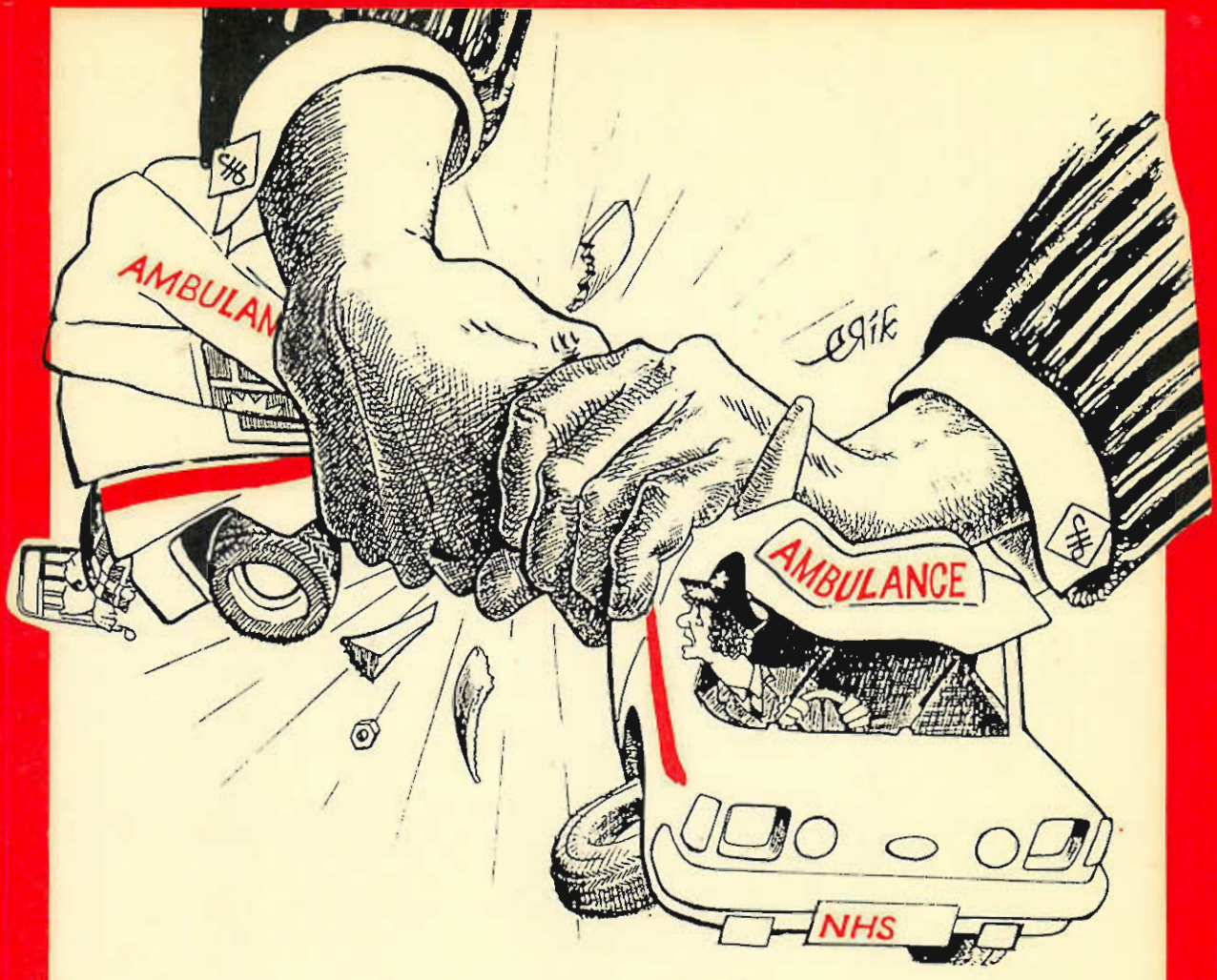
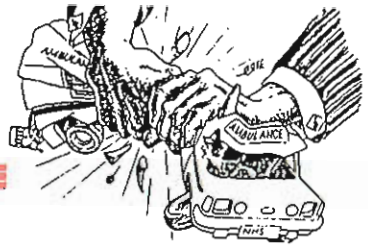


AMBULANCE ALERT

A report on the growing crisis facing the London Ambulance Service



AMBULANCE ALERT

A report on the growing crisis facing the London Ambulance Service

Researched and written by RADIANCE STRATHDEE and ALAN THORNETT, in cooperation with the London Ambulance Service unions' Convenors' Committee and London Health Emergency.

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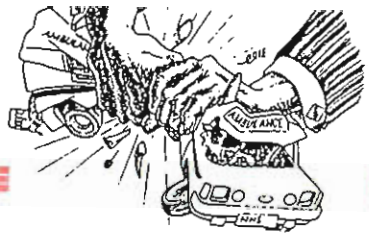


PREFACE

London's Ambulance Service has suddenly hit the headlines. The outcome of a major salary restructuring exercise, claimed by management to improve efficiency and eliminate "unnecessary" overtime, has been a disastrous cut of 40–60% in the provision of the non-emergency ambulance transport — which has been 80% of the work of the service, and is the mainstay of many outpatient and day hospital services.

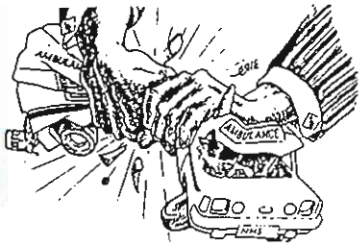
Refused government funding to underwrite the increased costs of the new structure, and having eliminated overtime working equivalent to 233 full-time posts the London Ambulance Service has, since the new structure began on March 1 this year, maintained its "999" emergency cover only at the expense of depleting the numbers of staff and vehicles available to transport elderly, handicapped and seriously ill patients to and from hospital appointments.

The cuts — affecting upwards of 3,000 patient journeys a week — came unexpectedly upon local hospital and Health Authority managements, who were neither consulted nor informed about the new arrangements. It is largely the public and vocal protest of hospital managements against these cuts which has ensured thar the issue has now drawn the limelight of media coverage: for once, hospital authorities feel they can complain against cuts which they have not themselves decided or imposed!

The cases that have been publicised — the seven handicapped children from Hilda Lewis House, Croydon, who were told that "because they can walk" they must use buses or taxis instead of the ambulance that had ferried them to the Maudsley Hospital for therapy; the elderly and infirm patients across London left to fend for themselves on public transport; the radiotherapy patients not collected for their treatment; the chaos of missed appointments, and the expense and inconvenience inflicted on elderly patients — ably sum up the impact of this latest crisis to hit London's Ambulance Service.

The hostile publicity appears to have forced the managing authority of the LAS — the SW Thames Regional Health Authority — to concede the need to appoint 100 extra staff to fill the gap left by the end to overtime working: they now say other spending is to be raided to produce more than £1.8m to fill some of the gaps left by their plan: but other shortfalls will remain.

There will be a gap of over 130 full-time ambulance drivers created by the new salaried structure; this alone will mean that hundreds of patients each week will be denied the ambulance transport they would have received prior to the new scheme. Yet this attempt at repairing the self-inflicted damage will also have long-term financial implications for the London Ambulance Service, which was in any event planned to lose 5% of its annual budget over the course of its



10-year Strategic Plan, and which acknowledged in that Plan the prospect of reduced services for the non-urgent categories of patient who represent the biggest expansion in the LAS workload.

That service had already been declining. Indeed, while Ministers boast that NHS figures show ever growing numbers of outpatient and day hospital cases, and while Health Authorities under government guidelines plan even more emphasis upon types of care outside hospital which require the support of ambulance services, it will come as a surprise to many to realise that the London Ambulance Service has witnessed an overall *cut* of 11% — some 333,000 a year — in non-emergency patient journeys in the period 1977–84.

The frightening gap between growing need and demand for ambulance services from a rapidly growing elderly population and an NHS planning to emphasise "community care" on the one hand, and the dwindling resources and inadequate staffing of the LAS on the other, is the subject of this disturbing study, conducted in February and March of 1986.

Researchers Radiance Strathdee and Alan Thornett, working with the trade union convenors committee of the London Ambulance Service and with London Health Emergency, have taken a critical look at the long term implications for patients, the hospital service and ambulance staff of the LAS Strategic Plan adopted last year by SW Thames RHA.

Their conclusions are that this particularly secretive and undemocratic sector of London's health service has systematically abandoned previous standards both for the emergency and the non-emergency services, and that standards continue to decline. The researchers point to:

- the absence of appropriate monitoring data;
- the lack of any scientific measurement of need for ambulance services not being met as the result of the continuing tightening of criteria for eligibility;
- increasingly restrictive "quotas"
- and inadequate resources.

They argue that the expected growth in the elderly population in the next ten years will create a truly massive shortfall of LAS ambulance provision, which SWTRHA planners, driven purely by cash limit criteria, have failed even to acknowledge.

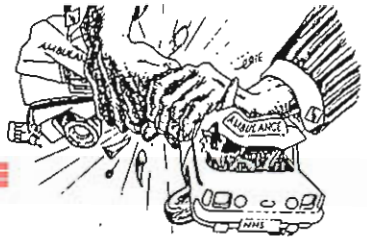
London Health Emergency welcomes this report — funded by the GLC prior to abolition — as an important warning to the people of London that the basic health service provision they have for many years taken for granted is under threat.

The ambulance convenors, alarmed at the decline in the service, and the implications for their members, have taken an important initiative in promoting this report.

Much damage has already been done: but it is still not too late for voices to be raised on all sides demanding a complete change of policy from the LAS and from London's NHS as a whole, to expand the service to meet the challenge of rapidly growing demand. This in turn requires a fundamental change in government policies for funding the NHS.

This report can hopefully provide the factual ammunition for anyone wishing to pursue the matter further.

John Lister
Publicity Officer
London Health Emergency
May 22 1986



INTRODUCTION

The National Health Service Act of 1948 placed the responsibility on Local Authorities to provide a free ambulance service for the whole population. In the three years or so which followed sharply increasing demand created by the concept of free health care caused the Service to expand rapidly. Since then, demand on the Service has risen, but at a much slower pace. In recent years demand has again risen rapidly.

In 1965 the establishment of the Greater London Council (GLC) led to the formation of the London Ambulance Service (LAS) as we know it today. In 1972 a new headquarters for the service was opened in Waterloo Rd, which contained a new centralised control system for the emergency service for the whole of Geater London, and a central administrative centre.

With the National Health Service reorganisation in 1974 the Ambulance Service nationally became a part of the NHS. The degree of democracy existing under the GLC was lost. The London Ambulance Service was put under the joint control of the four Thames Regional Health Authorities but it was to be adminstered on their behalf by one of those authorities: the South West Thames RHA.

Under this structure the London Ambulance Service is a single administrative and operational entity. It covers 610 square miles of Greater London, with a resident population of 7 million, plus visitors and the tourist industry.

It deploys 975 vehicles of which 384 are fully equipped and 621 are "sitting case" vehicles. It has a total staff level of 2,700 of whom 2,106 are operational personnel. For administration it is divided into four divisions which have small administrative units, but the main administration is controlled from Headquarters.

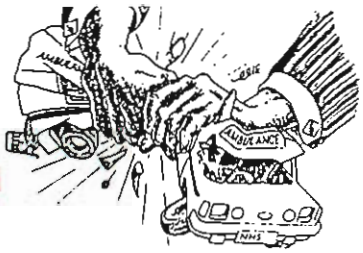
The service covers two distinct functions:

- The accident and emergency service, responding to 999 calls;
- The non-emergency service, which is essentially journeys which can be planned in advance. This is by far the biggest part of the service. In 1984/5 the LAS carried 469,582 emergency cases as against 2,009,231 non-emergency cases out of a total caseload of 2,697,644.*

The ambulance service uses three basic types of vehicle: the sitting vehicle; the tail-lift vehicle (which involves two crew members, for patients who are able to sit but unable to walk); and the ambulance with two crew members for recumbent patients.

The non-emergency service is by far the biggest part of the LAS, carrying over 2m patients, compared to 470,000 emergencies.

*93,627 patients were carried by the Ambulance Car-Service and 3,312 by rail or air.



The accident and emergency service handles all calls received through its central control in Waterloo. These include road traffic accidents and general accidents, with injuries ranging from the minor to the extreme. The bulk of calls however fall into the category of sudden illness or collapse, either at home or in a public place. These include cardiac arrest, where speed is at a premium; and mental patients who are frequently violent.

Increasingly, the emergency ambulance service is being called to assist patients when they get into difficulties in their own homes but are not adequately cared for by social services.

Approximately one third of the operational workforce of the ambulance service is used for the outpatient service, which is the highest single category of patient journeys.

The non-emergency service also includes provision of transport to day centres and day hospitals. All these categories involve different degrees of need, and therefore use particular types of vehicle and levels of staffing.

CRITERIA FOR ENTITLEMENT TO AMBULANCE TRANSPORT

Section 3 (1) (c) of the National Health Service Act, established in 1977, places a requirement on the Secretary of State to provide ambulance services to meet all reasonable requirements. This duty has been devolved to the DHAs except in the Metropolitan Counties, where it comes directly under the RHAs.

The criteria for entitlement to ambulance transport, and the details of those criteria are common to all Services, and are set out in DHSS Health Circular HC (78) 45 which came into force in December 1978. It sets out the following:

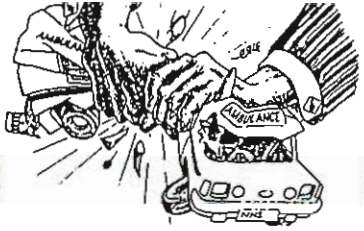
"Ambulance services are required to provide or arrange the provision of suitable transport, free of charge, normally to the nearest hospital or treatment centre with hospital based facilities where the necessary treatment can be obtained, to NHS convalescent homes, dentists' surgeries or Artifical Limb Appliances and Assessment Centres for any patient (emergency or non-emergency) who is considered by a doctor, dentist or midwife to be medically unfit to travel by other means" ... "In recent years the decline of public transport services especially in the rural areas, has made it more difficult for patients without access to private transport to travel to hospitals. In such areas a more flexible interpretation of 'medical need' for transport may be justified."

The SW Thames RHA Strategic Plan itself calls for "Stricter adherence to the medical criteria". It is difficult to see how a reasonable service can be maintained if the obvious social factors — such as the non-availability of suitable alternative transport is not taken into account.

The reference to the decline in transport services makes it clear that when the Circular refers to "other means" it is talking about other means of transport which are reasonably available to the patient: not means of transport which may be theoretically available but very inconvenient. This is the basis on which elegibility for ambulance transport has been traditionally based.

These criteria have, however, been increasingly challenged over recent years. More stress has been placed on the purely medical criteria, to the virtual exclusion of any other criterion. Those able to authorise ambulance transport were more strictly limited and defined, and time limits placed on the forward booking of the Service. The SW Thames RHA Strategic Plan itself calls for "Stricter adherence to the medical criteria". It is difficult to see how a reasonable service can be maintained if the obvious social factors — such as the non-availability of suitable alternative transport is not taken into account.

Direct pressure is now being placed on the patients themselves. A notice recently posted in London hospitals tells them that "MOST PATIENTS SHOULD MAKE THEIR OWN WAY TO HOSPITAL" ... "THE AMBULANCE SERVICE IS UNDER HEAVY PRESSURE AND SHOULD NOT BE USED UNLESS ESSENTIAL."



THE QUALITY OF THE SERVICE
THE "ORCON" STANDARDS

In 1974 the responsibliity for the provision of an Ambulance Service was transferred from the local authorities to the National Health Service. The opportunity was taken to rationalise the Service on a national basis. A report was commissioned from the Statistics and Operational Research Unit at the Cranfield Institute of Technology, to become known as the "Cranfield Report". It was designed to define the standards of service being provided and to lay down acceptable recommended national criteria for the Service.

Both the emergency and the non-emergency aspects of the Service were studied. With the emergency service it was considered that the standards can be effectively measured by an assessment of what was termed the activation time — the time taken to deploy an ambulance after a 999 call — and the response time — the time taken from deployment to arrival at the scene of the accident. The two added together gives the most important measurement the "total response time". This is the time lapse between the 999 call and the arrival of the ambulance at the scene of the accident.

The standard measure of the emergency service is the "total response time" between a 999 call and the arrival of an ambulance at the scene of the accident.

The standard established by the study for the emergency service in the metropolitan areas was for an activation time for 95% of calls to be within three minutes; and for response times for 50% of calls to be within 7 minutes and 95% of calls within 14 minutes. It gives total response times of 50% within 10 minutes and 95% within 17 minutes.

Table 1

MEASURE OF SERVICE	PERCENTILES	STANDARD VALUES
EMERGENCIES		
ACTIVATION TIME	95	3 minutes
RESPONSE TIME	50	7 minutes
	95	14 minutes

The non-emergency service naturally required different criteria. For these journeys the time of arrival and departure in relation to the appointment time was used — both the time of arrival prior to an appointment and time arrived late and the time spent waiting for transport home afterwards. The criteria established were as follows:

Table 2

Arrivals within the following times:

A) Planned:

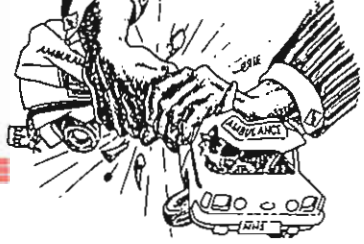
5% within 40 minutes early
25% within 20 minutes early
75% within 15 minutes late
95% within 40 minutes late

B) Special:

5% within 40 minutes early
25% within 20 minutes early
75% within 10 minutes late
95% within 20 minutes late

Waiting time after treatment:

50% within 30 minutes
95% within 90 minutes



The LAS trade unions had reservations as to the adequacy of the standards as a yardstick for quality but supported their application in the light of the necessity for some form of basic control.

The Report recommended that these standards be introduced as the basic criteria for the Service (in this case for the Metropolitan Services) and that the Ambulance Service undertook to record the necessary data to allow the criteria to be monitored. The data should be forwarded quarterly to the appropriate Ambulance Authority. They were circulated to the Health Authorities in DHSS circular HSC (15) 67 "Organisation Of Ambulance Services" and known generally as the ORCON standards. The LAS trade unions had reservations as to the adequacy of the standards as a yardstick for quality but supported their application in the light of the necessity for some form of basic control.

The standards were not actually made mandatory on the various authorities by the DHSS; but they clearly had the full authority of the Department behind them, and the pressure to accept the standards was overwhelming. In fact every Health Authority did accept the responsibility to introduce the standards and has operated them to one degree or another.

The Rayner scrutiny of 1983 in fact accepted that all Ambulance Services were regularly monitoring their emergency services at that time. We have tried to establish the extent to which that was the case, particularly in London.

In March 1980 the Croydon DHA complained of the falling standard of the ambulance service. Recruitment difficulties, the Croydon report said, "have made it increasingly difficult to maintain non-emergency services, especially to our geriatric day hospital ... at times the rehabilitation programme of some of the patients has been seriously affected."

In July 1980 the LAS Convenors Committee produced a trade union "Briefing Document" which concluded that "DHSS standards require that 50% of emergency calls be responded to in 7 minutes. LAS achieves that time in only 32% of its emergency calls."

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The extent to which the ORCON standards have been monitored by the ambulance services and the extent to which any figures produced may have been processed by the Regions is clearly a very important consideration.

ORCON Standard figures do appear in the DHSS Performance Indicators produced by each Regional Authority for each two year period. The most recently available of these indicators is for the period 1983/1984. The figures produced by the South West Thames Authority, which administers the LAS, show the scale of the problem. It gives a figure of 85.8% of ambulance calls meeting the ORCON Standards in England as a whole. Yet when turning to the Regional figures from which this figure is derived, most of them record no data. No data are recorded for the LAS in that period.

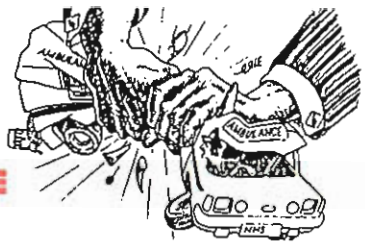
The official responsible for getting the figures together at South West Thames told us that many of the Authorities did not send in any figures at all.

The Health Authorities are very guarded about releasing any information about the ORCON Standards, but the official responsible for getting the figures together at South West Thames told us that many of the Authorities did not send in any figures at all. The LAS was better than most, but the figures were based on samples rather than established in the way laid down.

She was however able to give us LAS figures for 1983 and 1984 arrived at in this way, at least for the emergency service, even if they had not been recorded in the

MEASURE OF SERVICE	PERCENTILES	STANDARD VALUES
1983		
ACTIVATION TIME	91	3
RESPONSE TIME	27	7
	89	14
1984		
ACTIVATION TIME	95	3
RESPONSE TIME	25	7
	89	14

Table 3



Performance Indicators. In other Regions where figures were sent in, they were collated in a way not laid down by the DHSS.

From these figures we can see that while the standards require that 50% of emergency calls are responded to in 7 minutes, the LAS only achieves this in 25% of emergency calls. This shortfall means that in relation to total emergency demand of 469,582 calls, 113,346 are not reached within the time allowed. If we assume that 1% of these calls are critical, this means that 1,173 Londoners were put at risk.

The latest figures available for this report — from the final quarter of 1985 — show a further all-round worsening of this performance across London.

In relation to total emergency demand of 469,582 calls, 117,395 are not reached within the time allowed. If we assume that 1% of these calls are critical, this means that 1,173 Londoners were put at risk.

Table 4

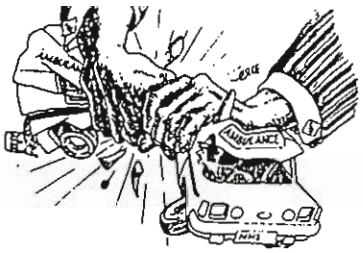
London Ambulance Service Standards of Service — Emergency Calls
Quarter Ending 31st December 1985 Statistics 2

Measure of Service	Percentiles	Standard Values	North West Division	North East Division	South East Division	South West Division	L.A.S. Total
Emergencies Activation Time	95	3 min	5 min	5 min	4 min	5 min	5 min
Response Time	50	7 min	9 min	10 min	9 min	9 min	10 min
	95	14 min	17 min	19 min	17 min	18 min	18 min

The minutes of the meetings of the London Ambulance Service Panel have in the past carried some ORCON figures for the emergency service, although these are not publicly available. They give figures which are consistently well outside the ORCON Standards, as can be seen from the following figures for June 1982 until 1985, taken from the minutes:

Table 5

MEASURE OF SERVICE	ACHIEVEMENT	STANDARD VALUES
JUNE 1982		
ACTIVATION TIME	4	3
RESPONSE TIME	9	7
	16	14
JUNE 1983		
ACTIVATION TIME	4	3
RESPONSE TIME	9	7
	17	14
JUNE 1984		
ACTIVATION TIME	4	3
RESPONSE TIME	9	7
	17	14
JUNE 1985		
ACTIVATION TIME	5	3
RESPONSE TIME	10	7
	19	14



The LAS will not say if they do monitoring, and therefore will not publish the results of any monitoring which may take place.

It is clear from all this that some monitoring has been carried out in London (it seems to have been carried out by the LAS Management Information Section) until quite recently, at least for the emergency service.

A major problem is the availability of information. The LAS will not say if they do monitoring, and therefore will not publish the results of any monitoring which may take place.

In June 1985 the four trade unions in the London Ambulance Service, NUPE, COHSE, GMBATU and TGWU, themselves carried out a monitoring exercise on the emergency service in relationship to the ORCON Standards. Their conclusion was that only 45% of calls were meeting the Standards. "Of the rest, 50% of the 999 calls are delayed up to three minutes and 5% by six minutes or more."

As the Strategic Plan 1984 concedes, only one survey of the non-emergency service had been done over the last 12 months. Indeed the Strategic Plan makes it clear that the standards are now generally disregarded. In referring to standards, it says: "There is little doubt however that compared to the target standards established in the ORCON Report of 1974, the poor performances identified in former years still prevail in many areas."

Significantly, when the trade unions pressed that a reference to the ORCON Standards be included in the recent agreement on a salaried wage structure, this was refused by management.

"There is little doubt however that compared to the target standards established in the ORCON Report of 1974, the poor performances identified in former years still prevail in many areas."

It is remarkable that a quality of service standard, strongly recommended by the DHSS, and which is still apparently the subject of monitoring to ensure compliance, is not included in the new major agreement covering all aspects of wages and conditions in the Service.

The only reasonable conclusion is that the LAS, and the Ambulance Service generally, has at the very least an ambivalent attitude to the Standards and at worst have withdrawn from the Standards but for political reasons are not prepared to make this publicly clear.

THE EMERGENCY SERVICE TRAFFIC

London traffic conditions represent a major problem to the ambulance service due to both the size of area covered and the density of the traffic. Furthermore at rush hour twice a day London comes to a virtual standstill. Traffic congestion in London is ten times greater than the national average, and has increased markedly over the last 15 years as can be seen from the table below. Average speeds in the morning peak period have fallen from 13.9 mph to 12.6 mph within central and inner areas of London representing a 9.3% decrease in the average speed. In the evening peak period, average speeds have fallen from 13.7 mph to 12.2 mph representing an almost 11% decrease in average speeds.

There is no evidence that the opening of the M25 has eased this situation or altered the trend. These traffic conditions are undoubtedly an important factor in the ability of the Service to meet the ORCON standards set by the DHSS(1).

In addition a study undertaken by the GLC traffic monitoring programme in 1982 has shown that the present geographical locations of ambulance stations result in a relatively poor service to specific districts within the central outer and inner areas of London(2).

On March 4th the Emergency Bed Service announced the first red alert in London since 1973.

HOSPITAL CLOSURES

However a third and more worrying development which has increasingly affected the ability of the Service to maintain adequate standards is the closure of hospitals and accident and emergency units.

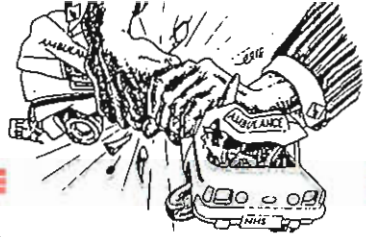


Table 6

LINK COUNT AND SPEED STUDIES SUMMARY OF AVERAGE SPEED RESULTS 1968–1985

	Primary roads (GDLP)	Central area	Inner area	Central & inner areas
Morning peak period				
1968–1970	24.3	12.7	14.4	13.9
1971–1973	25.0	12.9	13.8	13.6
1974–1976	24.1	14.2	15.3	15.0
1977–1979	23.0	12.3	13.3	13.0
1980–1983	26.2	12.1	13.5	13.1
1983–		11.8	12.9	12.6
	TOTAL	−7%	−10.4%	−9.3%
Evening peak period				
1968–1970	26.9	11.8	14.6	13.7
1971–1973	26.9	12.7	13.9	13.5
1974–1976	30.4	13.2	14.8	14.3
1977–1979	27.2	11.9	12.9	12.5
1980–1982	29.8	12.2	13.6	13.1
1983–		11.5	12.5	12.2
	TOTAL	−2.5%	−14.4%	−10.9%

Since 1975 a total of 40 casualty units have been permanently closed with a number of others under threat. Of those that remain open, not all stay open seven days a week or 24 hours a day. A survey has shown that in the seven months from January to July 1985 only eleven units stayed open for the whole of this period. Of the rest, 22 were closed for over seven days and the rest were closed for more than 50 days out of the 212 during that time(3).

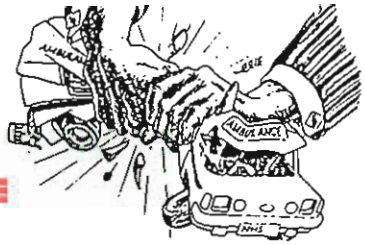
The total number of NHS hospitals has also decreased considerably. In 1968 London had 357 hospitals. By 1984 this figure had been reduced to 230. According to the plans of the four Thames Regional Health Authorities the number of hospitals in London will fall to 170 by 1991(4).

The wholesale closure of hospitals, a reduction in the numbers of acute and geriatric beds stemming from Government policies advocating "care in the community", and the temporary and permanent closure of accident and emergency units, all contribute to increasing demand on the Ambulance Service. The present situation in London in relation to emergency beds makes this very clear. On March 4th the Emergency Bed Service (EBS) announced a "red alert" (emergencies only admitted) which covered all Districts within the North West Thames RHA. This was the first red alert in London since 1973. Of the four London Regions three were already on "yellow alert" (non-urgent waiting list patients cancelled).

The reduction in acute beds causes additional problems for the LAS. A patient may be refused admission at the nearest hospital and an alternative unit must then be found which may be further away. This has resulted in ambulances being redirected from one unit to another.

Increased mileage and therefore the time taken per call resulting from closures is further aggravated by the rise in the incidence of home illness brought about by a policy of early discharge. The effects are cumulative: extended journey times leave fewer vehicles to cope with other incoming calls. These factors result in an overall decline in standards and increase the risks to the lives of patients. The resulting frustration among members of the public in turn places ambulance personnel under additional stress.

Since 1975 a total of 40 casualty units have been permanently closed with a number of others under threat. Of those that remain open, not all stay open seven days a week or 24 hours a day. A survey has shown that in the seven months from January to July 1985 only eleven units stayed open for the whole of this period.



PRESSURE ON AMBULANCE CREWS

An indication of the pressure on ambulance crews as a result of this situation is the alarming number of assaults on them. From August 1982 until July 1983 there were 124 assaults on crews, 110 on men and 24 on women. This appears to be due to a number of reasons: more unstable patients are being kept at home through "community care"; and there is more pressure on distraught families if an ambulance is late. This adds to the pressure on the crews themselves, who face the added problems of coping with difficult situations under those conditions.

Stress levels also emerge in the higher levels of sickness and absenteeism in the Service. The total number of days lost due to sickness in the London Ambulance Service rose from 3,864 in August 1983 to 4,406 in August 1985, an increase of 14%.

	ASSAULTS	MALE	FEMALE
AUG '83/JUL '83	124	110	14
AUG '83/JUL '84	120	96	24

Table 7

In many cases the attacks were serious — ranging from stabbings to kicks and frequently resulting in hospitalisation.

Stress levels also emerge in the higher levels of sickness and absenteeism in the Service. The total number of days lost due to sickness in the London Ambulance Service rose from 3,864 in August 1983 to 4,406 in August 1985, an increase of 14%.

THE NON-EMERGENCY SERVICE

Whilst the emergency side of the Service is under pressure, the non-emergency side gives rise to even greater concern with regard to capital resources and the maintenance of standards and service.

In 1979 a "quota system" was introduced, designed strictly to limit the number of out-patient journeys.

Though the quality of the service is not being monitored, measures have been taken to reduce demand. In 1979 a "quota system" was introduced, designed strictly to limit the number of out-patient journeys. This was combined with a tightening of the criteria of eligibility for ambulance transport. The results of this can be seen in a sharp reduction in non-emergency patient journeys. Thus in 1977 the LAS carried a total of 2,619,846 patients: by 1984 this had been cut by over 333,000 to 2,286,774.

This cutback of around 11% in patient journeys over five years has accompanied a major increase in demand on the non-emergency sector.

The non-emergency side of the Ambulance service, which accounts for around 80% of its work, is mainly concerned with three areas of patient transport:

- the transfer of patients to and from outpatients departments;
- transfers or discharge of patients who may require ambulance nursing care en route;
- the transfer of patients to and from the growing number of day hospitals.

This cutback of around 11% in patient journeys over five years has accompanied a major increase in demand on the non-emergency sector.

Recent policies of early discharge and the use of day surgery and short stay wards, combined with the greater number of day hospitals, have resulted in a dramatic increase in demand on the London Ambulance Service. This in turn has contributed to declining standards in both the provision and the quality of service provided, since there has been no corresponding increase in either capital expenditure or staffing levels.

The increase in the number of day hospitals is reflected in the much higher numbers of patient journeys to the day units. The total number of patient journeys to day hospitals rose from 6,500 per week in 1983 to 10,540 per week in 1984, an increase of 62% (7).

Acute Hospital Services 1978 – 1984
England
Figures for 1984 are given in brackets

Source: The Health Service in England, DHSS 1985.

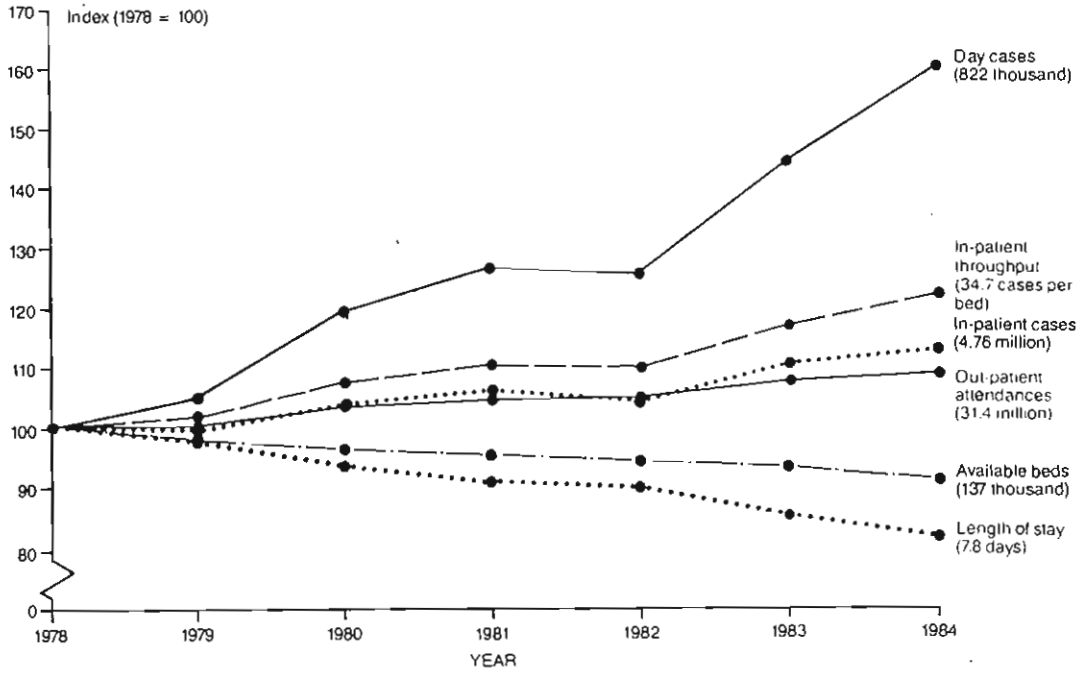
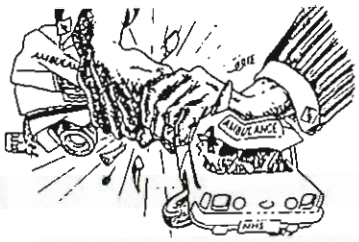


Table 5 Acute[1] hospital services 1978-1984
England

			Change[2] between 1978 and 1984		Change[2] between 1983 and 1984	
	1978	1984	Number	Percentage	Number	Percentage
In-patient cases (thousands)	4,204	4,762	+558	+13.3	+105	+2.3
In-patient throughput (cases per available bed)	28.0	34.7	+6.7	+23.8	+1.5	+4.6
In-patient average duration of stay (days)	9.4	7.8	−1.7	−17.5	−0.3	−4.0
Day cases (thousands)	543	872	+329	+60.6	+85	+10.8
Out-patient attendances (thousands)	28,407	31,379	+2,972	+10.5	+511	+1.7

[1]'Acute' is defined as all specialities except geriatrics, younger disabled, GP maternity, obstetrics, mental handicap and mental illness.

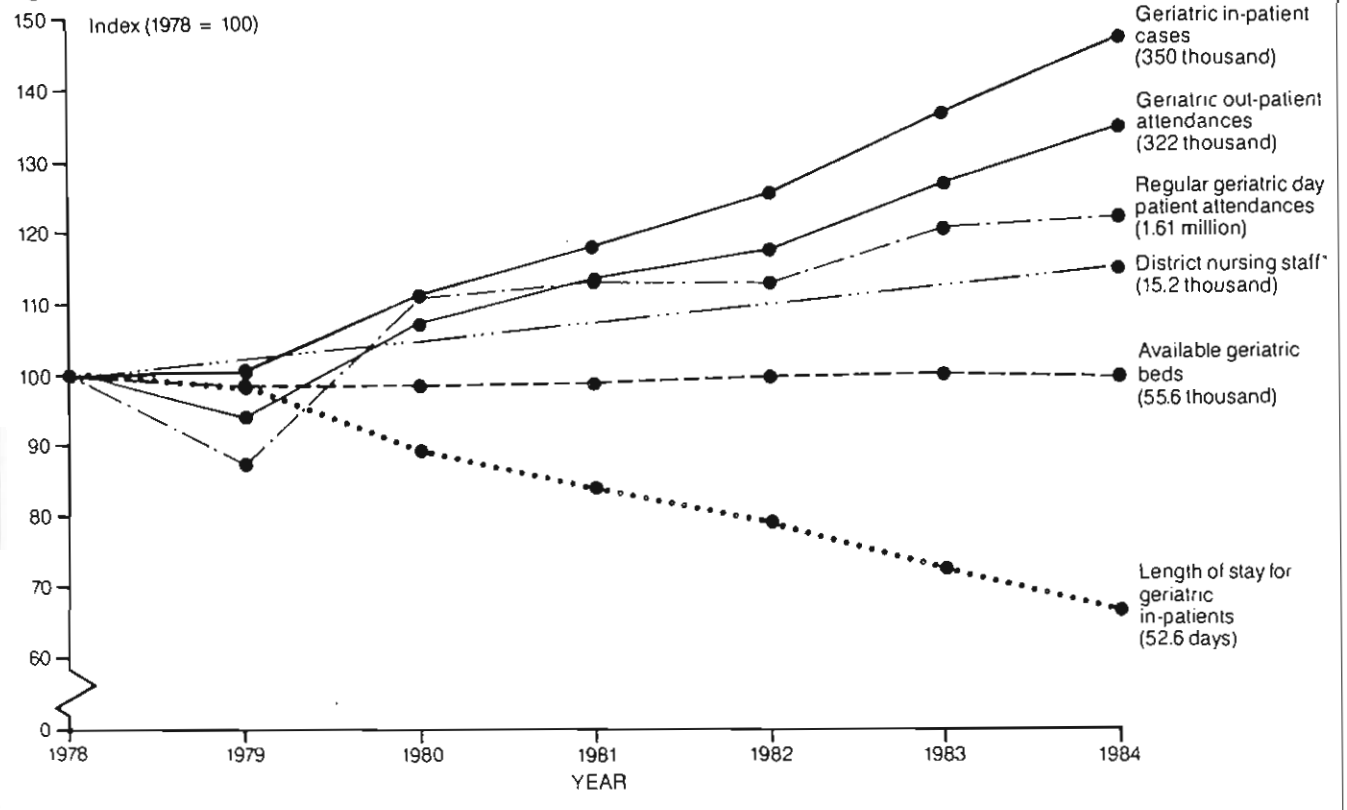
[2]Any apparent discrepancies are due to rounding.



Source: *The Health Service in England, DHSS 1985.*

Hospital and Community Health Services for elderly people 1978–1984 England

Figures for 1984 are given in brackets



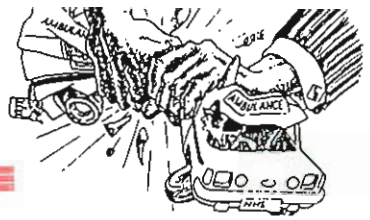
* This is the estimated trend in district nursing staff numbers for the period 1978 to 1983 as a whole (ie 1078 = 100). The provisional figure for 1984 is given in brackets. Year on year movements for district nursing staff are not available on a consistent basis over this period. No adjustment has been made in the staffing figures to take account of the change in nurses' basic contractual hours in 1980 from 40 to 37½ hours per week. On an adjusted basis over the period 1978 to 1984 the estimated increase in district nurses is 8%.

Table 8

Hospitals: Number of beds and patient activity in Regional Health Authority areas

Source: H&PSS. England

Area and Year[1]		Average daily no. of Available beds	Average daily no. of Occupied beds	Discharges and deaths	Average length of stay in acute specialties[2] (Days)	Day cases	New out-patients during year[3]	Total out-patient attendances[3]	New accident and emergency cases during year
N.W. Thames	1973	37,004	30,549	526,444	10.9	31,853	999,997	4,219,143	897,063
	1983	25,342	20,864	408,474	8.5	49,494	660,531	2,699,641	797,371
N.E. Thames	1973	28,626	23,392	376,532	11.7	23,643	654,089	2,806,903	652,875
	1983	28,741	23,922	526,398	9.0	51,725	834,745	3,731,453	994,831
S.E. Thames	1973	30,706	24,879	398,853	11.2	25,808	658,586	2,838,163	693,352
	1983	26,357	21,237	477,283	8.3	59,983	762,979	3,292,976	893,833
S.W. Thames	1973	41,228	34,178	406,010	11.2	15,285	687,314	2,974,188	631,575
	1983	23,719	19,998	329,334	8.3	33,676	494,316	2,067,089	577,754



An indication of the increase in day surgery and short stay wards in England can be seen in the table (left) dealing with acute hospital services, from DHSS annual report "The Health Service in England" 1985. Between 1978 and 1984 the number of day cases rose by 60.6% whilst the average in-patient length of stay fell from 9.4 days in 1978 to 7.8 days in 1984, representing a 17% decrease (8).

Administrative statistics for the four Thames Regions (Table 10, left) would seem to indicate an overall rise of 102% in the number of day cases between 1973 and 1983. However deficiencies in the data mean that caution must be taken in any analysis. For example the DHSS do not distinguish between deaths and discharges; and the Regional figures are not strictly comparable because of NHS reorganisation in both 1974 and 1982. Nevertheless a significant trend towards day cases can be discerned which will have a major impact on the ambulance service.

The total number of patient journeys to day hospitals rose from 6,500 per week in 1983 to 10,540 per week in 1984, an increase of 62%.

A Report on the London Ambulance Service by the Royal Institute of Public Administration (RIPA) argues that both day surgery and day hospitals represent the greatest source of potential demand on the Service (9). These trends indicate that a radical increase in resources is required if the ambulance service is to meet the present shortfall and rising future demand.

THE ELDERLY AND DISABLED — POPULATION CHANGE

Any assessment of the role of the Ambulance Service cannot be undertaken independently of the potential users. Elderly and disabled people form the largest proportion of those reliant on patient transport (a proportion which is likely to increase with the changes in the population structure). They also tend to experience great difficulties in using alternative forms of transport which require high levels of physical adaptability.

Whilst for the purposes of this paper it is necessary to identify those groups of elderly people with mobility problems, it is important to emphasise that a large proportion of those over 65 are in fact fairly fit and relatively healthy. However for significant numbers the ageing process is characterised by a gradual loss of mobility due to physical deterioration. This process can be interrupted by sudden severe loss of mobility stemming from either injury or acute illness. These factors have a greater significance when viewed within the context of past, present and future population growth.

As a proportion of the population the elderly have increased in absolute numbers from 5% of the population in 1901 to 15% in 1983. Although overall growth is levelling out, the proportion of those aged over 65 is expected to increase by 20% between 1983 and 2021.

As a proportion of the population the elderly have increased in absolute numbers from 5% of the population in 1901 to 15% in 1983. Although overall growth is levelling out, the proportion of those aged over 65 is expected to increase by 20% between 1983 and 2021 (10). The highest, and for policy purposes the most significant, changes in structure will be in the groups aged 75 and over with an expected increase on current levels of 30%. Numbers of those aged 85 and over are expected to increase by 98% with women forming approximately 70% of the total (11).

In Greater London the largest increase has been in the 75—plus age group which is expected to lead to a 40% increase in those aged 85 and over within the next decade (12). These changes will mean increased demand on the NHS as these age groups tend towards greater reliance and need for health and social service facilities.

The General Household Survey found that there has been a major increase in the numbers of elderly requiring assistance in self care and mobility activities. Just over 10% of all the elderly surveyed were unable to walk down the road on their own and just under 10% were totally unable to manage steps and stairs. As expected, restricted mobility increased with age. In the over 85 age group almost 50% needed help to walk and about 33% could not manage steps and stairs (13). The majority of those who suffer from any disability are therefore likely to be found in the older age groups who at present contain over half of all disabled people.

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Although only limited information exists on the numbers affected by differing degrees of disability, Table 11 gives some indication of how the changes in the population structure will affect the numbers of elderly and different degrees of incapacity.

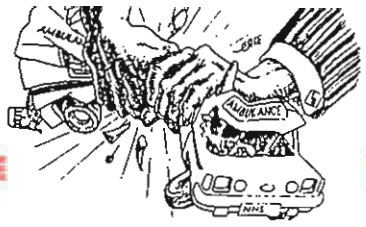
Many of those suffering from some form of incapacity area also likely to find it difficult to use alternative forms of transport, such as a car or bus. Mobility problems can also be intensified by fear stemming from the realisation on the part of the elderly of their own frailty and disability making them more vulnerable to accidents. This is further compounded by poverty and deprivation being greater amongst the disabled elderly. This factor is likely to increase as a result of the planned alterations to the benefits system contained in the recent White Paper.

A survey undertaken by Islington CHC in the out-patients department of Whittington Hospital gives some indication of the transport needs of persent users. Of the patients interviewed, 84% were aged over 60 and all experienced difficulty with mobility. Over 50% could not walk unaided, 24% were confined to a wheelchair and the remaining 26% could walk but were weak and frail with restricted mobility arising from heart disease or arthritis. Ambulance personnel were singled out for praise as in many cases they provided extra help by carrying the patient indoors, making a cup of tea, and generally ensuring that the patient was settled in properly before leaving (14).

A number of recent reports indicate additional problems for the elderly in London (15). The deficiencies in some community services, such as inadequate provision of family doctors and community nurses, combined with an increasing trend for the elderly to live alone with low levels of family help, result in greater isolation and increased dependence on hospital services. This is not compensated for by the

Degree of incapacity	Age 65–74	75+	All 65+
		Private households (1976)	
None	62.2%	27.4%	69.2%
Slight	19.8%	21.6%	20.4%
Moderate	14.7%	32.8%	20.8%
Severe	5.3%	18.2%	9.6%
Total	100%	100%	100%
Number	2571	1298	3869
	Estimated numbers in population 1983 (thousands)		
None	3000	900	3900
Slight	1000	700	1700
Moderate	700	1200	1900
Total	5000	3400	8400
	Estimated numbers in population 2001 (thousands)		
None	2800	1200	4000
Slight	900	900	1800
Moderate	700	1300	2000
Severe	300	700	1000
Total	4700	4100	8800

Table 11



higher than national average of some social services, indeed when these factors are taken into account, the total level of help they receive is well below the national average (16).

The trend for more elderly people to live alone is the result of a number of factors. Firstly, a large number of elderly people who have no children or relations or have outlived their partners are themselves living longer. Secondly, with increased longevity many of the older age groups are being cared for by people of their own age. Given the stressful nature of caring, they therefore put their own health at risk. Thirdly, the fall in the birth rate means there are fewer children to help, and particularly fewer daughters (since women make up the majority of carers). A recent Equal Opportunities Commission (EOC) report found that daughters were three times more likely than sons to be responsible for looking after an elderly parent (17).

The fall in the birth rate means there are fewer children to help, and particularly fewer daughters. A recent Equal Opportunities Commission report found that daughters were three times more likely than sons to be responsible for looking after an elderly parent.

There is now an overlap between the elderly and other vulnerable groups such as the mentally ill and the mentally handicapped. The increase in the numbers of elderly and very elderly has resulted in a profound change in the pattern of psychiatric morbidity. Almost 25% of those over 65 have some form of mental illness which can normally be treated. The increase within this group is likely to be small. However, dementia, which is a progressive degenerative illness, is likely to increase considerably. At present dementia affects 10% of those over 65 and 20% of those over 80. Throughout the next decade the number suffering from dementia is expected to increase by 20,000 (or 30% of the 1981 total) placing extra pressure on already inadequate services (18).

Mental health care for Londoners is mainly provided by 15 large hospitals which provide 90% of beds and are situated on the outskirts of the city. Services provided by the District General Hospitals (DGH) are extremely limited, with 11 health districts in 1981 providing no DGH inpatient facilities at all. Provision is also poor in terms of primary care, with some boroughs having no day care centre and others having only minimum levels of residential provision (19). However, the aim of Government policy is to close the large hospitals and increase the development of assessment and short-term care which is reflected in the declining amount of long-term hospital care. Again this will increase demand on the London Ambulance Service.

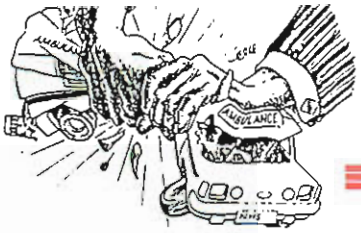
In relating change in population to transport needs, the requirements of different groups with differing levels and types of incapacity must be considered. Whilst the DHSS strictly defines the criteria to be met in the requisition of ambulances by stating that patients must be "medically unfit" to travel by other means, their attempts to make a distinction between medical needs and health needs may appear fine on paper but cannot be applied in the real world.

Changes in the population structure have therefore profound implications for those concerned with formulating social policy and for the public who must cope with both the changes and the policies.

The changes outlined will increase further the demands placed on health and social services which in turn increase demand for patient transport.

THE IMPACT OF GOVERNMENT POLICIES

In the past 25 years there has been a philosophical shift in welfare rhetoric away from the Victorian emphasis on institutional care. Increasingly politicians have stressed the importance of individual responsibility, criticised the apparent loss of community spirit and called for more care in the community. However, in reality the majority have always been cared for in the community by their families. For example only 2% of the elderly are in Local Authority residential care, a further 1% are in



Only 2% of the elderly are in Local Authority residential care, a further 1% are in private hotels and residential establishments, 2½% are in hospitals leaving the remaining 94.5% living in private households.

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Similarly 80% of severely handicapped children and 40% of severely handicapped adults live at home. As can be shown many of those caring for elderly or handicapped relatives do so with inadequate assistance from either statutory or voluntary bodies.

However, the phrase "community care" is used by various groups according to their own pressures, policies and requirements. Definition of the term therefore becomes important if rhetoric is to be translated into policy. Philip Abrams has argued that a search for purity of definition in relation to community care is misguided but he does identify three main senses in which it is commonly used. Firstly it may denote provision of residential services taking the form of a caring or therapeutic community which is client centred. Secondly the provision of professional and specialist staff within the community. Thirdly, the provision of services by local residents on a part organised or voluntary basis. For Abrams the first of these is institutional care, the second a type of community treatment and only the third definitively "community care" (20). This serves to highlight the fact that community care can be used to describe profoundly different policy objectives: care in the community dependent on a level of formal provision; and care by the community with the emphasis on informal caring networks.

The stress on community care took shape in the late 1950s particularly in relation to mental health. Since then there has been a growing disillusionment in institutional care, aided by various reports which emphasised deficiencies in terms of staffing and conditions within specific establishments (21).

The 1963 Government White Paper "Health and Welfare: the development of community care" stressed care in the community, but since then sucessive reports have either implicitly or explicitly altered this to care by the community. A prime example of this was the Seebohn Report in 1968 which advocated "... a community-based and family oriented service ..." which would involve local residents, encourage the participation of a large number of volunteers and be supported by an area team of generic social workers (22).

In the search for ways of reducing public expenditure on social welfare the present Government have strongly advocated "community care". The 1981 consultative document "Care in the Community" put forward various suggestions relating to the expansion of community based services with the stated aim of improving the "... legal, administrative and financial framework" in order to reduce dependence on in-patient care for the mentally ill, the elderly and handicapped". The document stated that "funds would have to come from existing resources" (23).

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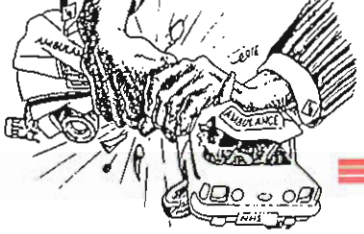
Before the present policies can be fully assessed it is necessary to look at the main methods of Government control over resource allocation to the NHS and the Personal Social Services.

RESOURCE ALLOCATION

RAWP, named after the Resource Allocation Working Party of 1976, is the name given to the system used by the DHSS to set targets and allocate resources from the NHS to the Regions and the Districts. It was originally viewed as a response to the perceived inequalities in the distribution of health provision between the so-called "over provided" south and the undoubtedly underprovided north. However, since its introduction criticism has mounted. The major problem is that whilst the acknowledgement of comparative need was welcomed, the introduction of RAWP took place at the same time as big cuts in public expenditure, resulting in the four Thames Regions suffering real cuts in order to transfer an increase in funding to other areas. Whilst the working party formulated the system at a time of growth in



health expenditure, it was applied during the introduction of "cash limits": so rather than passing on differential growth, it passed on cuts.

The allocation figure awarded is derived from the population of each RHA weighted to take account of the differing health needs of different populations. The two main elements involved in calculating the weighted population are as follows:

1) Standardised Mortality Rate (SMR) — the ratio of actual deaths to those expected adjusted for the differing sex and age make up of the Region's population — used as a crude estimate of illness.

2) Expected usage of health services based on the different age and sex composition of the Region derived from the national average rates of usage by different age and sex groups.

On top of this a further adjustment is made for inter-Region flows and an extra element, the Service Increment for Teaching (SIFT), added for the teaching hospitals.

For the London Ambulance Service, target expenditure is calculated by multiplying the crude population by overal Regional SMRs.

This formula has, however, a number of flaws. The use of the Standardised Mortality Rate measures illness only by deaths, and ignores the fact that particular illnesses may require long term and high cost care but lead to few deaths. To allocate a Region with a high death rate more funds hardly seems the best way of achieving high standard health care.

A further flaw stems from the practice of basing allocation on national rates of spending. This discourages Regions from being responsive to local circumstances or to changing needs. This formula is concerned with geographical equity and not socio-economic inequality. For example it takes little account of deprivation and underprovision within certain areas of London which has meant that resources for inner London have been squeezed to breaking point. Its application at a time of reduced growth has meant that expenditure can only be increased in one area at the expense of cuts in the others (24).

At District level these problems become more acute with data becoming less dependable as the area decreases in size. The inequalities between the Districts become even greater than those between Regions. A further problem arises with the presence of teaching hospitals: the allocation of SIFT is not enough to offset the high cost of the teaching hospitals that tend to be concentrated within London. The adjustment for inter Region flow does not allow for the greater complexity of cases which the teaching hospitals attract.

The introduction of RAWP took place at the same time as big cuts in public expenditure, resulting in the four Thames Regions suffering real cuts in order to transfer an increase in funding to other areas.

The introduction of cash limits in 1975/76 was designed to increase central control of expenditure by funding in advance. Budget limits set were real rather than target budgets. But the planned cash limits never match the cost of actual provision, thus making cuts inevitable. The impact of the cuts in health provision have affected the number of both acute and geriatric beds. The policy of closing the smaller hospitals in the acute sector has led to hospitals closing to all but emergency admissions and cancelling waiting list operations in order to keep a sufficient number of emergency beds available.

The traditional split between acute and chronic care has meant that services for the elderly, mentally ill and the mentally handicapped have always received less than their share of resources. Despite the fact that 50% of NHS beds are reserved for these groups they get only 20% of NHS resources (25). London already has 15% fewer geriatric beds than the national average and this has been exacerbated by the application of RAWP. This must be seen within the context of an insufficient level of community based services and the greater isolation of the elderly in London. There is no evidence that a transfer of resources from the acute sector to develop community services has taken place. It would seem that no London Region is providing hospital services to the required level for the elderly and that rather than

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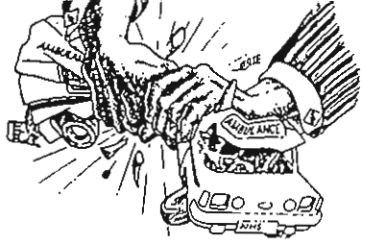


releasing resources for community based services they are using them in an attempt to restore standards in hospital care (26).

Government claims that the NHS is receiving increased resources are very misleading. The increased demand from the growing numbers of elderly for NHS resources, and the cost of new equipment and techniques alone would require a 1.5% increase in expenditure per year over and above the rate of inflation. Cuts within the four Thames Regions will in fact result in the total NHS annual budget being reduced between 1982 and 1983 and 1986 and 1987 by £27 per person in inner London and £5.70 in outer London (27).

PERSONAL SOCIAL SERVICES

The Personal Social Services have also been subjected to expenditure cuts. The Rate Support Grant was reduced from 60% of Local Authority expenditure in 1979/80 to 46% in 1985/86 despite the fact that these services are a vital part of any policy aimed at enabling the elderly and disabled to live in their own homes. Whilst most Local Authorities have tried to protect social services from the worst of the cuts, the Government have been exerting even tighter control through GRE (or Grant Related Expenditure) and in particuar through the social services element of GRE (28).

GRE differs from the previous system which calculated spending needs in relation to past expenditure. Instead, spending need is now assessed in relation to the average cost of the provision of service to each client or each unit of service. The assumed level of spending needs is set and the Rate Support Grant cut if expenditure exceeds this figure.

As with RAWP there are a number of flaws in estimating the GRE which have resulted in growing criticism. Firstly, inadequate allowance is made for social and economic deprivation or for the varied and changing needs of elderly groups. Secondly, the majority of Local Authorities fall well below the expenditure calculated for the GRE, mainly because inadequate data and over-complex methodology results in an underestimation of the level of need and therefore in an underprovision of service. Given the rising level of demand, provision of most services is sufficient to meet neither existing needs nor those of the future. Whilst the number of day centres for the elderly has increased substantially, residential care and meals on wheels have all suffered substantial reductions in both level and scope. In addition increased charges for home helps and meals on wheels are likely to reduce the take-up of these services.

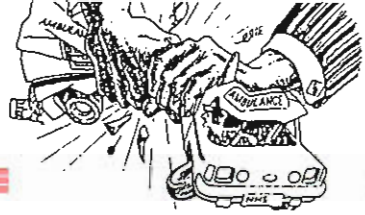
Cuts in social expenditure indicate that Government policies have been based on the fallacy that "community care" is a less expensive option than institutional care.

The use of the GRE appears to take no account of even the Government's own policy on community care, indicating that policy statements are rather different to policy commitments.

JOINT FINANCE

The reorganisation of the NHS in 1974 resulted in the removal of health functions from the Local Authorities. The provision of services for groups such as the elderly, the mentally ill and the mentally and physically handicapped whose needs overlap both health and social services, requires close collaboration between the services.

This was to be achieved by the creation of Joint Consultative Committees made up of members of Health and Local Authorities who would be the main mechanism for co-ordinating services, backed by advice from Joint Care Planning Teams. Collaboration is however not just an administrative problem but also one of philosophy, since health services tend to be directed towards cure rather than care. In the 1982 NHS reorganisation further problems were created by the removal of Area Health Authorities which resulted in the Health Authorities and Local Authorities having different boundaries.



However, collaboration has also been made difficult by the method of financing. As the client groups were shared by both Health Authorities and Local Authorities it became evident that if the current services were to be provided additional finances would have to be forthcoming.

Thus in addition to capital and revenue the DHSS allocation to Regions also contains an element for joint finance. This is calculated according to their population and weighted to allow for the number of in-patients for mental illness and of people aged over 75. This money is intended to sponsor and assist schemes undertaken by the Local Authority: but the final decision on whether to undertake a project rests with the District Health Authority.

Differing systems of allocation are used by the four Thames Regions but the manner in which it may be used for revenue expenditure is subject to fairly strict guidelines. Revenue expenditure is provided in full by the Health Authority for the first three years of a project, tapering over a seven year period, at the end of which the Local Authority must meet the full cost. Capital may be provided for up to two thirds of the capital cost of a project but this is not a strict guideline. Where the revenue expenditure is intended for a project that supports the transfer of a patient from a hospital into the care of either a Local Authority or a voluntary organisation then Joint Finance may be used for the entire revenue costs for ten years and part of the revenue costs for up to thirteen years.

In considering joint funding it is important to note the increased pressure on Local Authorities that we have seen in this report. After committing themselves to a project many Local Authorities have found themselves unable to meet the revenue expenditure necessary to keep a project going once the joint funding has stopped. Problems of fianance, where ratecapping makes many Local Authorities reluctant to engage in joint projects, and the additional problem of the lack of co-terminosity of boundaries have prevented innovation and failed to reverse the overall decline in health and welfare services. In addition the proportion allocated under joint finance makes up only 1% of health service expenditure and even this proportion has decreased for the London area over the past years (29).

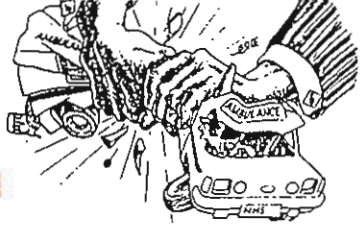
An inadequate level of service providing only minimal care has been further stretched to meet demand. This has been accompanied by massive cuts in social expenditure indicating that Government policies have been based on the fallacy that "community care" is a less expensive option than institutional care.

The effects of these policies are such that neither health nor social services can provide the necessary level of care needed to rehabilitate patients back into the community: nor can they provide the care needed to maintain them there. Instead, policies will increasingly result in an intolerable burden being placed on families and a vicious circle of ill health and dependency on health services.

Ambulance personnel are increasingly being called on to fill the gaps in health and social service provision. Thus when an elderly and disabled person falls out of bed or cannot reach the toilet they turn to the LAS. The faster throughput of patients totally ignores patients' needs and differing circumstances. Ambulance staff are often expected to return patients to homes where they live not only alone but in conditions which exacerbate ill health. In some cases staff have refused to leave the patient and returned them to the hospital.

The growth in the elderly population, increased emphasis on community and domicillary care, but above all Government policies of reducing welfare expenditure have had a critical effect on the provision of health and social services and therefore hold profound implications for the ambulance services. As the Select Committee on Health and Personal Social Services have pointed out "Desperately little attention would seem to have been paid to the effects on transport services of community care policies..." (30)

Ambulance personnel are increasingly being called on to fill the gaps in health and social service provision. When an elderly and disabled person falls out of bed or cannot reach the toilet they turn to the LAS.



DEMOCRACY AND ACCOUNTABILITY: THE EVOLUTION OF THE NHS

The National Health Service Act of 1948 created a universal health care system, free at the point of use but resting on a tripartite base which separated primary care, hospital services and community health services.

- General Practitioners, dentists and opticians remained as independent contractors;
- The hospital services were controlled by Hospital Management Committees and Regional Hospital Boards except for the Teaching Hospitals which although funded centrally were under the control of independent Boards of Governors;
- The responsibility for community health services remained with Local Authorities — but psychiatric, geriatric and maternity specialists were removed to the hospital sector.

In terms of administration this represented a dramatic break with past practice. The public health sector shifted reliance from an insurance-based system to one collectively financed from general revenue. The takeover by national government of voluntary and municipal hospitals meant in effect that health care was now nationalised.

Greater government control resulted in Local Authorities having only a residual role in health care; and the retention of the independent status of teaching hospitals led to a health care system that was primarily "curative" and hospital based.

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The medical profession was split between those who wished to see a consultant-based service with a stress on technical efficiency, and those whose interests lay with the general practitioner system. Nevertheless both General Practitioners in the community and the consultants in the different specialist areas could act to prevent policies made by the bureaucrats which they saw as a threat to their interests.

The development of the National Health Service serves to illustrate many of the present weaknesses inherent in the system. The structure and priorities are largely determined by bureaucratic and medical "experts". Hospital and community health services are administered separately from family practitioner services and the required co-operation and co-ordination of Local Authority services and the NHS has never been achieved. Recent re-organisations have done little to alter this situation.

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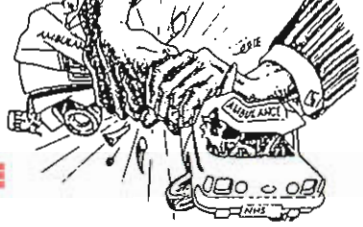
National Health Service and Re-organisation

The desire to reduce public expenditure on health and the increased demand from the elderly resulted in a greater stress on efficiency and effectiveness. The DHSS found it increasingly difficult to shape policies, particularly in the area of chronic care, since this lacked not only status but the articulate representation of consumers and the medical profession which the acute sector enjoyed.

The stated objective of the 1974 re-organisation was to influence and aid the integration and rationalisation of existing resources in order to provide better health care for clients. But the creation of a three-tiered system consisting of RHAs, AHAs and DHAs did little to advance democracy or to unify services.

Within local District Management teams both GPs and consultants had right of veto over policy strategies, and unification of services remained a myth (as General Practitioner services within Family Practitioner Committees illustrates). While some members were appointed by the Area Health Authority, over half were appointed by the medical profession, and (most damagingly) financial provision was separate, coming direct from the DHSS.

Community Health Councils were also introduced, an attempt in theory to democratise delivery of service. However no CHC member was directly elected.



The RHA could appoint up to one sixth of members, one third came from voluntary groups and the rest were nominated by the Local Authority. Although individual CHCs have helped to publicise issues of importance to the community, as long as they remain a purely advisory body with no executive power their advice can always be ignored.

The 1982 re-organisation changed nothing in terms of democracy and accountability. Area Health Authorities were removed, leaving only the Regions and Districts; this sharpened the boundaries even further between Health and Local Authorities.

At present the health service is organised in a strictly hierarchical fashion which permits little influence by the majority of workers, clients or the community which it serves. At the top ultimate control rests with the Secretary of State and his/her department, the DHSS.

The philosophy behind this is "delegated authority downwards and accountability upwards". All RHA chairpersons and members are appointed by the Secretary of State as are those of the Family Practitioner Committees. The Secretary of State also appoints the Chairperson of DHAs and the RHA appoints the members.

In this context, the administration of the London Ambulance Service by one of the four regions which share responsibility for a balkanised Greater London Health Service, is possibly the least democratic and least accountable system available. Over and above the obvious bureaucratic obstacles of raising discussion, SWTRHA has become obsessively secretive with supposedly public documents and information on the ambulance service: there seems little chance of elected London councillors or concerned members of the public obtaining anything like full information on the state of the capital's Ambulance services.

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INADEQUACIES OF THE SERVICE

A survey caried out by Hampstead Community Health Council has identified the three most commonly voiced complaints regarding patient transport by the London Ambulance Service:

- Non-arrival or lateness of the ambulance, often leading to missed appointments for out-patient clinics;
- Patients are often kept waiting for long periods — sometimes up to two or three hours — before being taken home;
- The provision of ambulances for day hospitals is not sufficient to meet demand.

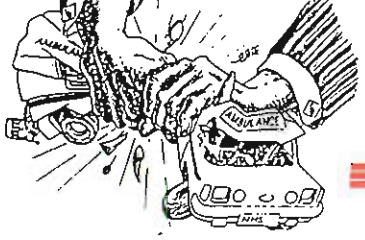
Those who are lucky enough to obtain transport are subject to increasingly long journeys, often not arriving at the hospital until mid-day and then having to leave at three. This means that the benefit received is cancelled out by the stress of the journey and the shortness of time actually spent in the unit. Finally, many journeys are increasinlgy lost through cancellation, and many so-called "low priority" patients (such as discharges from hospital) are left in a position where they must find their own way home even though they may be weak from treatment (31).

The Government's response has been to call for a larger role to be played by the voluntary sector: but in the case of patient transport this is exceedingly problematic.

Voluntary organisations often provide much-needed help — sometimes in a more flexible way than statutory services. They may act as advocates for specific groups publicising areas of need that may otherwise be overlooked. Nevertheless the points in favour of voluntary organisations are outweighed by the problems involved. The role of voluntary organisations in patient transport is both limited and fraught with dangers.

Voluntary groups are often underfinanced and understaffed. Volunteers may be difficult to enlist in either sufficient quantity or, in terms of training, lack the skills necessary to provide a proper service. Patient transport requires a degree of

Many so-called "low priority" patients (such as discharges from hospital) are left in a position where they must find their own way home even though they may be weak from treatment.



Increasingly they are being asked to carry patients with needs that they cannot meet. This includes both patients with disabilities who require specialised transport, and patients who may require sensitive and skilled handling.

commitment and reliability that volunteers would find impossible in many cases to provide no matter how enthusiastic. In addition the legitimacy of voluntary organisations is not sanctioned by popular participation. Their lack of accountability makes then unsuited to the provision of an essential service such as patient transport.

Richmond Community Voluntary Service have stated that the increased pressure to provide transport is a cause for concern. Increasingly they are being asked to carry patients with needs that they cannot meet. This includes both patients with disabilities who require specialised transport, and patients who may require sensitive and skilled handling. Richmond make it quite clear that whilst they may provide occasional transport for social and recreational purposes they can never be a substitute for a proper essential service (32).

Given these problems it is little wonder that the London Community Health Council and Association of Community Health Councils have "... identified travel to and from health service facilities as one of the most important problems facing the population of London in need of National Health Service care." (33)

THE LAS 10 YEAR STRATEGIC PLAN

The ten year "STRATEGIC PLAN" produced by London Ambulance Service management is designed to cover the development of the Service during the period from 1985 until 1995. It details a dramatic decline in the service to the public provided by the LAS.

The Plan is designed to reshape the Service within the cash constraints laid down by the overall Regional Strategic Plan of the South West Thames Regional Health Authority. This imposes a half per cent per annum revenue reduction for each of the next ten years. At the same time it recognises that this will take place under conditions of an unprecedented increase in demand on the Service brought about by Government health care policy.

The Plan fully accepts that the two biggest factors involved in this increased demand on the Service are the increased day hospital provision and community care programmes. The Plan openly states that:

"during the next ten years there will be unprecedented changes in the nature and the volume of the non-emergency services as result of the DHA's policies aimed at community care. In particular, day hospital patients, which are considered to warrant a high priority for ambulance transport, are expected to increase by 240%. At the same time the demand from the other categories of non-emergency patients is expected to remain static."

This staggering figure is based on a projected 75% achievement by London District Health Authorities of national target figures for increased day care provision over the next ten years.

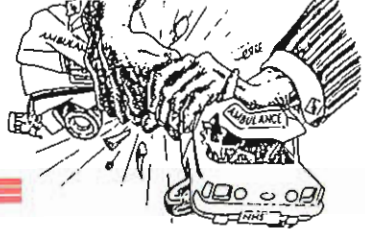
The South West Thames Authority accept that there will be a 100% increase in demand.

The South West Thames Authority dispute the figure on the basis that 75% of target may not in the end be achieved. They do however accept that there will be a 100% increase in demand; which would still place an intolerable burden on the London Ambulance Service as it exists at the present time.

The mention of community care in this respect is not backed by any figures or analysis. There is no attempt to quantify the obviously dramatic implications for the Ambulance Service, which are at least as great as those created by the day hospital policy.

Other increased demands on the system are also mentioned: including the long term historical trend for demand on the Service to increase, and the fact that the increased patient demand is comprised of a greater number of "chair" cases requiring the assistance of two staff.

The conclusions of the Report on the implications of all this for the level of service



which will be possible on the reduced budget are modest in the extreme. All it concedes is that:

"it seems increasingly likey that in the second half of the plan period there will be some lower priority patients whose need the London Ambulance Service will be unable to meet."

Alternatively they say elsewhere in the Plan:

"it may well be as a last resort, that there will have to be a reduction in the level of service provided."

Again:

"Whilst the service will pursue policies aimed at improving efficiency, reducing wasted resources and ensuring that those most in need of transport receive it, it is considered that, eventually, demand will outstrip supply. This will leave some patients outside of the Ambulance Service."

"It is considered that, eventually, demand will outstrip supply."

Whilst all this is a recognition that there will be cuts arising out of the constraints laid down by the Region on the Service, London Ambulance Service management have shrunk from recognising anything like the full implications involved.

THE EMERGENCY SERVICE

The Plan provides for the emergency service to be maintained at "present levels" for the next ten year period and this to be achieved with the smaller overall budget by the transfer of resources from the non-emergency sector.

Not that demands on the emergency service are going to remain static. Despite the fall in the population of London the historical trend is still for demand on the service to increase. In addition the report recognises that the community care policies and the increasing number of elderly and infirm people in the community will increase the number of emergencies to be dealt with. The plan accepts that London will see an extra 18,000 "chair cases" per week.

Despite the fall in the population of London the historical trend is still for demand on the service to increase.

The Plan also recognises that conditions are becoming more difficult. "The progressive closure of Accident and Emergency units will have its own effects on resources and therefore quality by increasing the distance travelled and the time occupied per call." It goes on to show that the average length of an emergency journey has gone up by 10% since 1978.

The quality of the service is measured by the ORCON standards established by the DHSS in 1974. The Plan makes it clear that the ORCON standards are not being met, that there is no intention to ensure that they are met and that they are effectively no longer recognised as a measure of quality for the London Ambulance Service.

WHAT DOES THE PLAN PROPOSE?

The Plan actually claims that the bulk of the increased demand will be met despite the reduction of resources, although they do accept that there will be an inevitable shortfall. How do they propose that this seemingly impossible objective can be achieved?

The key to this presented in the Plan is a massive increase in productivity; "In order to maintain the existing commitments and to undertake an additional 18,000 'chair' cases (per week) it will be necessary to improve productivity further by an estimated 60%."

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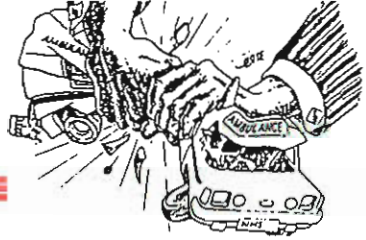
The Plan goes on to detail how this 60% is going to be achieved. It calls for changes in work practices by the ambulance staff; mainly in the form of a "revision" of work rotas. It calls for some capitalistion, particularly in vehicle scheduling, through a computerised central control system. It calls for a drive to reduce "lost journeys", particularly through the introduction of the Ambulance Liaison Officers.



There is no evidence at all that productivity can be increased by a significant amount in the LAS and 60% cannot be seen as a serious proposition. Some productivity will be achieved by the introduction of computerised control, since the evidence from ambulance drivers is that there is a serious degree of misdirection of journeys — two ambulances being sent at the same time to the same street for example: but this would not produce the productivity the LAS are talking about. The new Salaried Wage Structure is an attempt to increase productivity through more management control and revision of work rotas; but increases in productivity which simply put an increased burden on the ambulance drivers are likely to be counterproductive in other ways.

Most of the measures proposed however have little to do with the productivity of the Service and a lot to do with reducing the patient load by altering the elegibility criteria for ambulance transport. In particular it says: "Transport arrangement for patients attending psychiatric day hospitals will need to be reviewed in the light of recent evidence which indicates an over-provision of ambulance transport for such patients."

Most of the measures proposed however have little to do with the productivity of the Service and a lot to do with reducing the patient load by altering the elegibility criteria for ambulance transport.

At the same time maternity cases are to be disqualified from ambulance transport. Equally significantly the Plan says that Districts and Family Practitioner Committees will be encouraged to limit demand by "Stricter adherence to the medical criteria" for ambulance transport.

THE SALARIED STRUCTURE

In November 1985 agreement was reached at national level between unions and management at the Ambulance Whitley Council for a new salaried pay structure covering the Ambulance Service in England, Scotland and Wales. It was implemented in England and Wales on March 1st 1986 and will be implemented in Scotland six months later.

The proposals followed a claim for such a structure from the trade unions and a feasibility study carried out by HAY-MSL management consultants who delivered their final report in May 1985.

The new structure provides for susbtantial increases in the basic rate of pay whilst absorbing the majority of existing ad-hoc payments and overtime. At the end of the day it provides for a net increase in weekly pay for the majority of ambulance staff, but it must be self financing by the end of the first year.

The structure was accepted by a large majority of Ambulance staff nationally by ballot vote. Most opposition to it came from the London Service, altough there was still a two to one acceptance.

The main attraction of the Salaried Structure for the management side is its implications for direct management control. On working practices it says the following:

The main attraction of the Salaried Structure for the management side is its implications for direct management control.

"The trade union side agreed that all working practices that prevented a cost effective and efficient service being provided be removed."

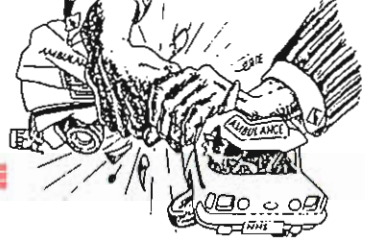
This amounts to a major surrender by the trade unions of the control which they had previously established. It effectively precludes joint arrangements and establishes full management control of all aspects of the service.

On the provision of ambulance transport it goes on:

"They also accept that after consultation with the staff, it is management's right to determine the levels of service provided and how all aspects of the work are organised and operated."

Management would have the right after consultation to determine both the staffing levels and the level of the service to be provided.

An important aspect of this is duty rotas. Previously for example, duty rotas operated from 8.00am until 4.00pm on the day shift, with additional cover provided



by overtime. Under the new agreement there would be two shifts — 8.00am until 6.00pm and 9.00am until 7.00pm. The general principle is that management are free to fix working hours in the way best suited to them.

The previous grading structure is replaced by a three grade structure which extends flexibility between grades.

The proposed structure requires local agreements to be established within the framework of the national scheme. The general principles of this from the management side were set out in a confidential circular to all Regional and District managers of the Ambulance Service. It called for a "radical reappraisal" of existing working practices and "strongly reaffirms the right of management to manage."

The general principles called for a "radical reappraisal" of existing working practices and "strongly reaffirms the right of management to manage."

It recognises that the trade unions retain the right to refer disputed matters to national level, but it makes quite clear that management are ultimately determined to push through the principles of the agreement:

"During the course of the negotiations both sides acknowledged that in the normal way matters could be referred by either side at local level to the Joint Secretaries where difficulties on a local agreement could not be resolved. It is not the intention of the management side that such exceptional references should usurp the role of mangement. Indeed in drawing up the proposed agreement the management side included in paragraph 2 reaffirmation that the level of service to be provided, its organisation, the determination of manning levels and the deployment of staff (including the patterns of working) are all matters after consultation for management decision and review."

The principles involved are that the agreement gives most of the ambulance staff improved pay levels in return for a fundamental surrender of control to management. It gives management the ability to change working conditions and to improve productivity to try and meet the 60% increased productivity called for in the Strategic Plan.

Again the circular makes the point:

"The new payment system is intended to allow management to staff the service on the basis of what management determines is necessary for operational purposes."

The offer:

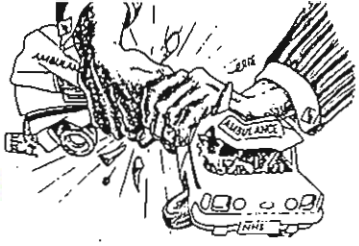
"Permits a high degree of flexibility for local mangement to enable major changes to be made in the organisation and delivery of the service, leading to greatly improved productivity and effectiveness."

It is a means of trying to meet the rapidly increasing demand under the conditions of the reduced budget imposed by the RHA. Instead of taking on additional staff, more is to be extracted out of the existing labour force.

The structure provides for an ongoing review of efficiency levels and working practices and points towards future negotiations on a new discipline procedure. Management clearly have absentee levels in mind in this.

In practice the introduction of the new salaried structure has been a disaster for patient services. Two months after its introduction management has admitted it has reduced non-emergency services by 40%. Every assumption made by management prior to the introduction of the structure has been proven to be wrong.

- Their assumption that the overtime worked was unnecessary was wildly inaccurate. Lack of overtime working is now recognised to be the primary reason for the 40% cut in non-emergency services: the hours cut amount to the equivalent of 233 full-time staff. As a result 3,000 patients a week — 150,000 a year — have been denied ambulance services.
- On top of this, LAS management assumed that the abolition of local agreements and complete management control would lead to higher efficiency and offset the cost of the new salaried structure. This has not been the case either. They now have



a £1.8m deficit arising from the new structure, along with an erosion of efficiency levels.

In the South West division alone the total number of vehicles for the non-emergency service has undergone dramatic reductions. Sitting-case vehicles have been reduced from 48 to 27, ambulances from 28 to 18 and coaches from 41 to 31. These figures do not take into account absence, holiday or sickness levels and therefore the total number of vehicles actually in operation per day will be considerably less than the above figures imply. Similar reductions have taken place in the three other divisions. This indicates that what the "management determines is necessary" falls far short of what the public would regard as an adequate essential service. What we are seeing is the implementation of the Rayner Scrutiny into the ambulance service, which was issued in 1984. Rayner recommended that the responsibility for non-emergency transport should lie with each DHA and that Districts should also take financial responsibility for this provision: but while the LAS is clearly cutting back there is no sign that DHAs have the resources or inclination to establish local substitute services.

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IMPLICATIONS FOR WOMEN

As the report has indicated recent expenditure cuts within the context of growing demand has resulted in an ambulance service that is insufficiently funded to provide the essential link between the patient and health service. This has important implications for women.

Problems surrounding patient transport have a direct bearing on women in two ways. Firstly women make up the largest proportion of elderly and chronically ill. As such, their demand for ambulance transport, a demand which will increase with the change in the population structure, is high. Secondly, in relation to women's role as carers, recent Government policies have resulted in an increase in the already disproportionate burden that women bear.

The effects of this are twofold. The role of caring affects in turn their chances of obtaining paid employment: this will result in women becoming the next generation of elderly poor. Yet it has been estimated that if women's unpaid contribution to caring was costed this would amount to £6.4 billion each year.

Supportive services must be directed towards the specific groups they care for and any respite scheme either in the form of short stay residential care or the provision of day-hospitals must take account of the vital role played by the London Ambulance Service.

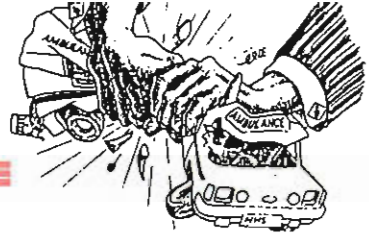
The proposal to eliminate maternity cases from emergency ambulance provision can only result in severe hardship for the women who require this service.

There is another obvious effect on women from the planned cutbacks: the proposal to eliminate maternity cases from emergency ambulance provision can only result in severe hardship for the women who require this service. It further underlines the unwillingness of LAS management to face up to the responsibility to match the level of service to the level of need.

As the main consumers of health services, the insufficiency of both the emergency and non-emergency ambulance service is likely to have a major impact on women's health. Provision of services without the means to reach them will lead to higher levels of stress and illness.

IMPLICATIONS FOR ETHNIC MINORITIES

To a degree the implications for the ethnic minorities overlap with those for women. However black and ethnic minority women are often faced with a stronger cultural pressure to care for their elderly and disabled relatives. Because of racism and



sexism and their disadvantage within the employment sector they again face additional stress. Black and ethnic minorities tend to be concentrated in the lowest paid sector and frequently in employment which is physically demanding. Poverty and stress can then result in their being less able to provide the level of care required and their experiences of racism may result in them being less likely to ask for the services to which they are entitled.

CONCLUSIONS

● An important factor which this report has highlighted is the obfuscation and secrecy with which the London Ambulance Service and the Regional Health Authority surrounds the release of information. As the LAS is part of the National Health Service the degree of democratic accountability which existed when the service was managed by the GLC, has now been lost, leaving the public with little abilty to influence the provision of service.

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● Information is also vital if proper planning and monitoring of the service is to be carried out. Yet neither the DHSS, SWTRHA nor the LAS appear to collect and collate the necesary information on client needs or the standards and quality of service. This suggests that "Strategic Plans" are not underpinned by hard data and that even the present very narrow definition of accountability upwards is in fact disregarded. In our discussions with an official at SWTRHA it was openly acknowledged tht the sampling methods used by the LAS to collect data on ORCON standards of the Emergency service were unsuitable: but both the Regional Health Authority and the DHSS felt that they could not put pressure on the LAS as they already knew that resource cuts and rising demand were having a detrimental effect on the standards and level of service.

● At a time when resources are being cut and demand is rising it is of the utmost importance that the public are fully aware of the associated health risks. At present the necessary information is neither openly divulged nor published in an appropriate form, resulting in the public being unaware of the inadequacies until they require ambulance transport.

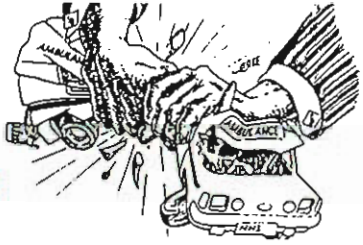
● In the short term, and in the absence of any real democracy in the NHS, least of all in London, both SWTRHA and the LAS management must increase the flow of information to all interested bodies. Consultation must involve both a willingness to incorporate suggestions into plans formulated and a sufficient time period in which all parties can put forward their suggestions.

● The effects of government policies directed towards "community care" have been considerable. As we have seen, demand is increasing; but this is made up of patients with varying needs. The LAS plans noted the rising demand from day hospitals, but assumed that other patient categories would remain static. However this is not the case, as the increased demand from day surgery and short-stay wards indicates.

● For the LAS management, the Service is viewed as completely resources dictated. Demand which will not fit into existing resources will not be met.

● For the LAS management, the Service is viewed as completely resources dictated, which ignores all other aspects of the service. Demand which will not fit into existing resources will not be met. No attempt is made to assess demand from varied groups with specific transport needs. Instead, all we have are quota systems and the tightening of eligibility criteria in order to reduce demand.

● The LAS must adopt a more realistic approach to the meeting of demand by increasing the amount of data collected in relation to the needs of different



categories of patients. This again would involve proper consultation with all interested parties including the patients themselves.

- Whilst to all intents and purposes the Regional Health Authority treats the LAS as a District Health Authority there are strong grounds for regarding it as a vital community service. As we have seen from this paper, if anything other than lip-service is to be paid to the idea of care in the community, then the role of the LAS cannot be looked at in a vacuum, but must be viewed as an integral part of health provision. The LAS must face up to the implications of community care.

The introduction of the salaried structure has had a devastating effect on the service. The refusal adequately to fund the structure has resulted in a 40–60% cut in terms of vehicles and staff in an already inadequate service.

- In view of the well-documented increase in demand facing the LAS, and their present inability to meet standards, the plans set out by SWTRHA and the LAS are both contradictory and inadequate. The introduction of the salaried structure has had a devastating effect on the service. The refusal adequately to fund the structure has resulted in a 40–60% cut in terms of vehicles and staff in an already inadequate service. It has been estimated that at least 3,000 additional non-emergency patients per week will be deprived of ambulance transport as a direct result of the way the salaried structure has been implemented.

- The impact of thse cuts is increased by the lack of accountability or democracy in the management of LAS: District and hospital managements across the capital have complained of the chaos resulting from the LAS cutbacks, which have been imposed without consultation.

- The now definitive break by the LAS from the DHSS ORCON quality standards has to be viewed as very serious indeed. There is now no effective yardstick for measuring the quality of the emergency service, and all the evidence suggests that actual service levels are moving ever further from the ORCON targets.

- In the interests of patients across London it is crucial that the LAS should abandon its present cost-directed policy, and set out to match services to a proper measure of actual need. The dramatic 330,000 annual cut in non-emergency patient journeys since the 1979 "quotas" runs clearly counter to the government claims of increased numbers of outpatients and day cases: the new 150,000 cut brought about by the salaried structure spells further chaos and suffering.

The adequate funding of this service is plainly the responsibility of central government and would require a major change in existing government policies which centre on reallocating resources out of London.

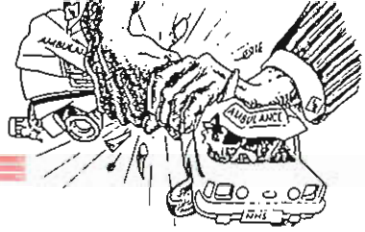
- The arbitrary cutback in the funded operational establishment of the LAS from 2660 to 2106 in July 1983 has also been a factor in limiting the service and sharply reducing the number of non-emergency patient journeys.

- The artificial "quota" system introduced in 1979 and subsequent measures to tighten the criteria for non-emergency ambulance services must be abandoned, and services restored to their previous levels.

- This must mean an expansion both in the workforce and in the number of vehicles deployed by LAS. Precise numbers are hard to establish in the light of the inadequate information published by SWTRHA; but if 233 additional full-time staff are needed to compensate simply for the effects of the salaried structure then clearly several hundred additional ambulance personnel and dozens of new vehicles will be needed to meet the real level of demand for non-emergency services in the light of plans to expand commuity care.

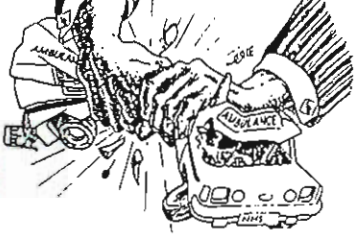
- The adequate funding of this service is plainly the responsibility of central government and would require a major change in existing government policies which centre on reallocating resources out of London.

- The salaried structure also alters the training requirements for those working on the non-emergency side of the service where a lower grade of ambulance staff will provide the bulk of the cover. The day side must not be allowed to become a low status area by dropping high standards of training. Many non-urgent patients require



medical care en route and many patients attending specialist clinics have a range of needs which necessitate the standards of training and experience of grade 4 personnel.

● Some of the figures are frightening for patients. The LAS Strategic Plan admits to a projected 240% increase in day hospital patients, and argues that a 60% **increase** in productivity is necessary to meet projected non-emergency demand. Yet since the introduction of the salaried structure the service has been **cut** by more than 40%. What hope does that offer the elderly, disabled an seriously ill patients of tomorrow?



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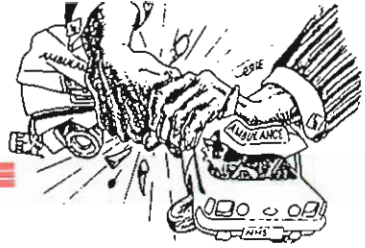

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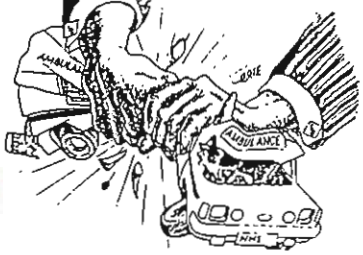
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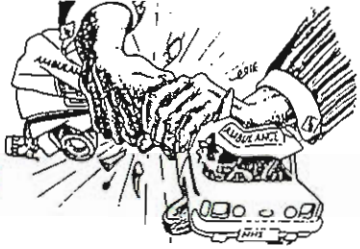
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