difficulties for the management team to share resources to meet the targets;
- The structure does not free up management resources to identify opportunities for the integration of services or for further development of the service;
- It would be difficult to understand roles and responsibilities and the divisional boundaries could be blurred, making accountability and communication more difficult;
- Due to the complexity of the structure, there may be a reluctance for high calibre managers to apply for senior posts;
- The difficulties of communicating with three Boards will impact on the development of a seamless service and common protocols;
- There are no financial benefits in terms of savings on audit fees or Board costs; and
- It is unclear whether benefits from joint procurement would be achieved by this option.

6.2.3 Wider health community benefits

A key benefit of this option is that it would maintain a local focus and identity, yet the countywide management team would be able to operate at a strategic level addressing the national agenda. It would also demonstrate to all stakeholders that locally changes had been made to the service to address the need to improve performance, although it is doubtful that all local issues will or could be addressed with this option.

There is capacity for developing new opportunities to interact with the wider healthcare community, but there may difficulty to gain consensus to progress these across the three Boards. There will also need to be good senior management in place in each of the existing divisional structures to implement the cross county decisions and retain connections with the local health community and other emerging services.

6.2.4 Transitional risks

The main risks associated with implementing Option 2 are: the ability to recruit a strong management team; clarity with the Management Team about the strategic direction for the three separate organisations; and ensuring that there is a good communications strategy because of the complexity of the organisational arrangements.

6.2.5 Conclusion

There was a view that this option was an interim solution and that ultimately a single trust would emerge.

6.3 Option 3 – the preferred option

Option 3 is the preferred option of this review. With the formation of one trust with one Board and one Chief Executive across AGW, the critical mass generated will provide opportunities to recruit a strong Management Team which will have clear lines of accountability to their respective divisional structures within each county. Though Option 2 also has the potential to create more critical mass to support service delivery, the accountability arrangements are more blurred than in Options 1 and 3.

6.3.1 Patient benefits

Option 3 has the greatest potential to achieve benefits for patients. By integrating the three trusts, resources can be pooled, good practice can be shared, and a progressive management culture can be created. The structure of Option 3 will encourage more collaborative working across AGW which will benefit patients, especially those living at the border of the county.

There will be one clinical lead for the service who will have greater potential to take forward initiatives such as PGDs (Patient Group Directives). This clinical lead will have greater opportunity to bring strategic direction and planning to the implementation of clinical protocols and linking these protocols with the PCTs and acute trusts over a wider geographic area. However it will be important for the single trust to be sure that there are good clinical links with local health communities.

A larger organisation will have the ability to tackle issues such as clinical audit, training and service developments more effectively than with Option 1 or Option 2.

The option provides the best opportunity for moving the national ambulance service agenda forward for the benefit of patients as staff will be better trained and better equipped to respond to patient needs.

6.3.2 Organisational benefits

Option 3 will create greater critical mass to take forward new ways of working as it will provide more time for managers to think strategically and have flexibility to implement their strategies. Greater critical mass will also ensure the organisation will:

- Create more potential for the presence of 'around the clock' management rather than reliance on-call managers;
- Recruit and retain high calibre staff;
- Be in a better position to share good practice;
- Allow more flexibility to deploy resources to meet performance targets and to deploy resources more equitably across AGW;
- Enable more specialist expertise in areas such as IT and Communications and Human Resources;
- Create a more cohesive approach to support services across AGW.

Option 3 is the most viable in the long term for ambulance trusts in AGW. A larger organisation will have greater economies of scale and therefore potentially lower reference costs ensuring a more financially secure future than Options 1 or 2. The opportunities for resource sharing across the three counties will support the operational functions of the ambulance services thus securing a more operationally viable organisation. The single trust will have a larger budget, therefore it will be easier to identify potential savings across AGW and make more strategic decisions about investing for the long term future.

6.3.3 Wider healthcare community benefits

Option 3 has a clearer structure than Option 2, therefore it will allow firmer relationships to develop with other organisations. The management structure under Option 3 will free up more time for strategic thinking across the county and so that the management team can address issues of service integration with other PCTs, acute trusts, Local Authorities etc. Under Option 2, the cross county structure is more blurred which may lead to more confusing partnering relationships.

Option 3's management structure will enable the single Ambulance Trust to look more strategically over a wider geographic area. There is the risk that the management team will become more distant from the local issues, however a good quality middle management layer should maintain local accountability.

This option provides greater opportunities for reforming working practices and creating new patient pathways which would create efficiencies for the whole health community.

Commissioning under Option 3 will be more complex than under Option 1, however once established, the commissioning arrangements will be clearer than under the structure of Option 2.

6.3.4 Transitional risks

In Option 3 there are more issues to address than in either Options 1 or 2 because there will be more changes to roles and responsibilities in the creation of one organisation. Due to there being one Executive Team rather than three, there would be uncertainty about the future of the service and the potential impact that this option will have on the existing Ambulance Trust staff. The issues associated with Option 2 would also be applicable to this option.

6.3.5 Experiences of other merged trusts

As part of our review of the future configuration of Ambulance Trusts in AGW, we contacted the Chief Executives of the following Ambulance Trusts created by the merger of smaller services:

- Bedfordshire and Hertfordshire Ambulance Service NHS Trust
- East Midlands Ambulance Service NHS Trust (EMAS)
- Hereford and Worcester Ambulance Service NHS Trust
- London Ambulance Service NHS Trust
- North East Ambulance Service NHS Trust
- The East and North Yorkshire Ambulance Service NHS Trust (TENYAS)
- Two Shires Ambulance Service NHS Trust
- West Country Ambulance Service NHS Trust

In addition to talking to the Chief Executives of the above trusts we also spoke to the Chief Executive of the Staffordshire Ambulance Trust NHS Trust. Staffordshire was chosen as it is regarded as a high performing three-star trust but is smaller in scale than the majority of the trusts mentioned above. It was felt by both the review team and the Steering Group that this would provide an interesting insight into the importance of size (i.e. In terms of income, staffing, population served, area covered) on management and performance levels.

The Chief Executives of the larger Ambulance Trusts commented that they are able to:

- Have greater flexibility in the use of resources and an ability to drive through efficiencies for reinvestment in the service for the benefit of patients;
- Attract higher calibre staff through the payment of higher salaries;
- Invest more in management development initiatives than smaller services;
- Afford more specialist staff who can be dedicated to a particular function than would be possible in a smaller service(e.g. Clinical Governance, Risk Management, Emergency Planning, Business Development, Service Improvement, Quality Management);
- Have greater flexibility in terms of their budgets due to their large income base;
- Avoid the problem experienced by smaller services where managers are often asked ‘to wear a number of hats’ and are not able to focus on one particular aspect of the service, This can place significant pressure on management within the smaller services;
- Use their larger capital base to invest in infrastructure renewal (fleet, buildings, IT and Communications systems);
- Co-ordinate training more effectively and economically due to their larger workforce; and
- Invest more resources into research and development of clinical protocols and care pathways.

The Chief Executives also commented that:

- Mergers per se do not save money but they do provide opportunities to identify and realise efficiency savings and avoid significant capital costs;
- There is a need to keep demonstrating what is the added value from the merger and what will be the benefits to patients;
- That merging three relatively poor performing services (according to the star rating system) will not in itself create a three star trust overnight;
- There can often be a short term dip in performance as managers take their ‘eye off the ball’ and focus on internal issues rather than service delivery and operational performance;
- In one case the Chief Executive stated that he would not have been able to achieve his recent successes had he been going through a merger at the time;
- Larger services does not necessarily mean that there is less accountability as this can be addressed through the design and implementation of effective organisational structures and community engagement programmes; and
- The timing of any proposed merger is important. December to March tends to be a very busy period for most Ambulance Trusts.

Of those that had experienced mergers first hand the key learning points offered included:

- If merger of existing services is the agreed way forward then there should not be a prolonged period of time before the new organisation is created. The broad consensus was for a new trust to be in place by 1 April 2006. Whilst it was recognised that a longer lead-in time would enable more detailed planning to be carried out concern was expressed that this may create more uncertainty with staff which could lead to problems of morale, commitment to the new organisation and possibly increased staff turnover at all levels;
- For a merger to be a success all of the staff from each of the former services needs to be committed to the process;
- There needs to be fairness, equity and consistency in all dealings with staff and other stakeholder groups;
- Develop corporate policies and procedures but deliver them at a local level;
- There is a need to create a new culture and identity for the new service;
- Streamline the commissioning process and make it more effective;
- Don't underestimate the time it takes to achieve real change in organisational, attitudes and harmonisation of procedures etc; and
- There needs to be a period of stability post-merger in terms of retaining Board members and members of the Management Team for a reasonable period of time.

With regard to Option 2, there was no support for this option. The following comments on this option were expressed:

- It would place significant pressure on the Management Team that was appointed.
- It would lead to inefficient use of management time due to travelling between Trusts.
- There would be problems of access to the Management Team by the staff from individual Trusts.
- It would not be sustainable in the long run and could be seen as simply a 'stepping stone' to full merger.

Discussions with the Chief Executive of a relatively small but high performing and well regarded Ambulance Trusts offered a counter view to the perceived benefits of creating larger Ambulance Trusts, the points made included:

- There is an optimum size for an efficient and effective Ambulance Trust and research indicates that such a service should serve a population of between 1.2 and 2 million.
- Rather than merge three relatively poor performing trusts, each trust should be charged with developing and implementing a performance plan to raise performance prior to any consideration of merger. Once performance of all trusts has improved to an acceptable level then is the time to consider merger proposals.
- The overriding need is for strong and effective leaders and managers who have a thorough and deep understanding of Ambulance Trusts.
- The perceived under-funding of some Ambulance Trusts often masks the root causes of poor performance which are largely due to inefficiency in deployment of resources and a lack of effective policies and procedures at a corporate level.

We have taken the above comments, advice and guidance when evaluating the three options we have been asked to consider in relation to the Ambulance Trusts in AGW.

6.3.6 Conclusion

Option 3 is the preferred option of this review as it is the configuration which can demonstrate the greatest benefit to patients in terms of improving services to meet localised patient need. Option 3 will create more organisational benefits both strategically and operationally and will generate wider benefits for the healthcare community. In recommending implementation of Option 3, it must be acknowledged that there have been difficulties in merging other Ambulance Trusts and the new organisation should benefit from the experiences of these Trusts.

7 Organisation transition

7.1 Introduction

We have identified the indicative work streams for Options 2 and 3. There would be a lot of work to do but it should be achievable by April 2006 if proper consideration is given to the points raised below:

- The transition process needs to be funded and have dedicated support. A change programme such as this cannot succeed without dedicated project management.
- The development of a strong and effective project management structure.
- The creation of effective planning teams to share information and plan how the respective services will come together to form new organisations without there being any adverse effects on individual service performance during and after the transition.
- It will require effective co-ordination of actions across all stakeholders, while ensuring that existing operations continue unaffected.
- Communication and engagement of ambulance staff and the public will be important in ensuring that the outcome is successful.

7.2 Outline transition plan

The outline workstreams are listed below, as an initial framework for discussion that would need to be developed and changed by stakeholders. They are not exhaustive but provide an indication of what would need to be done, no milestones or timescales have been attached to the workstreams, but this would be the first stage of developing the project plan.

The potential workstreams and tasks that would need to be completed include:

- Putting programme and project management arrangements in place;
- Recruiting a Chief Executive;
- Configuring an executive Management Team;
- Recruiting a Trust Board;
- Defining and communicate the organisations vision;
- Developing strategies and plans;
- Reviewing terms and conditions for staff; and
- Consultation and communication with all stakeholders.

Following submission of our report to the Steering Group, we anticipate it being circulated to each Ambulance Trust for their consideration. Each trust will then need to consider our preferred option from their own trust's perspective. We anticipate discussions taking place between the Trust Boards affected by our proposals as they evaluate the implications for service deliver in their respective communities.

Should the Boards of individual Ambulance Trusts support the preferred option contained within this report, a formal process has to be undertaken to dissolve existing trusts and create a new trusts.

During the review we have discussed the three options with stakeholders and have encouraged all interested parties to communicate their views to us. We have also tried to be as open as possible and ensure that the review process was as transparent as could be and that all interested parties understood the process.

We are conscious that any management re-organisation of services will lead to anxiety and uncertainty amongst the staff of each Ambulance Trust and we think it is essential not only to be seen to be acting fairly in the interest of staff but also for the successful implementation of the preferred option of services that an effective communication system is implemented. Communication, if it is to be effective, needs to be two way and to be seen to be honest and open.

It is equally important that any coming together of Ambulance Trusts is seen as the creation of a new organisation building on the best of all former Ambulance Trusts. Whilst there may be differences in size of services coming together in terms of turnover, staffing levels, area covered and population served the

proposed changes should not be viewed by any of the trusts involved as a “takeover”. To do so would create completely the wrong atmosphere and adversely affect morale within the new organisation. All effort must be made to create new identities and cultures which are unique to the new trust.

Once AGW SHA and other stakeholders have indicated the preferred option which they are able to support it is important that as much advanced planning is carried out prior to the proposed implementation date of April 2006. We have used this as the implementation date rather than giving a longer lead in time is that there is a strong desire that if change is going to take place it would be better that it is completed promptly.

Whilst it will not be possible for any working parties to commit the Board and senior management team of the successor trust to particular policies before they are actually appointed a great deal of preparatory work can be completed in advance of those appointment being made. The main areas where we believe separate working parties should be established as soon as possible under the guidance of the overall project management team are as follows:

- Personnel (Organisational Structure, Terms and Conditions of Employment, Recruitment and Training);
- Vehicles and Fleet Management;
- Finance (Investment Plans, Capital and Revenue Position);
- Potential financial costs and savings from the integration of the three trusts;
- Communications, Controls Assistance, Command and Control and Information Technology;
- Clinical Audit (protocols);
- Contractual Issues (PTS, cross boundary activity);
- Risk Management;
- Estates; and
- Corporate Governance

We recognise that the establishment of working parties to address detailed implementation issues will place additional work on senior management teams at a time when they will also be supporting the consultation process with their stakeholders and continuing to ensure the delivery of the national performance targets. However, we believe it is essential that senior management play a full and active part in the implementation planning process as this will be a major factor in the success of the new structures.

8 Conclusions and way forward

8.1 Conclusion

The decision to review the configuration of the Ambulance Trusts in AGW has come about from a recognised need to identify opportunities to develop ambulances for the future. The majority of stakeholders indicated that the need for change is a necessity and that the status quo cannot continue.

In summary, we believe that Option 3 as the preferred option will achieve the stated purpose of this review – to recommend an option which will deliver the best service to residents in line with the service framework.

8.2 Way forward

In determining the way forward the following recommendations are made:

- The SHA should take a lead in progressing the implementation of Option 3;
- The content of this report should be considered by each respective organisation;
- Once each organisation has considered this report, there should be some form of consultation with the wider health community;
- Once a decision has been made in principle based on internal and external consultation, further detailed legal advice should be sought on the legal process to be followed;
- A Project Board should be established to direct the integration of the three Ambulance Trusts. This Board should encompass senior representation from each of the three Ambulance Trusts;
- Subject to remaining within legal frameworks and NHS Regulations, the SHA should proceed with the appointment of a single Chief Executive to provide leadership for the proposed single Ambulance Trust.
- Once the Chief Executive is appointed, a project group needs to be established to direct and drive the change process;
- Specific project management support for the Project Board should be identified and appointed;
- The Project Board should appoint a Project Manager to drive the day to day progress of the integration project; and
- The Project Manager will have oversight from the Project Board and in consultation with the relevant stakeholders, produce a detailed Project Plan to achieve the integration of the three Ambulance Trusts by April 2006. The project plan must include key milestones and detailed steps and actions required.

Appendix 1 Terms of Reference

SPECIFICATION

Developing Ambulance Services for the Future
A review of the Ambulance Service Configuration in the AGW SHA Area

Terms of reference

The AGW SHA wishes to commission in partnership with key stakeholders a study to examine the future configuration of Ambulance Services. The specification requirement is:

"To undertake an option appraisal of the options for the future configuration of ambulance services currently provided by the Avon Ambulance Services NHS Trust (AAST), the Gloucestershire Ambulance Service NHS Trust (GAST) and the Wiltshire Ambulance Service NHS Trust (WAST) and to make a recommendation as to the preferred option that will deliver the best service to residents in line with the service framework."

The work will fully examine three options for meeting the likely future needs:

- Retention of the existing organisational arrangements;
- The creation of an integrated management team across the three organisations;
- The establishment of a single new NHS Trust with a distinct divisional structure.

Scope

A good deal of work has already been accomplished, and the commissioning of this work by AGW SHA anticipates that full use will be made of data, material and decisions reached to date. A summary of the background to this work is attached at Appendix A.

The assessment of need for change in order to deliver current and future services - in terms of organisational governance and the broader NHS agenda -needs to be clearly described. Consultants will consider risks and benefits of each option using an agreed methodology also addressing the service and resource implications in the short, medium and longer term.

As part of the proposal, consultants will need to identify and specify the criteria that they intend to use for testing the options and how they intend to involve key stakeholders in the overall process, given the high profile of public and media interest in this work.

The analysis will take financial aspects fully into account and consider the revenue and capital implications of each of the options. The current financial baseline of each organisation should be established and confirmed. Savings and potential strategic investments, along with any relevant transitional costs from either of the options should be set out in comparative tables.

Outputs

Proposals should be submitted setting out the following:

- methodology for the appraisal including approach to financial and organisational modelling
- the process for involving key stakeholders
- timescales and costs
- Quality assurance arrangements
- detail on the proposed project team including CVs and any recent examples of other public sector reviews of this type.

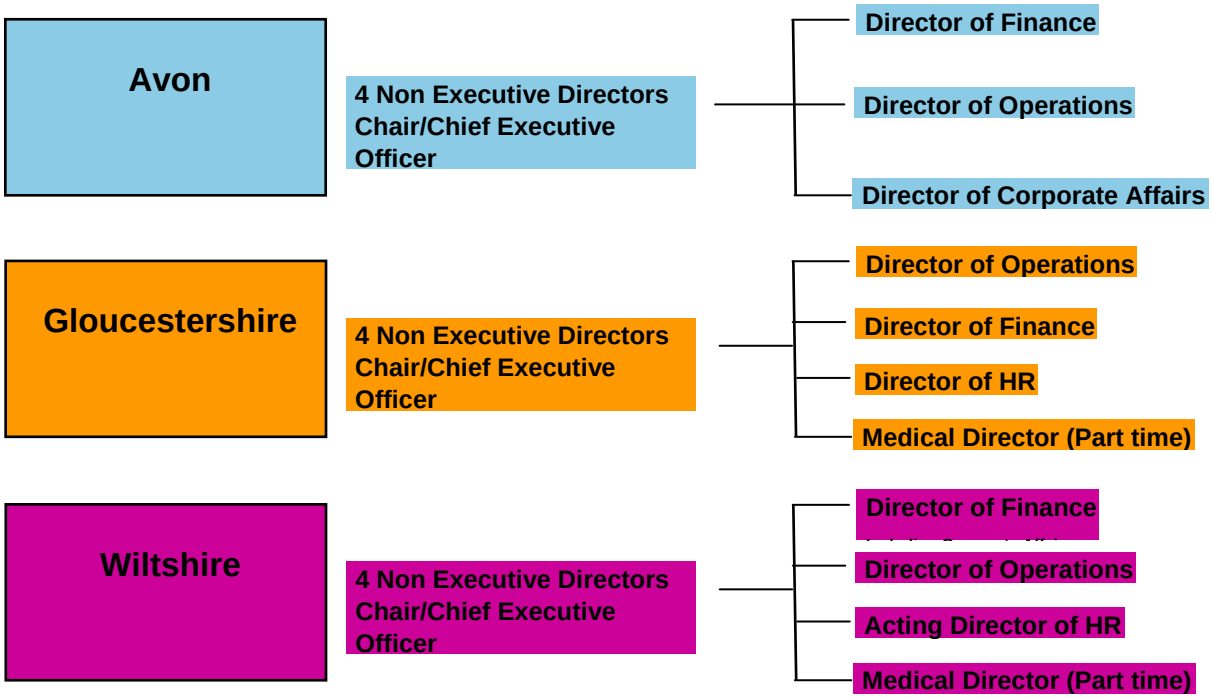
The report will be considered by the Steering Group and following confirmation will be placed in the public domain.

Project arrangements

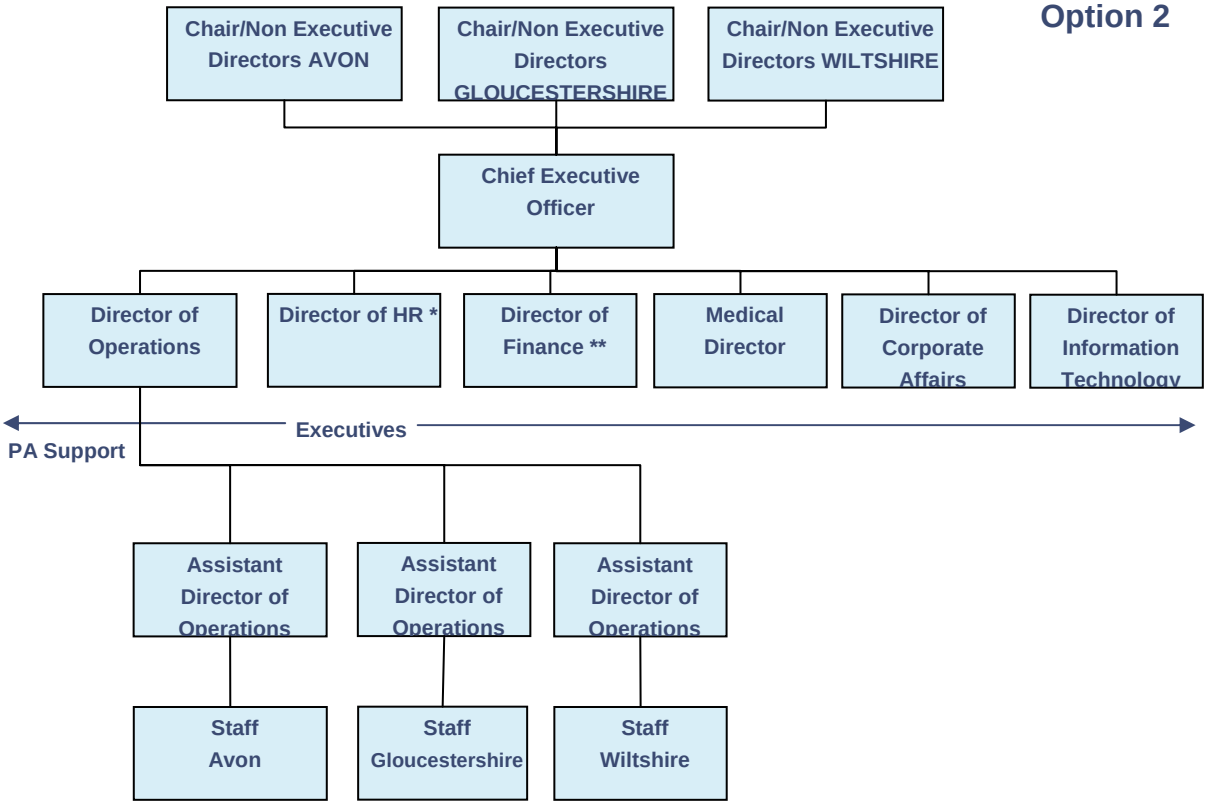
Consultants will produce a report and recommendation for the Project Steering Group (membership attached at Appendix B). Day to day liaison will be with the Director Corporate Affairs and Special Projects at AGW SHA. Other assistance will be available from a technical advisory group consisting of the 3 Ambulance Trust Chief Executives and Mr Alan Murray, previously a Chief Executive of an Ambulance Trust. Advice and support for patient and public involvement matters is available through a Communications and PPI group established to support the review.

Appendix 2 Structures for the proposed options

Option 1



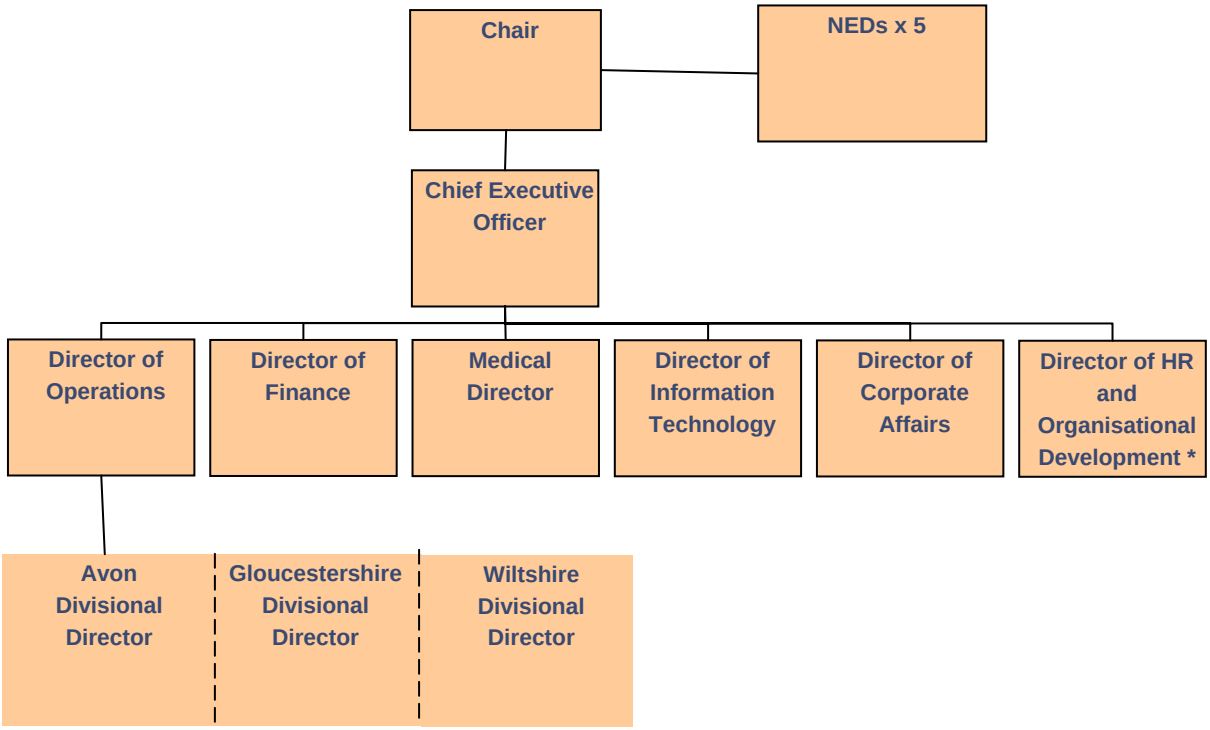
Option 2



*To include organisational development, training and education

** To include business development commissioning

Option 3



* Includes Training and Education

Appendix 3 List of Steering Group Members

Name	Job title	Organisation
Anthea Millett	Chair	AGW SHA
Trevor Jones	CE	AGW SHA
Rachel Pearce	Director of CA & Special Projects	AGW SHA
Kevin Hogarty	Chief Executive	Avon Ambulance Service NHS Trust
Louis Victory	Chair	Avon Ambulance Service NHS Trust
Phillip Selwood	Chief Executive	Gloucestershire Ambulance Service NHS Trust
Keith Scott	Director of Operations	Gloucestershire Ambulance Service NHS Trust
Carolyn Elwes	Chair	Gloucestershire Ambulance Service NHS Trust
Tim Skelton	Acting Chief Executive	Wiltshire Ambulance Service NHS Trust
James Carine	Chair	Wiltshire Ambulance Service NHS Trust
Carol Clarke	Joint Chief Executive	Kennet and N Wilts PCT/West Wiltshire PCT
Ron Crook	Chair	Kennet and N Wilts PCT
Mary Hutton	Director of Finance	Bristol North PCT
Arthur Keefe	Chair	Bristol North PCT
Caroline Fowles	Chief Executive	Cheltenham & Tewkesbury PCT
Ruth FitzJohn	Chair	Cheltenham & Tewkesbury PCT
Jan Stubbings	Joint Chief Executive	Swindon PCT/S Wilts PCT
Michelle Howard	Chair	Swindon PCT

Appendix 4 Interviews with Stakeholders and Others

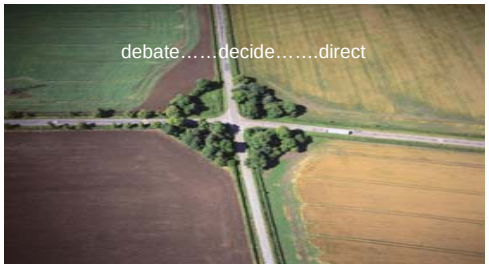
Organisation	Stakeholders & others
Avon, Gloucestershire and Wiltshire Ambulance Trusts	- Chairs - Chief Executives - Non-Executive Directors - Trust Management Teams - PPI Representatives - Control Room Managers
Lead Commissioning PCTs	- Chairs - Chief Executives - Non-Executive Directors - PPI Representatives
AGW Strategic Health Authority	- Chief Executive - Chair of Steering Group - Director of Corporate Affairs - Non Executive Director
Fire Services	- Gloucestershire Chief Fire Officer - Wiltshire Chief Fire Officer
Police	- Gloucestershire Chief Constable - Wiltshire Chief Inspector
Other Ambulance Trusts	- Chief Executive, Bedfordshire and Hertfordshire Ambulance Service NHS Trust - Chief Executive, East Midlands Ambulance Service NHS Trust - Chief Executive, Hereford and Worcester Ambulance Service NHS Trust - Chief Executive, London Ambulance Service NHS Trust - Chief Executive, North East Ambulance Service NHS Trust - Chief Executive, Tees, East and North Yorkshire Ambulance Service NHS Trust - Chief Executive, Two Shires Ambulance Service NHS Trust - Chief Executive, Westcountry Ambulance Service NHS Trust - Chief Executive, Scottish Ambulance Service NHS Trust - Chief Executive, Staffordshire Ambulance Services NHS Trust

Appendix 5 Interim Presentation to Steering Group 6 May 2005

Government and Public Sector

Developing Ambulance Services for the future – a review of the Ambulance Service configuration in the AGW SHA area

6 May 2005



PricewaterhouseCoopers

Agenda for today

Part one

- Progress to date
- Who we have seen
- Key headlines
- Issues leadership will need to consider
- SWOT analysis summary

Part two

- Evaluation
- Transitional issues
- Work remaining

Progress to date

- Conducted 27 interviews
- Conducted a SWOT analysis with some of those we have met
- Reviewed and analysed documentation that has been made available
- Agreed and tested the evaluation criteria against each of the 3 options
- Conducted financial analysis of organisational management structures
- Conducted some high level benchmarking of the 3 Trusts and comparison with other Ambulance Trusts
- Received 7 responses to our confidential post box

Who we have interviewed

- **Avon, Gloucestershire and Wiltshire Ambulance Trusts**
  - Chairs
  - Chief Executives
  - Non-Executive Directors
  - Trust Management Teams
  - PPI Representatives
- **Lead Commissioning PCTs**
  - Chairs
  - Chief Executives
  - Non-Executive Directors
  - PPI Representatives
- **Ambulance NHS Trusts**
  - Hereford & Worcestershire
  - North East
  - Bedfordshire & Hertfordshire (16/5)
  - West Country (17/5)
  - Scottish
- **AGW Strategic Health Authority**
  - Chairperson
  - Chief Executive
  - Chair of Steering Group
  - Director of Corporate Affairs
- **Fire Services**
  - Gloucestershire Chief Fire Officer
  - Wiltshire Chief Fire Officer
- **Police Services**
  - Gloucestershire Chief of Police
  - Wiltshire Chief Inspector

Key headlines

- There is a feeling that people want to "just get on with it" – a sense of inevitability
- Option 1 is favoured by some ("Why fix if it's not broken?") and it's recognised as providing local services with local focus
- Option 2 is seen by most as a half-measure and whilst providing some strengths is unlikely to result in long term improvement
- Supporters of Option 3 believe that it is the most likely to deliver the modernisation agenda as long as a local focus can be retained
- Early indications are that the 3 options are unlikely to result in significant cost savings in the short term
- Opinions appear to be polarised around Option 1 and Option 3 with virtually no support for Option 2

Issues leadership will need to consider

- Retention of a local focus remains top priority
- Ensuring that a drop in performance does not happen
- Addressing concerns over redistribution of resources
- Avoidance of inequity in terms of access to services
- Manage any change by planning and resourcing it adequately
- Build on best practice where it exists
- Ensure change results in patient benefit – people believe passionately in the services they are providing

Strengths and weaknesses

	Strengths	Weaknesses
Option 1	Local focus Retains identity	Limited capacity/resources Scale of organisations Future viability
Option 2	Potential to share good practice Economies of scale Bigger player nationally	3 Boards – limited change in bureaucracy Staff perception – worst option Accountability confusion
Option 3	Greater critical mass Economies of scale Potential to deliver modernisation Potential to utilise resources more effectively	Cultural change issues Leadership needs to have total commitment Personal agenda's get in the way

Opportunities and threats

	Opportunities	Threats
Option 1	Consolidation Improve relationships	Recruitment & retention Loss of control Ability to deliver future change
Option 2	Standardisation Adoption of consistent practices Potential to build clinical networks	DH may not be convinced Inequality of resources Stronger leadership in some areas
Option 3	Bigger player nationally Strengthen local focus Greater integration with others Financial and performance stability	Public / staff perception Internal politics as a blocker Lack of ownership Lack of desire to change

Part two - evaluation

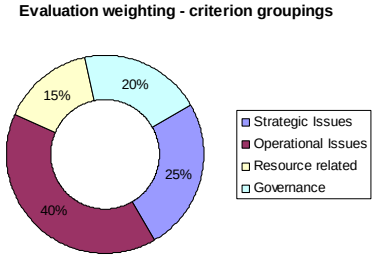
The following slides cover:

- evaluation introduction
- evaluation groupings & weightings
- draft evaluation weightings
- summary of methodology
- considerations for scoring options
- transitional issues
- work remaining

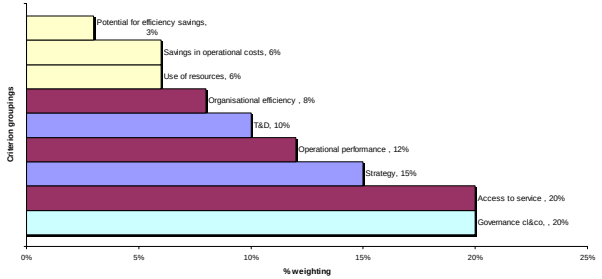
Evaluation introduction

- The evaluation is based on qualitative and quantitative data
- We have grouped the criterion into 4 key groups
- Each group has been weighted with each sub-criterion being allocated a weight
- We will:
  - use a traffic light system with points allocated
  - conduct some sensitivity testing
  - test findings with the technical group

Evaluation grouping & weighting



Draft evaluation sub-criterion weighting



Summary of evaluation methodology

1. Score each criterion against traffic light system
2. Red 1 point, Yellow 2 points, Green 3 points
3. Add score for each criterion grouping
4. Multiply this by the weighting to provide a score for each option against each criterion
5. Once all criterion/options scored then apply transitional assessment
6. Produce overall score
7. Test out findings

Considerations for scoring options

Definition of the Scores	Red	Yellow	Green
Potential	NONE	SOME	SIGNIFICANT
Savings: Generate: Reduce Cost; Cost Avoidance; Increased Efficiency.	LOW	MEDIUM	HIGH
Sustainability	SHORT TERM	MEDIUM TERM	LONG TERM
SWOT analysis			
Interviews			
Documentation reviews			
National Guidance			
Comparative data/information			

Supporting evidence & information

Transitional issues

- Assumption that each option will face differing transitional issues
- Propose to evaluate transition risks and benefits for each option and allocate 100% weighting to this
- Transitional assessment to include:
  - Potential service risks
  - Potential benefits
  - High level costs
  - Time to recover costs

Work remaining

- Test out with the steering group the proposed weighting of the evaluation criteria
- Conduct evaluation and sensitivity testing
- Complete financial analysis
- Meet with the technical group on 13 May to test out evaluation and logic of outcomes
- Prepare draft report for presentation on 23 May
- Finalise report

Appendix 6 Sensitivity analysis

Analysis 1 – with original weighting

	Group Weighting	Option 1	Option 2	Option 3
Patient Benefit – Now				
Operational performance		**15%**	**15%**	**15%**
Ability to achieve service improvements		1	2	3
Capacity and capability to achieve performance targets		1	2	3
Access to service		**20%**	**20%**	**20%**
Improves integration with primary and secondary care services		1	2	3
Enables a seamless service to be developed with common protocols		1	2	3
Coverage of Trust area, staff per '000 populations		1	2	3
Generates equity between communities	**45%**	1	1	3
Organisational efficiency		**10%**	**10%**	**10%**
Ability to deploy resources across the Trusts in a flexible manner in order to match demand		1	1	3
Ability to be a financially and operationally viable organisation in the long run		1	1	3
Provides a critical mass to cope with future change and has capacity & capability to grow		1	2	3
Improves corporate governance arrangements		1	2	3
	Total	**1.5**	**2.6**	**4.5**
Patient Benefit - Future				
Strategic issues		**15%**	**15%**	**15%**
Consistency with national and local ambulance/NHS Strategies		2	2	3
Addresses local issues		2	2	3
Capacity and capability to respond to new market opportunities		2	1	3
Improved response to commissioning	**25%**	2	2	3
Training & People Development		**10%**	**10%**	**10%**
Enables a better equipped workforce		1	1	3
Increased liaison with tertiary education centre and WDC		1	2	3
Current best practice to be used		1	1	3
	Total	**1.5**	**1.5**	**2.7**

	Group Weighting	Option 1	Option 2	Option 3
Patient safety				
Improves accountability arrangements	**18%**	1	1	2
Encourages sharing of best practice		1	2	3
Improves clinical governance arrangements		1	2	3
Common clinical protocols & procedures		1	2	3
	Total	**0.72**	**1.26**	**1.98**
Value for money				
Use of resources	**12%**	**4%**	**4%**	**4%**
Enables services to be shared (e.g. finance, HR, etc)		1	2	3
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients		1	1	3
Increase in purchasing power		1	1	3
Makes better use of assets including IT resources		1	1	3
Potential for efficiency savings		**4%**	**4%**	**4%**
Savings in Board costs (e.g. exec, non-exec, executive benefits)		1	2	3
Savings in management team costs		1	2	3
Early retirement costs & costs of management change		3	2	1
Savings in cost of procurement (revenue & capital)		1	1	3
Savings in Audit fees		1	1	3
Potential for shared service arrangements		1	1	3
Savings in operational costs		**4%**	**4%**	**4%**
Savings in HQ Estate costs (depreciation, rate of return, rent, repairs)		1	1	3
Fleet maintenance, EMDC Costs		1	2	2
Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)		1	1	3
	Total	**0.60**	**0.72**	**1.44**
Total score of analysis 1		**4.32**	**6.03**	**10.62**

Analysis 2 – with adjusted weighting

Criteria	Group Weighting	Option 1	Option 2	Option 3
Patient Benefit - Now				
Operational performance		**12%**	**12%**	**12%**
Ability to achieve service improvements		1	2	3
Capacity and capability to achieve performance targets		1	2	3
Access to service		**16%**	**16%**	**16%**
Improves integration with primary and secondary care services		1	2	3
Enables a seamless service to be developed with common protocols		1	2	3
Coverage of Trust area, staff per '000 populations		1	2	3
Generates equity between communities	**35%**	1	1	3
Organisational efficiency		**8%**	**8%**	**8%**
Ability to deploy resources across the Trusts in a flexible manner in order to match demand		1	1	3
Ability to be a financially and operationally viable organisation in the long run		1	1	3
Provides a critical mass to cope with future change and has capacity & capability to grow		1	2	3
Improves corporate governance arrangements		1	2	3
	Total	**1.17**	**2.02**	**3.05**
Patient Benefit - Future				
Strategic issues		**12%**	**12%**	**12%**
Consistency with national and local ambulance/NHS Strategies		2	2	3
Addresses local issues		2	2	3
Capacity and capability to respond to new market opportunities		2	1	3
Improved response to commissioning	**20%**	2	2	3
Training & People Development		**8%**	**8%**	**8%**
Enables a better equipped workforce		1	1	3
Increased liaison with tertiary education centre and WDC		1	2	3
Current best practice to be used		1	1	3
	Total	**1.2**	**1.2**	**2.2**

Criteria	Group Weighting	Option 1	Option 2	Option 3
Patient safety				
Improves accountability arrangements	**20%**	1	1	2
Encourages sharing of best practice		1	2	3
Improves clinical governance arrangements		1	2	3
Common clinical protocols & procedures		1	2	3
	Total	**0.8**	**1.4**	**2.2**
Value for money				
Use of resources	**25%**	**8%**	**8%**	**8%**
Enables services to be shared (e.g. finance, HR, etc)		1	2	3
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients		1	1	3
Increase in purchasing power		1	1	3
Makes better use of assets including IT resources		1	1	3
Potential for efficiency savings		**8%**	**8%**	**8%**
Savings in Board costs (e.g. exec, non-exec, executive benefits)		1	2	3
Savings in management team costs		1	2	3
Early retirement costs & costs of management change		3	2	1
Savings in cost of procurement (revenue & capital)		1	1	3
Savings in Audit fees		1	1	3
Potential for shared service arrangements		1	1	3
Savings in operational costs		**8%**	**8%**	**8%**
Savings in HQ Estate costs (depreciation, rate of return, rent, repairs)		1	1	3
Fleet maintenance, EMDC Costs		1	2	2
Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)		1	1	3
	Total	**1.25**	**1.50**	**3.00**
Total score of analysis 2		**4.42**	**6.08**	**10.86**

Analysis 3 – with equal weighting

	Group Weighting	Option 1	Option 2	Option 3
Patient Benefit - Now				
Operational performance		**8.3%**	**8.3%**	**8.3%**
Ability to achieve service improvements		1	2	3
Capacity and capability to achieve performance targets		1	2	3
Access to service		**8.3%**	**8.3%**	**8.3%**
Improves integration with primary and secondary care services		1	2	3
Enables a seamless service to be developed with common protocols		1	2	3
Coverage of Trust area, staff per '000 populations		1	2	3
Generates equity between communities	**25%**	1	1	3
Organisational efficiency		**8.3%**	**8.3%**	**8.3%**
Ability to deploy resources across the Trusts in a flexible manner in order to match demand		1	1	3
Ability to be a financially and operationally viable organisation in the long run		1	1	3
Provides a critical mass to cope with future change and has capacity & capability to grow		1	2	3
Improves corporate governance arrangements		1	2	3
	Total	**0.83**	**1.42**	**2.5**
Patient Benefit - Future				
Strategic issues		**12.5%**	**12.5%**	**12.5%**
Consistency with national and local ambulance/NHS Strategies		2	2	3
Addresses local issues		2	2	3
Capacity and capability to respond to new market opportunities		2	1	3
Improved response to commissioning	**25%**	2	2	3
Training & People Development		**12.5%**	**12.5%**	**12.5%**
Enables a better equipped workforce		1	1	3
Increased liaison with tertiary education centre and WDC		1	2	3
Current best practice to be used		1	1	3
	Total	**1.4**	**1.4**	**2.6**

	Group Weighting	Option 1	Option 2	Option 3
Patient safety				
Improves accountability arrangements	**25%**	1	1	2
Encourages sharing of best practice		1	2	3
Improves clinical governance arrangements		1	2	3
Common clinical protocols & procedures		1	2	3
	Total	**1**	**1.75**	**2.75**
Value for money				
Use of resources	**25%**	**8.3%**	**8.3%**	**8.3%**
Enables services to be shared (e.g. finance, HR, etc)		1	2	3
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients		1	1	3
Increase in purchasing power		1	1	3
Makes better use of assets including IT resources		1	1	3
Potential for efficiency savings		**8.3%**	**8.3%**	**8.3%**
Savings in Board costs (e.g. exec, non-exec, executive benefits)		1	2	3
Savings in management team costs		1	2	3
Early retirement costs & costs of management change		3	2	1
Savings in cost of procurement (revenue & capital)		1	1	3
Savings in Audit fees		1	1	3
Potential for shared service arrangements		1	1	3
Savings in operational costs		**8.3%**	**8.3%**	**8.3%**
Savings in HQ Estate costs (depreciation, rate of return, rent, repairs)		1	1	3
Fleet maintenance, EMDC Costs		1	2	2
Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)		1	1	3
	Total	**1.25**	**1.50**	**3.00**
Total score of analysis 3		**4.46**	**6.04**	**10.88**

Appendix 7 Transitional issues

Overall scores on transitional issues

	Option 1	Option 2	Option 3
Transitional Issues			
Ease of transition	3	1	2
Costs of transition	3	2	1
Additional investment required	3	3	1
Time taken to recover transition costs	3	3	1
Risk of transition	3	2	1
	2.7	**1.98**	**1.08**

Ease of transition

(Key: 1 difficult → 3 easy)

Criteria	Option 1	Option2	Option 3
Degree of difficulty in implementing a particular course of action due to the need to obtain agreement or consensus on the way forward.	3	2	1
The timescale it will take to realise a potential benefit.	3	2	2
The complexity of the particular task	2	2	2
The amount of staff time needed to be devoted to the particular initiative	1	2	2
Recruitment of executive directors and other senior management	2	1	3
The need to gather, assess and interpret data and information on the particular subject area	3	2	3
Total score	**14**	**11**	**13**

Risk of transition

Criteria	Option 1	Option 2	Option 3
Political	No change in structure therefore problems not addressed	Risk of some loss of local identity, Lessening of corporate accountability,	Risk of loss of local identity
Economic	Insufficient funds to resource service not able to take forward modernisation agenda	project management: Costs associated in the changes with mgt arrangements legal costs i.e. contractual agreements, HR, estates, procurement	Project management greater then Option 2. Costs associated in the changes with mgt arrangements legal costs i.e. contractual agreements, HR, estates, procurement
Sociological	No improvement of service to patients	Communication with staff and public, managing dips in performance and morale	Communication with staff and public, managing dips in performance and morale
Technological	Not able to invest in new technology e.g. digital radio, communications, CAD	Lack of investment and missed opportunity to share services	Project management: aligning services, contracts, cost, system failures

Appendix 8 Benchmarking

Part I: Facts and Figures

(Source: 2003/04 annual report or information published on the Trust website, unless otherwise stated)

	AAST	GAST	WAST	If merged
Star Rating				
2004	0 star	2 star	0 star	
Basic facts				
Area covered (km^2)	1,350	2,654	3,677	7,681
Static populations (in millions)	1.0	0.57	0.6	2.2
'000 Population per km^2	740.7	214.0	168.9	
Visitors to AGW (UK)** (in millions)	2.7	1.7	1.6	
Visitors to AGW (Overseas)** (in millions)	0.29	0.24	0.24	
Resources				
Stations	12	10	9	31
Stations per 100 km^2	0.89	0.38	0.24	0.40
'000 population per station	83.3	57.0	66.7	71.0
Fleet : Total	*	109	80	
A&E vehicles	43	31	36	110
PTS vehicles	47	27	11	85
Rapid responder vehicles (cars & motorcycles)	12	3	9	
Operational staff				
Total staff employed(WTE)	494	364	302	
A&E staff (inc technician)	273	159	187	
A&E staff as a % of total staff	55.3%	43.7%	61.9%	
PTS staff	79	65	31	
Control and planning staff	65	31	27	
Fleet, general support and management	63	27	52	
Activity (source: Department of Health 03/04)				
Total journeys undertaken (in '000)	291.9	165.8	164.5	622.2
Emergency journeys (in '000)	61.7	32.5	29.1	123.4
Urgent journeys (in '000)	18.6	12.3	11.6	42.4
Special or planed journeys	211.6	121.0	123.8	456.4
Financial Information				
Income 2003/04 (£'000)	17,447	10,284	12,382	
% Increase on 2002/03	3.4%	(5.4%)	4.1%	
Income 2002/03 (£'000)	16,877	10,872	11,892	
Management cost 2003/04 (as a % of income)	5.3%	9.1%	7.8%	
Management cost 2002/03 (as a % of income)	4.8%	*	6.8%	
Prompt payment (numbers)	97.4%	79.6%	71%	
Prompt payment (£)	97.6%	86.5%	85%	
Hospital Flows				
A&E services	**BRI** (33%) **Frenchay** (23%); **Southmead** (15%), **RUH** (15%), **Weston** (14%).	**Cheltenham General;** **Gloucester Royal**	**Great West** (40%); **RUH** (25%); **Salisbury District** (20%)	

	AAST	GAST	WAST	If merged
Complaints				
Total formal complaints received in 2003/04	69	23	85	
Complaints related to A&E service	48 (inc. urgent)	17	*	
Complaints related to PTS	21	6	*	
% of complaints dealt within 20 days	86%	65%	67% (annual average)	

* Information not available

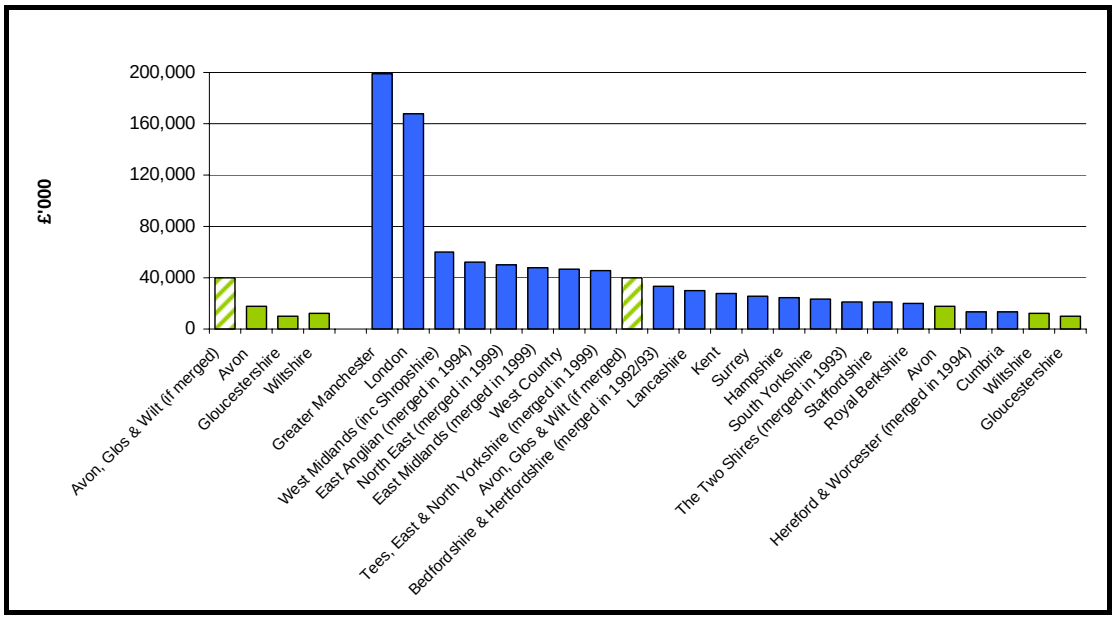
** From South West Tourism Statistics

Part II: Benchmarking

Income - in comparison with other Ambulance Trusts including some merged trusts

The following chart illustrates that Income-wise, all three trusts are considered to be on the lower end. If three trusts merge, it will create a single trust with an income of over £40m.

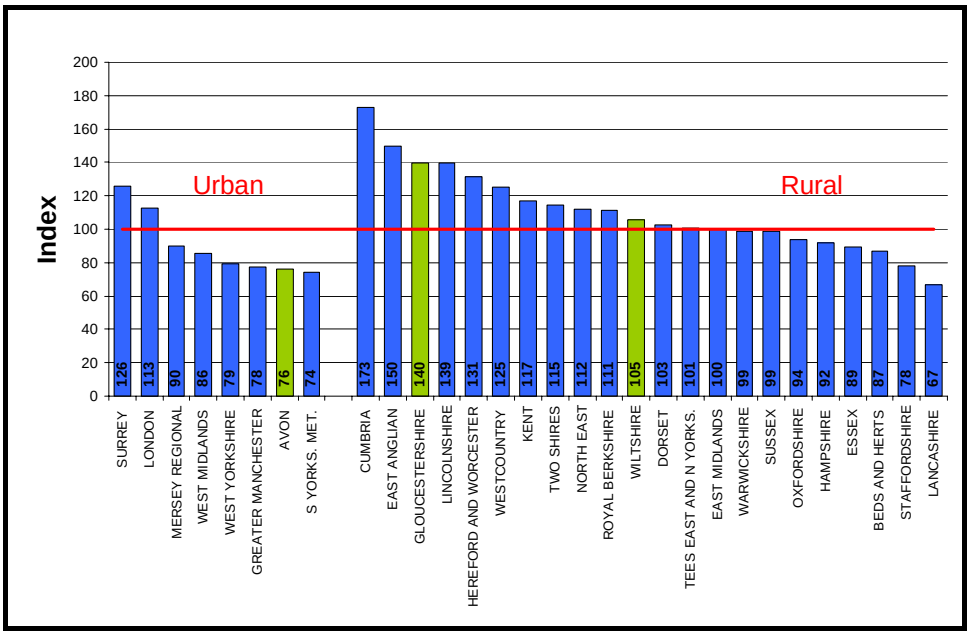
Figure A-1: Income (Source: annual report 2003/04[6])



2003 Reference Cost Index (RCI)

This chart shows that both GAST and WAST have high RCI. However, AAST has one of the lowest RCI. If three trusts merge, we would expect the merged trust's reference cost to be close to national average as some cost savings are likely to be made.

Figure A-2: 2003 RCI (Source: Department of Health)



[6] Not all trust's income figures were available for this analysis

Activity – in comparison with other ambulance services

Activity-wise, the number for journeys undertaken in 2003/04 by three trusts is again on the lower end of the comparative group.

Figure A-3: Total journeys undertaken in 2003/04 (Source: Department of Health)

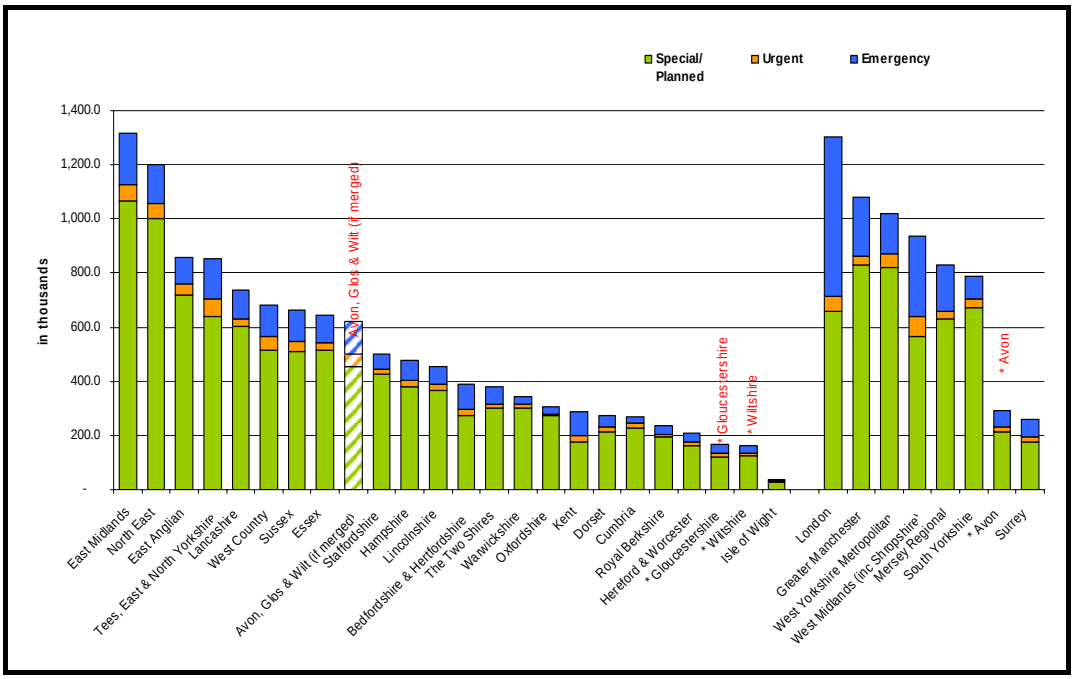


Figure A-4: Journeys undertaken per '000 population – in comparison with some merged trusts

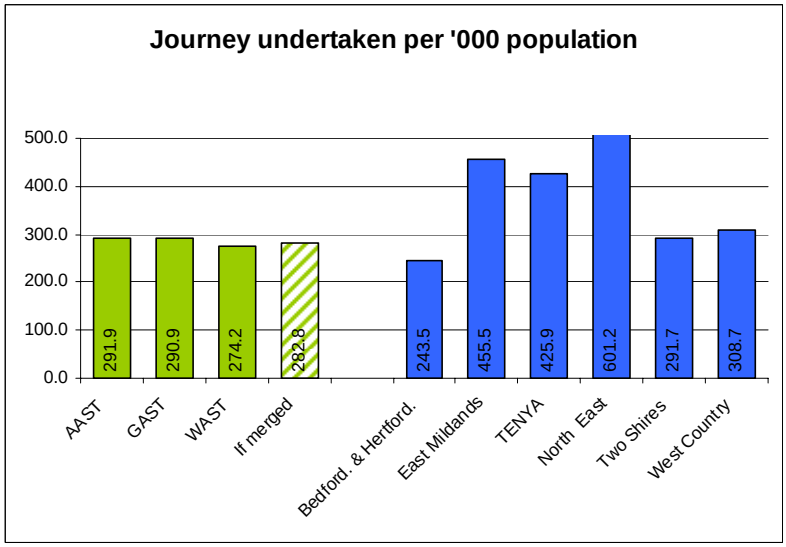
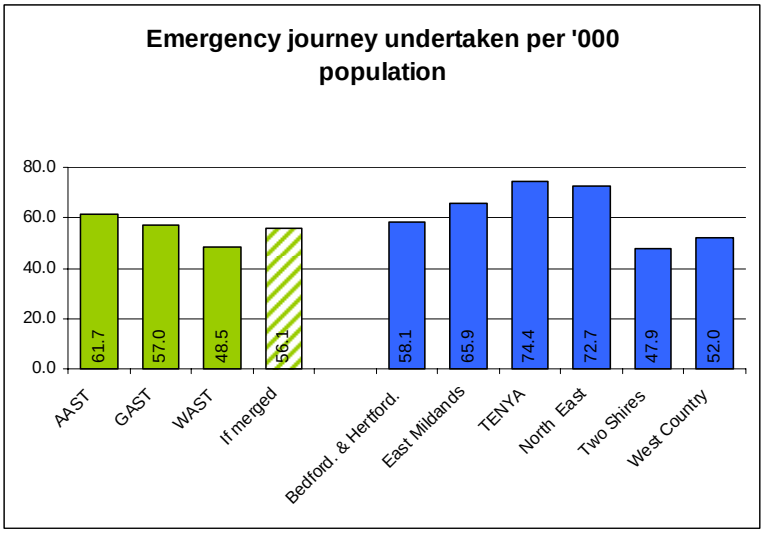


Figure A-5: Emergency journeys undertaken per '000 population – in comparison with some merged trusts.



Performance on key government targets

All Ambulance Trusts in England are required to deliver a number of national response time targets. 2003/04 performance data shows that GAST was the only trust in AGW managed to meet most of these targets.

Figure A-6: meeting Category A calls targets (Source: Department of Health)

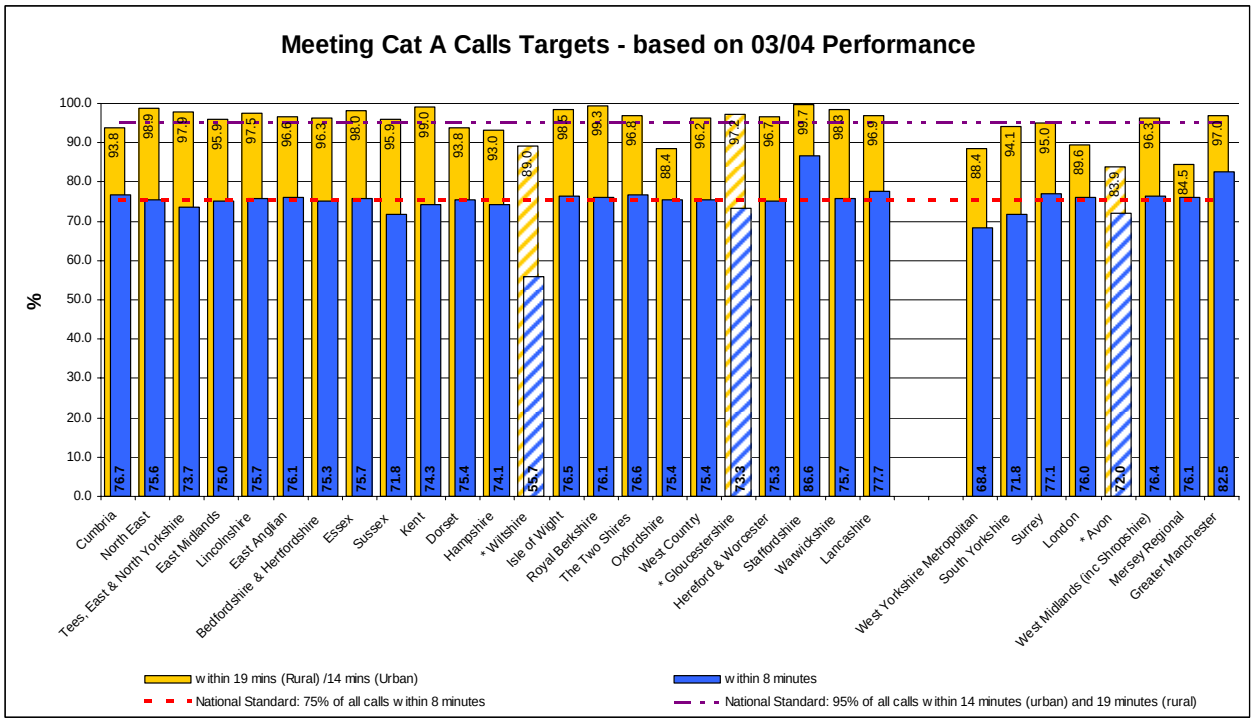
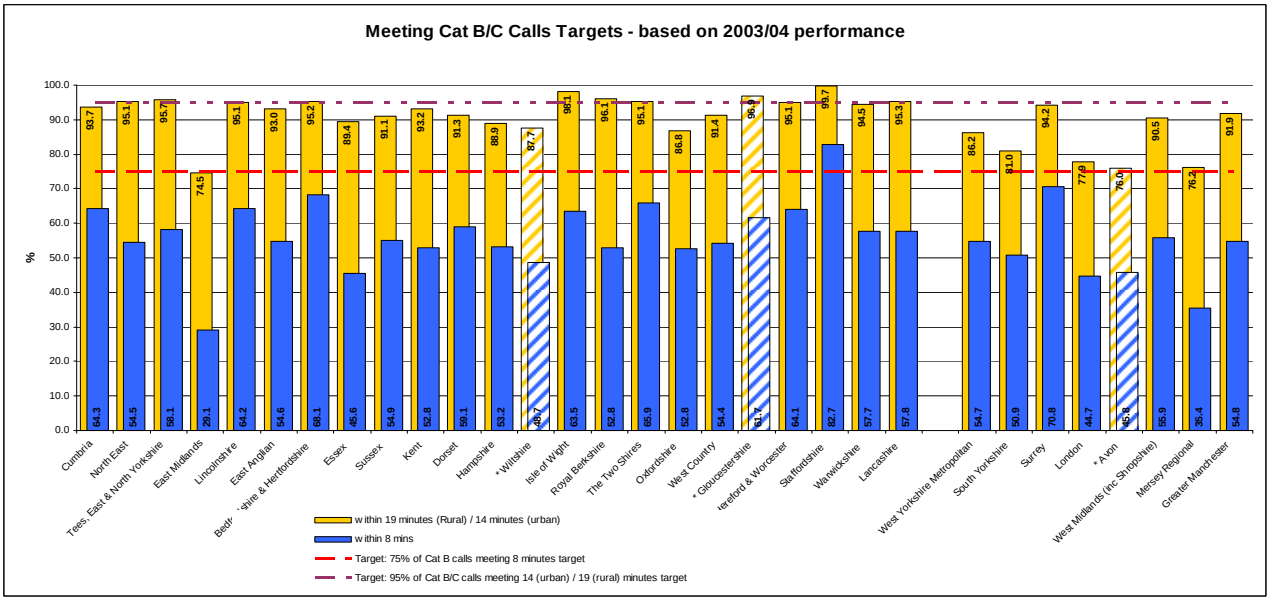


Figure A-7: meeting Category B/C calls targets (Department of Health)



Resources

The following charts are intended to show how current resources within AGW are distributed. If three trusts choose the Option 3, how its resource level will be like in comparison with some other merged trusts.

	Bedford & Hertford	East Midlands	Tees, East & North Yorkshire (TENYA)	North East	Two Shires	West Country	Hereford & Worcester
Year	**1992/93**	**1999**	**1999**	**1999**	**1993**		**1994**
Performance Rating 2003/04	**3 star**	**2 star**	**1 star**	**3 star**	**3 star**	**2 star**	**3 star**
Area covered (km^2)	**2,865**	**7,220**	**11,655**	**7,769**		**15,540**	**3,910**
Area covered	**Bedfordshire and Hertfordshire**	**Derbyshire, Leicestershire & Nottingham-shire**	**Cleveland, Humberside & North Yorkshire**	**Northumbria & Durham**	**Northampton-shire & Buckingham-shire**	**Cornwall, Devon & Somerset**	**Hereford & Worcester**
Static populations (in millions)	**1.6**	**2.89**	**2**	**2**	**1.3**	**2.2**	**0.72**
Population per km^2 (in '000)	**558.5**	**400.3**	**171.6**	**257.4**		**141.6**	**184.1**
Stations	**23**	**38**	**37**	**44**	**17**	**53**	

- **Funding**

Figure A-8: Funding per head

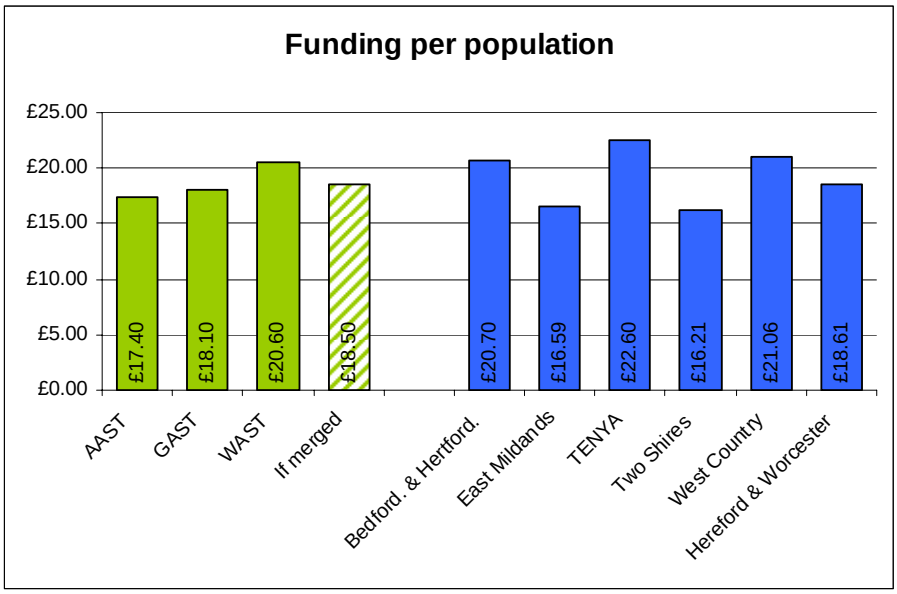
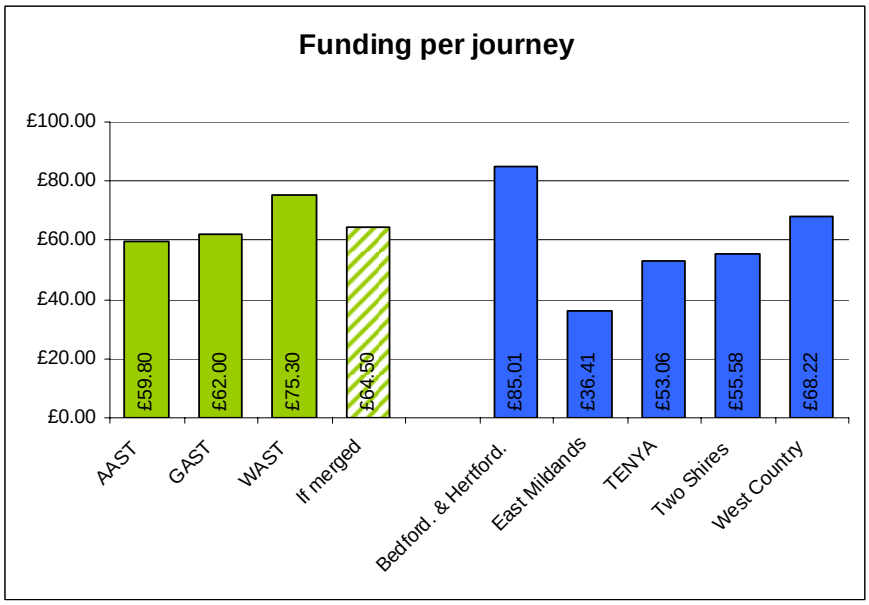


Figure A-9: Funding per journey



- **Staffing**

Figure A-10: A&E staff (including Ambulance Technicians) as a % of total workforce

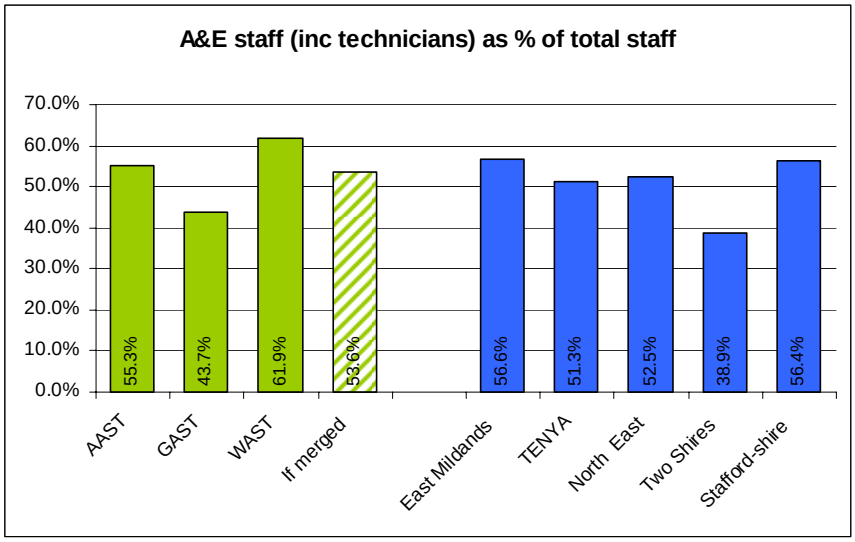


Figure A-11: All staff per '000 population

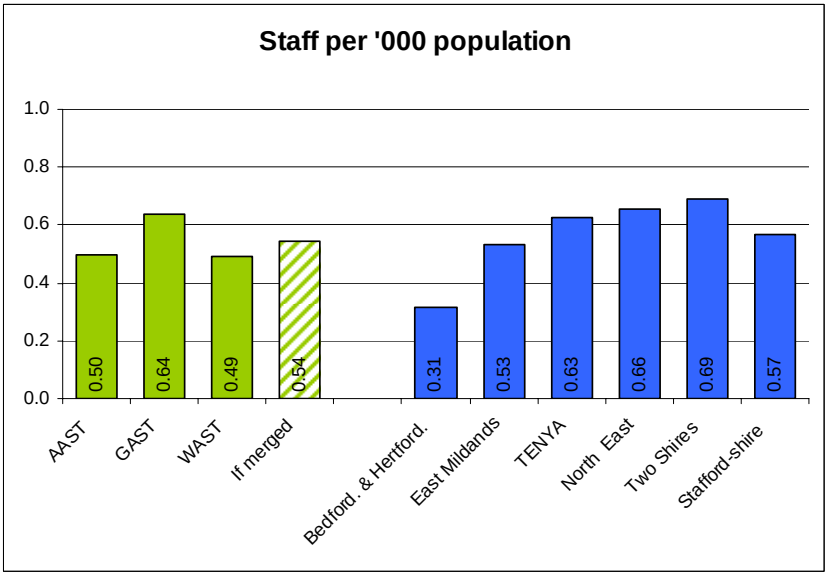
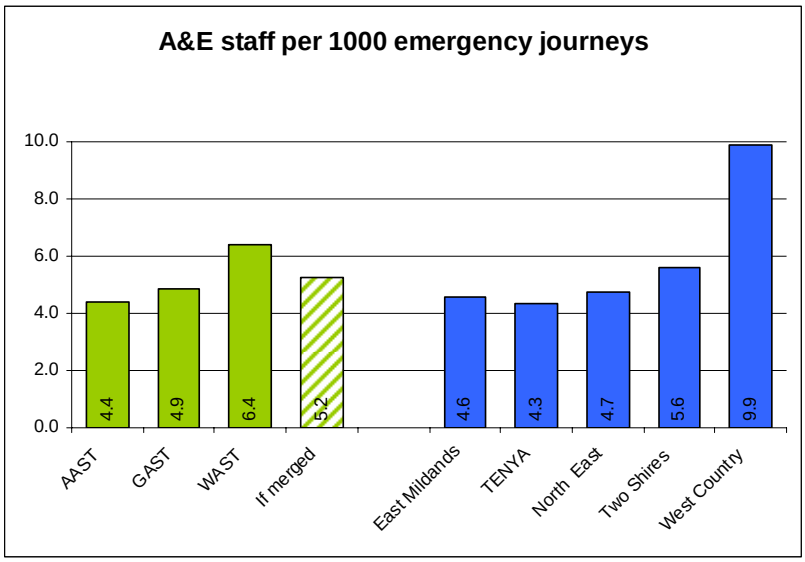


Figure A-12: A&E staff (inc. technicians) per 1000 emergency journeys



- **Stations**

Figure A-13: Number of stations per 100 sq km

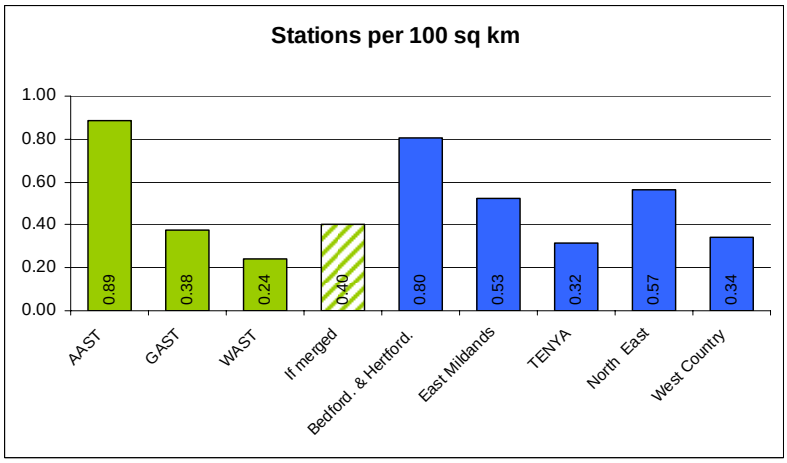
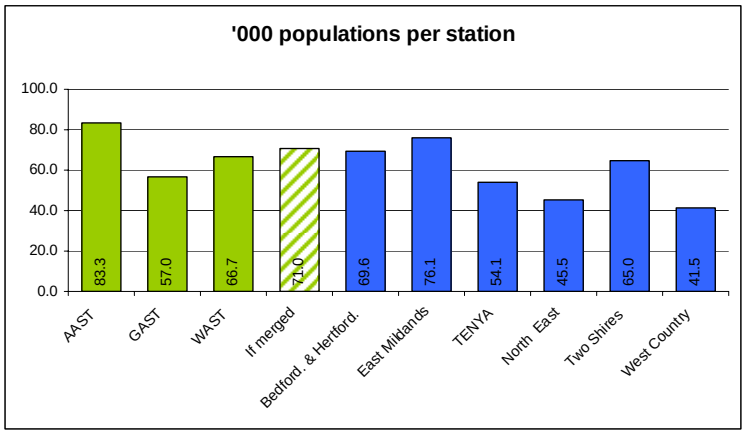
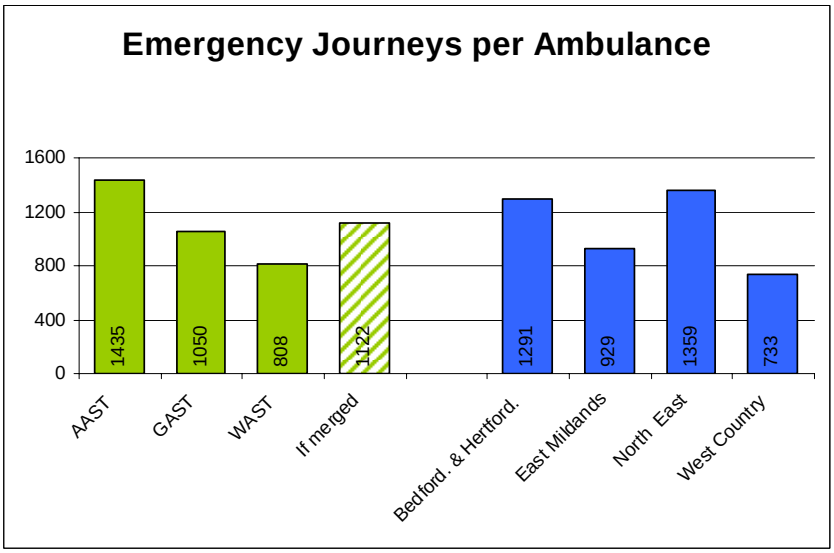


Figure A-14: '000 population per station



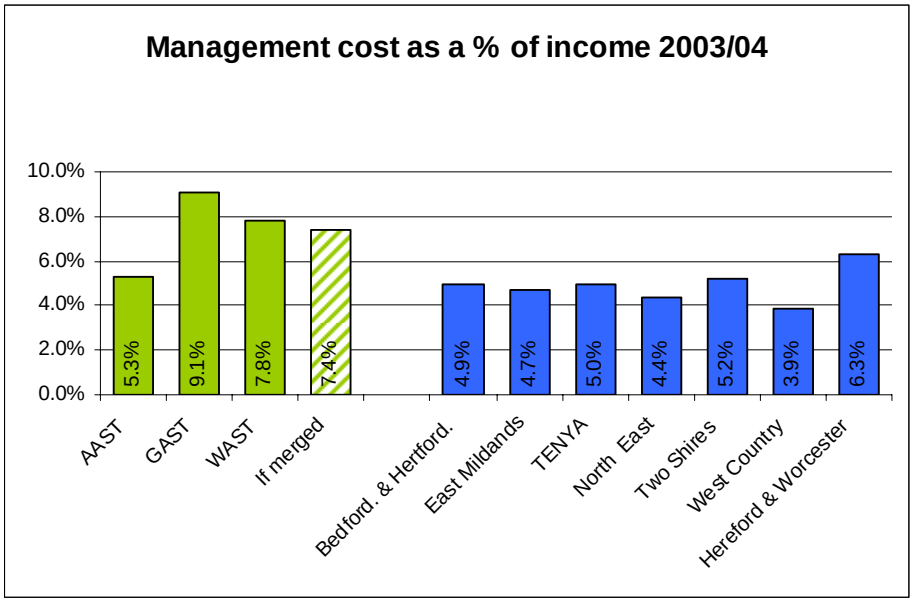
- **Ambulances**

Figure A-15: '000 emergency journeys per ambulance



Management Costs

Figure A-16: Management costs as % of income



Appendix 9 Financial analysis

Structure cost – Option 1

	Salary	On-costs	Total Salary Costs
	£	£	£
AAST			
Chair	17,493	1,349	18,842
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
			42,210
Chief Executive	81,793	20,297	102,090
Director of Corporate Services	60,888	13,395	74,283
Director of Finance	66,890	16,303	83,193
Director of Operations	55,043	13,127	68,170
			327,736
GGST			
Chair	15,819	1,186	17,005
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
			39,490
Chief Executive	72,700	15,994	88,694
Director of Operations	66,600	14,652	81,252
Director of Human Resources	47,000	10,340	57,340
Director of Finance	59,000	12,980	71,980
Medical Director (0.45 WTE)	43,355	9,538	52,893
			352,159
WAST			
Chair	17,164	1,287	18,451
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
			42,845
Chief Executive			*65,752*[7]
Director of Operations	50,000	11,000	61,000
Director of Finance & Corporate Affairs	59,670	13,127	72,797
Director of Human Resources			*57,327*[8]

[7] The Acting Chief Executive is on secondment from the SHA. This is considerably less than the full payroll cost incurred by the SHA.

[8] The Acting Director of HR is on secondment from Swindon & Marlborough Trust, this does reflect the full payroll cost.

Medical Director (0.40 WTE)	30,968	6,813	37,781
			294,657
Total Costs			**1,099,097**

Structure costs – Option 2

	Salary	On-costs	Total Salary Costs
	£	£	£
Integrated Board			
Chief Executive	90,000	19,800	109,800
Director of Operations	75,000	16,500	91,500
Director of Finance	75,000	16,500	91,500
Medical Director	85,000	18,700	103,700
Director of Information Technology	55,000	12,100	67,100
Director of Corporate Affairs	60,000	13,200	73,200
Director of HR and Organisational Development	55,000	12,100	67,100
			603,900
AAST			
Chair	17,493	1,349	18,842
Assistant Operations Director	38,096	8,381	46,477
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
Non-Executive Director	5,782	60	5,842
			88,687
GAST			
Chair	15,819	1,186	17,005
Assistant Operations Director	38,096	8,381	46,477
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
Non-Executive Director	5,229	392	5,621
			85,967
WAST			
Chair	17,164	1,287	18,451
Assistant Operations Director	38,096	8,381	46,477
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
Non-Executive Director	5,673	425	6,098
			89,322
Total Costs			**867,877**
Potential savings on Option 1			**(231,221)**

Structure cost – Option 3

	Salary	On-costs	Total Salary Costs	Comparable Trusts
Integrated Trust				
Chair	17,493	1,349	18,842	
Non-Executive Director	6,000	450	6,450	
Non-Executive Director	6,000	450	6,450	
Non-Executive Director	6,000	450	6,450	
Non-Executive Director	6,000	450	6,450	
Non-Executive Director	6,000	450	6,450	
			51,092	
Chief Executive	90,000	19,800	109,800	75-80
Director of Operations	75,000	16,500	91,500	60-65
Director of Finance	75,000	16,500	91,500	60-65
Medical Director	85,000	18,700	103,700	75-80
Director of Information Technology	55,000	12,100	67,100	50-55
Director of Corporate Affairs	60,000	13,200	73,200	50-55
Director of HR and Organisational Development	55,000	12,100	67,100	50-55
			603,900	
Total costs			**654,992**	
Potential savings on Option 1			**(444,106)**	

Note:
We have included the costs of Divisional Directors and PA Support in the financial summary.

Support Staff Savings

Assume cost based reduced by 25%

	WTE	£
AAST		
Admin & Finance - Finance	3.60	73,271
Finance - Senior Manager	1.00	38,861
Admin & Finance - Personnel	4.00	81,412
Planning, Health & Safety	1.00	31,639
Senior Manager - Personnel	3.00	94,917
Information Assistant	0.53	10,787
Information Officer	1.00	35,161
IT systems Support	2.00	51,909
Admin & Finance - Corporate Services	2.80	66,716
	18.93	**484,672**
25% savings		***121,168***
GAST		
Deputy Finance Director	1.00	38,861
Senior Financial Assistant	1.00	29,996
Financial Assistant	1.81	38,003
HR Secretary	2.00	51,498
	5.81	**158,358**
25% savings		***39,589***
WAST[9]		
Senior Manager - finance	1.00	40,328
Management Accountant	1.00	29,996
HR Admin Assistant	1.00	22,078
AAT Qualified Finance Assistant	1.00	20,996
Finance Officer	0.70	14,945
Payroll officer	0.50	10,870
HR Admin Assistant	0.40	14,640
IM&T Manager	1.00	38,268
	6.60	**192,122**
25% savings		***48,030***
Total savings		**208,788**

Note

On the TFR3 return for 2003/04, there are administration and clerical salary costs totalling £5m. For the financial summary, we have assumed that savings of 10%could be achieved.

[9] WAST costs include on-costs

Saving in estates

- The estate costs of HQ are not easy to calculate. AAST has an ambulance station attached to its HQ. GAST's HQ and control room are in the same building.
- WAST' costs for its HQ have been assimilated for 2004/05, and it shows that the cost is £101,000, which equates to approximately 10% of the total premises costs.

	AAST	GAST	WAST	Total
	£	£	£	£
PREMISES AND FIXED PLANT - 2003/04				
Electricity	87,183	23,880	44,177	
Gas	38,070	21,287	34,658	
Other Fuels (including oil and coal)	4,227		4,324	
Water and Sewerage	28,905	14,084	14,400	
External General Services Contracts	0	12,934	159,067	
Furniture, Office & Computer Equipment	191,452	18,933	81,017	
Computer Hardware, Maintenance Contracts & Data Processing Contracts	198,987	95,740	197,225	
Business Rates	(88,691)	93,974	145,363	
Rent	264,058	23,778	117,731	
Building and Engineering Equipment	227,517	8,607	8,882	
Building & Engineering Contracts	0	26,917	98,765	
Total Premises and Fixed Plant	**951,708**	**340,134**	**905,609**	**2,197,451**
Estates Saving = 10%	*95,171*	*34,013*	*90,561*	*219,745*

Early Retirement & Redundancy

Summary of conditions:

Qualification for early retirement

You must be aged between 50 and retirement age with at least 5 years pensionable service. You will be entitled to the following benefits:

A pension of 1/80th of the final years pensionable pay for each completed year of service, enhanced by:

Service up to 10 years – doubled;
Service of 10 years of more increased by 10 years;
Subject to the maximum years which could be worked by 65 and not more than 40 years overall.

Early Retirement - Example

For an individual who is aged 55 with 20 years service in the NHS on a salary of £50k, the costs would be:

20 years service + 10 years service = 30 years service
(As the individual has more than 10 years service they are entitled to an enhancement of 10 additional years service)

Pension:
1 year divided by 80 years x £50,000 x 30 years = £18,750

Lump sum retiring allowance:
3 x £18,750 = £56,250

Extra membership element

Pension:
1 year divided by 80 years x £50,000 x 3 years = £1,875

Lump sum retiring allowance:
3 x £1,875 = £5,625

Cost to employer

Pension cost to age 60 = £18,750 x 4.428 = £80,025

Plus

Costs from age 60 = £1,875 x 12.747 = £23,900

Plus

Cost for early payment of basic sum retiring allowance = £56,250 x 0.136 = £7,650

Plus

Extra membership element of lump sum retiring allowance = £5,625

Total = £117,200

Qualification for redundancy pay

For non NHS employees and NHS employees between the ages of 18 and 40, for each complete year of service, up to a maximum of 20, employees are entitled to:

For each year of service at 18 years or over but under 22, half a weeks pay;
For each year of service at 22 years but under 41, one weeks pay; and
For each year of service at 41 years but under 65, one and a half weeks pay.

For employees aged over 40, the scheme provides for two weeks pay for each year with an overall maximum of 50 weeks. In addition, those aged between 41 and 49 have an entitlement to a further two weeks for each year of service up to a maximum of 16 weeks.

If you have up to 10 years membership, the membership is doubled, subject to the maximum you could have had by age 65.
If you have 10 or more years membership, the membership is increased by 10 years subject to the maximum you could have had by age 65.
Total membership cannot be increased to more than 40 years.

Redundancy - Example

For an individual who is between 41 and 49 and has 20 years service with an average salary of £35k, the costs would be:

2 weeks pay x 20 years service = 40 weeks

2 weeks further pay x 20 years = 40 weeks but maximum allowed is 16 weeks.

40 weeks + 16 weeks = 56 weeks

Salary costs per week = £35,000 divided by 52 weeks = £673 per week

£673 x 56 weeks = **£37,688**

Appendix 10 Final scoring for each option

	Option 1	Option 2	Option 3
Patient Benefit - Now			
Ability to achieve service improvements	R	Y	G
Capacity and capability to achieve performance targets	R	Y	G
Improves integration with primary and secondary care services	R	Y	G
Enables a seamless service to be developed with common protocols	R	Y	G
Coverage of Trust area, staff per '000 populations	R	Y	G
Generates equity between communities	R	R	G
Ability to deploy resources across the Trusts in a flexible manner in order to match demand	R	R	G
Ability to be a financially and operationally viable organisation in the long run	R	R	G
Provides a critical mass to cope with future change and has capacity & capability to grow	R	Y	G
Improves clinical governance arrangements	R	Y	G
Patient Benefit - Future			
Consistency with national and local ambulance/NHS Strategies	Y	Y	G
Addresses local issues	Y	Y	G
Capacity and capability to respond to new market opportunities	Y	R	G
Improved response to commissioning	Y	Y	G
Enables a better equipped workforce	R	R	G
Increased liaison with tertiary education centre and WDC	R	Y	G
Current best practice to be used	R	R	G
Patient safety			
Improves accountability arrangements	R	R	Y
Encourages sharing of best practice	R	Y	G
Improves clinical governance arrangements	R	Y	G
Common clinical protocols & procedures	R	Y	G
Value for money			
Enables services to be shared (e.g. finance, HR, etc)	R	Y	G
Ability to release resources that can be deployed in areas that will have direct and indirect benefit to patients	R	R	G
Increase in purchasing power	R	R	G
Makes better use of assets including IT resources	R	R	G
Savings in Board costs (e.g. exec, non-exec, executive benefits)	R	Y	G
Savings in management team costs	R	Y	G
Early retirement costs & costs of management change	G	Y	R

	Option 1	Option 2	Option 3
Savings in cost of procurement (revenue & capital)	R ●	R ●	G ●
Savings in Audit fees	R ●	R ●	G ●
Potential for shared service arrangements	R ●	R ●	G ●
Savings in HQ Estate costs (depreciation, rate of return, rent, repairs)	R ●	R ●	G ●
Fleet maintenance, EMDC Costs	R ●	Y ●	Y ●
Capital cost avoidance (i.e. economies of scale regarding capital schemes/plans)	R ●	R ●	G ●