ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Introduction

The purpose of this report is to reflect upon my placement in the Emergency Department at PEH, and to discuss the objectives set.

Objective 1 - Identify key factors of health within the local population, and evaluate this in the context of global health

Guernsey, being a western country, has strong ties to that of western health factors and epidemiology. Many parallels are seen with my experience in the UK, and this is easily attributed to common factors within the regional determinants of health:

- Socio-economics – As with a lot of healthcare systems, there is a huge lack of social support to back up medical services. While it is widespread in the NHS, guernsey is not free from failed discharges, social admissions, and delays in discharge, due to the inefficiencies, lack of provision, and poor funding of social care in the community. This has a major impact on patient care and support, as well as a huge strain on general practice, which feeds into A&E visits and avoidable admissions.

- Physical environment – Generally, the physical environment carries the same issues as that of the west and particularly the UK. Unlike in other parts of the world, there are no dangerous animals roaming, no poisonous creatures, nor war and famine. There is a now debunked theory of increased radiation exposure due to granite presence on the island, but when it comes to health protection from the environment and community, little issues arise. It may be noted that this is different on a global health scale. Access to a variety of food, education, water, and healthcare are all protective factors of health.

- Individual characteristics and culture – western cultures leave their footprint on the health of the population. Alcohol, smoking, obesity, all commonplace and tolerated by the public. These factors are all major factors of metabolic and chronic disease, commonly encountered in healthcare. Drug use has a fringe presence, however there is a rise of cannabis use, which has begun to present its own health consequences in general practice and A&E.

Objective 2 - Understand how local and regional health provision compares to that of the UK.

Provision in Guernsey has many organizational differences to the UK:

- Specialty and sub-specialty availability – the system is consultant and SAS run, with no junior doctors present. As such, consultants are frequently on call, but the standard setup is vastly different to the NHS. A good example of this is that instead of having every specialty available, a consultant physician may be responsible for all and any medical related patients, not just those

that fall under the traditional remit of their CCT.

- Agreements with NHS services – Tertiary care not available can be provided by the
- Numbers – while the numbers are obviously much smaller, the proportion of patients seen and requiring care is steadily growing, partly down to an aging population. This is clearly something that the state must be aware of, particularly with the obstacles to recruitment in guernsey. The UK is a good lesson on what happens when warning signs are ignored, and mitigations are abandoned.

However, with these differences, many obstacles still mirror that of the UK. These include:

- As stated previously, poor social care results in pressures in GP, A&E, and secondary care. Much like the issues this causes in the NHS, guernsey struggles to manage community care and much of this is down to organization, funding, and staffing. While throwing more money at the issue is likely to make some positive difference, there is a remarkably high risk that increasing budgets increases inefficiency and poor execution, disproportionately. Which is significantly linked to the next point.
- There is the same disconnect between policymakers and frontline staff. While local influence is often resisted, policymakers often contribute to the inefficiencies and poor practices and protocols of the healthcare system. As with the NHS, input from frontline staff who understand the system is seldom sought, opting for a disconnected conclusion that's effectiveness rarely leaves paper.

Objective 3 - Explore how the provisions of healthcare in a non-NHS system compares to that of the UK.

Within a non-NHS system, the main differences were:

- Fee-paying: As previously stated, healthcare in guernsey is part funded. Primary and emergency care is charged at the point of care, whereas any secondary care is paid for by the state. Children are charged at a flat rate, and many choose to take out private health insurance plans to cover any such charges.
- Policy and practice: The leads for departments have more say and influence over their practices and governance. While not perfect, with substantial bureaucracy tailing decision makers, there is certainly more freedom for clinicians to mould their environment and meet the needs of patients and staff. In the emergency department, this has not only led to better patient outcomes, but better performance outcomes which strengthens the department morale and resilience.

Objective 4 - Understand the benefits and limitations of practicing emergency medicine in the Channel Islands compared to mainland UK.

While I can only speak on my experience in guernsey, what I have taken from my experience is a system that is often superior to that of the NHS, for example:

- Local clinical governance: like previous points, local clinical governance is truly local. Practice is less protocolized, and there is more freedom to practice based upon a doctor's clinical judgement, without restraint of rigid guidelines and "the way things have always been done."
- Departmental organization: Nurses play a front-and-center role in the emergency department. Triage, immediate care, assessment, and soon requesting of imaging. Doctors collaborate with nurses and patient care gains significant enhancement from their deployment. While the role of nurses in this way is not absent in the NHS, it is much less complicated. Instead, nurses here are automatically trained for a diverse, enhanced, all-rounded practice. Nurses here are valuable in any role they may be rota'd to. This brings good flexibility, but also a lot of trust in the nursing team.

However, I am conscious that limitations and the same pitfalls are still seen in Guernsey, such as:

- Reliance on specialist care from mainland UK – such as cath labs, burns units, spinal centers, neurosurgery, and other tertiary provisions. All must be evacuated to the UK, often at the mercy of the weather allowing for flights out.
- A fee-paying system does not deter patients who can be managed conservatively or in primary care. Many attendances were not necessary medically, which questions whether such A&E attendances are increased in a free at point of use service like the NHS.
- Funding healthcare can be an obstacle to access. I saw a few cases where patients stopped collecting prescriptions or seeking primary care due to costs, resulting in aggravated presentations, never mind the financial barriers to social care for a lot of the adult population.

Conclusion

Guernsey experiences a healthcare system and health population heavily stamped with western and British traits. However, the hybrid paid system, along with the challenges unique to the island, allow the healthcare service to slightly deviate from what we have come to expect from the NHS. Often this is positive. Yet, I see a notable risk that the failings of the NHS may not be heeded here in Guernsey.