Chapter 11
Dealing with the Austerity Challenge

Robert Till and Anthony Marsh

Introduction

Austerity is a term used in economics to describe government policies which are designed to reduce spending and budgets during adverse economic conditions. Blyth (2013) describes austerity as a form of voluntary deflation in which the economy adjusts through the reduction of wages, prices and public spending to restore competitiveness, which is best achieved by cutting the state's budget, debts and deficits.

Whilst the current government has implemented an austerity policy, it is important to note that the National Health Service (NHS) is receiving more investment than ever before. In the 2008–2009 NHS report, Sir David Nicholson, the then NHS chief executive, sets out the 'Nicholson challenge'. This challenge, through the implementation of the Quality, Innovation, Productivity and Prevention (QUIPP) programme, instructed the NHS to deliver efficiency savings of £ 15–20 billion between 2011 and 2014. The efficiency savings are not direct cuts to budgets, but a method of creating £ 15–20 billion more value from the current budget.

An ambulance service now has to do more with less, particularly those ambulance services that hold NHS Foundation Trust status. A foundation trust has to be run as a business. The board of directors has to guarantee a continuity of service and operate as a going concern, whereby it guarantees to pay its bills and debts as laid out in Monitor's Risk Assessment Framework. Monitor is the regulatory body

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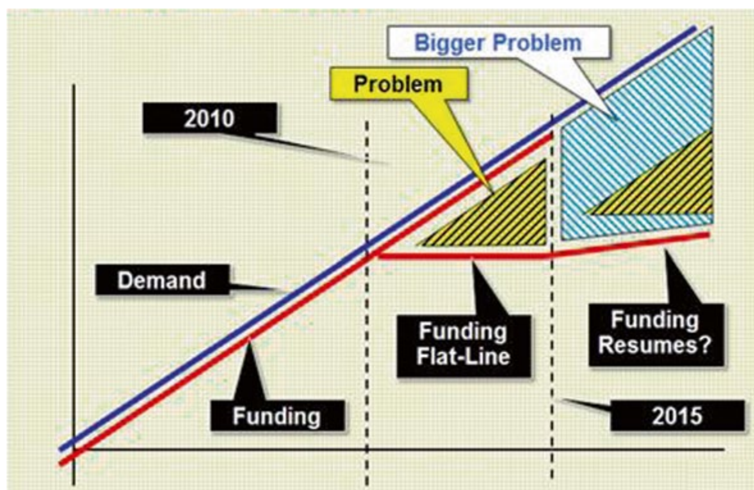

Fig. 11.1 The NHS funding gap (2010–2020). (Lilley 2013)

for foundation trusts. If a trust cannot manage its budget or provide the correct level of service, it will go out of business. To achieve this, the board of directors sets out the target surplus it plans to achieve as part of its 2-year operational plan within the context of a 5-year strategic plan.

Figure 11.1 includes 3a graph illustrating the financial challenge faced by the current NHS context.

As can be seen above, demand rises every year. Until 2010, funding was increased to attempt to meet the rise in demand, but this then flatlined in 2010, and the NHS had to create its own efficiencies to release access to the additional money. It is unclear what will happen in 2015 regarding funding. It is, however, very unlikely that funding will match demand. If demand does continue to rise at its historical rate, then after 2015 the NHS will have to at least double its efficiencies to fill the gap in funding.

The critical question is whether this is possible. As ambulance services have already had to streamline its operations and structure and create efficiencies between 2010 and 2015, how will a trust create the necessary efficiencies between 2015 and 2020. Pre-hospital, community care and commissioning arrangements will have to change radically to enable such efficiency savings.

Changes in Attitude and Demographics

Within the NHS, austerity measures are being further compounded by the change in demographics. The increasing proportion of elderly in our population places ambulance services under increased pressure. The Lords Committee on Public Service

and Demographic Change (House of Lords 2012) cited figures from the Office for National Statistics that forecast a 50% rise in the number of patients over 65's and a doubling in patients over 85's between 2010 and 2030.

A significant proportion of ambulance responses are to assist elderly patients. Some of the most common types of calls include:

- Assisting the frail elderly who have fallen out of bed uninjured, but are unable to assist themselves back up
- Treatment and transport of an elderly patient who has fallen and suffered a traumatic injury requiring hospital treatment and/or admission
- Primary care-related medical conditions or exacerbation of a chronic medical condition

Ambulance services also respond to an increasing number of psychiatric- and social-related problems. Patients who have self-harmed or are having suicidal thoughts often rely upon the ambulance service for assistance. These cases can prove difficult for paramedics to deal with as transport to a hospital emergency department may not be required, and getting assistance from suitably trained professionals can be difficult to arrange, especially out of hours. A similar problem exists with patients who call because of social reasons, although they need help the ambulance service is limited in what support they can provide and can spend excessive lengths of time on scene arranging support meaning that they are not available to respond to other emergencies.

Various measures have been employed to deal with these types of cases by improving relationships with our partners. These include working more closely with the police, general practitioners (GPs) and safeguarding colleagues.

- Ambulance staff are encouraged to make a vulnerable adult safeguarding referrals for those patients who are at risk from further harm or self-neglect.
- Alternate response vehicles which may be used for cases where a patient has fallen over in their home and are unable to get back up, however, are uninjured. These patients do not require a double crewed paramedic ambulance. There may be a multidisciplinary vehicle such as a GP and paramedic or a police officer, paramedic and psychiatric nurse. These resources can be targeted to the calls where patients maybe ordinarily be transported to hospital because no alternative can be found. The GP may provide medication or a prescription that the paramedic cannot and the psychiatric nurse will be able to refer directly to mental health services.

Due to improvements in medical and social care, people can survive longer from chronic conditions or actually be successfully treated and discharged from previously fatal acute episodes, whether that be medical or traumatic in origin.

Attitudes towards healthcare have also seen changes; there is now greater emphasis on the principle of wellbeing and holistic care. Historically, people would only seek medical assistance when it was absolutely necessary. If they were not embarrassed, then they certainly did not want to 'bother the doctor'. The ambulance

service was definitely a last resort and was only called if there really was no other option. (Foster et al. 2001) stated:

> Help was only sought when it was considered absolutely necessary. The stoicism was felt to reflect the shared values of 'our generation' and the experience of having to pay to see a doctor prior to the establishment of the NHS.

With increased health awareness, people are now far more likely to visit their GP for investigations. There is also an attitude that there must be a medical solution, no matter what your symptoms. This combined with people working for much longer hours, means that the relatively new out-of-hours services are being utilised more than ever. This has had an impact on the NHS and local government.

The role of the ambulance service has changed too. People no longer just call an ambulance if they have life-threatening complaints that render them unable to get to the hospital themselves. The public will call upon the ambulance service for a multitude of reasons. This could be because they are unsure who else can help them. Hopefully, with the introduction of services such as 111 (a free NHS telephone triage-based signposting service), these occurrences will be reduced. Patients are sometimes identified as needing to attend an emergency department, but do not require an emergency ambulance. However, due to ease, lack of other transport or even because it is a common assumption, people think you can be seen straight away if transported by ambulance—they dial 999.

By improving triage, training clinical staff to make more detailed assessments and jointly working with other healthcare providers to develop alternate pathways of care, both ambulance responses to incidents and the need to convey patients to a hospital could be reduced.

Is Austerity the Catalyst for Innovation?

To create efficiencies, ambulance service leaders, and indeed, the NHS and partner organisations have had to think differently and adapt many of their processes. Some of these could include:

Using Resources to Maximum Efficiency

Traditionally, ambulance services operated by ensuring responding ambulances were mobilised out of an ambulance station, where there could be a varying number of vehicles and varying styles of rota. Usually, the number of ambulances operating out of that station would remain similar on a day-by-day and hour-of-the-day basis. The rotas may have had different start and finish times and are operated for 8-, 10- or 12-h shifts. An ambulance crew would be deployed to an emergency call from the station and then on completion of the incident be returned to their ambulance station where they would wait to receive the next call.

This model was deemed inefficient for several reasons. First, having a set number of ambulances on duty meant that during quieter periods, there was a chance that ambulance crews will remain at the station and on standby, consequently not actually working. Second, having staff and ambulances return to 'their' station meant that some areas may have shortage of ambulances and others may have several ambulances available. For example, three ambulances in town A could be dealing with emergency calls, but, in town B, there were three ambulances available at the station. When the next emergency call is received in town A, the ambulance has to respond from town B which increases the response time and potentially puts the patient at risk.

Creating a performance cell (as discussed earlier in Chap. 8) makes it possible to forecast demand profiles using historical data and also forecast the areas in which emergency calls are most likely to be received hour by hour. This makes it conceivable to plan rotas and match the number of ambulance crews to the expected number of calls. It then allows ambulance control staff to deploy ambulances to standby areas in the order of the forecast priority.

To make the most of this, a new efficient ambulance model has been adopted by several services. This was explained in more detail in the chapter titled 'Modernising Ambulance Services'.

Aligning Hospital and Pre-hospital Specialist Care

Acute hospital trusts have undergone a reconfiguration of services. Not all hospitals provide the same specialist care. This has an impact on ambulance services, as not all patients are now transported to the nearest Emergency Department. Most notably are patients who have suffered from serious trauma, cerebrovascular accident (CVA, stroke) or myocardial infarction (MI, heart attack). Traditionally, patients suffering from these conditions would have been transported to their nearest acute hospital, where they would receive the necessary treatment. If that treatment was unable to be carried out at this hospital, then the patient would be stabilised and then transferred to another hospital for more specialist care.

However, following the reconfiguration of hospitals, specialist acute centres provide the specific care required for each of these patient groups and the local emergency department or hospital trust may not. This reconfiguration reduces the duplication of services within an area and therefore reduces overall costs. As a result, ambulance services have had to adapt the way they operate as the specialist care centre which can treat the patient may not be the nearest hospital. To care for patients during the increased journey times to these centres, paramedics have received extra training and new equipment, and drug regimens have been introduced. This example shows that the NHS as a whole has saved money because services at hospitals are not duplicated; however, because of the extra training and equipment as well as the increased cost associated with longer journeys, the cost to the ambulance service has been increased.

Prioritising and Developing Rigorous Processes

To create the efficiencies required, every department within the ambulance service has had to prioritise and carry out a detailed analysis of its processes. Heads of department are required to do more with less. Services provided, procurement and organisational structure, including staffing levels, are all factors that need streamlining to make sure they are cost effective.

It may be necessary for directors to hold regular meetings with heads of department to refocus and challenge the efficiency drive. The savings made in each department can then be monitored and realigned at a strategic level, which should increase savings and ensure that foundation trusts are succeeding.

Occasionally, an ambulance service may need to spend money in order to save money in the long term. For instance, investing in information technology (IT) infrastructure may be expensive; however, it is probably necessary to improve service and mitigate risk. Likewise, purchasing or renting new property for standby locations, as part of the hub and spoke model, may initially be expensive, but this outlay cost will save money in the long term, as large older ambulance stations are expensive to maintain.

Strategy for Prevention

There is a basis to argue that an increased percentage of money should be spent on health promotion and prevention. If the NHS invested heavily in promoting good health and wellbeing, it may reduce the cost of managing disease to a level which justifies the increased health education expenditure.

For instance, a single visit to a GP on its own is not a large cost to the NHS, but there could be a knock-on effect. If a patient attends a GP out-of-hours appointment for a minor ailment that could have been self-diagnosed and self-treated that GP will not be available to see a patient who may be in greater need. As a result, the second patient may decide to call an ambulance as they have been unsuccessful in gaining an appointment. The ambulance is unable to treat the patient because they require medication not carried by a paramedic, and, because the GP appointments are all full, he or she may have to transport that patient to an emergency department. So in this hypothetical instance, the cost of a single visit to the GP has created the need to pay for an emergency ambulance response and admission into a hospital emergency department.

Examples of different practices exist in other parts of the world and other discipline areas. In Cuba, there is considerably less investment in healthcare than in other countries worldwide, but clinical outcomes are better, despite the per capita spend on healthcare being significantly lower; life expectancy is similar to the USA, but with healthcare costs 96 % lower (Fitz 2011; Campion and Morrissey 2013).

The UK Fire Service has also seen success in concentrating on fire prevention and education, so much so, that it is very rare for a death to occur due to fire. Fire crews spend such little time actually fighting fires as a result of their successful fire prevention campaigns. Fire crews spend a significant proportion of their time

based in the community, fitting and checking smoke alarms and offering fire safety advice. If more money was allocated from existing budgets to undertake health promotion and disease screening/prevention, the ambulance service might see a reduction in call demand and consequent costs.

Lack of Control Over Internal and External Factors

There are many external factors and some internal factors that are out of ambulance services control and have a direct effect on ambulance service expenditure. Internally, the Agenda for Change (NHS pay-structure) pay increments that staff are assessed and awarded for each year has a significant cost implication. On average, an employee can expect an increment rise of around £ 800–1500, depending upon their position within a pay band. This means there can be multimillion pound salary increases when the increments are multiplied across an organisation as large as a regional ambulance service. It is vital that an ambulance trust recognises and plans the future workforce. Costs such as continued professional education, education and even the costs associated with longevity in post and an ageing workforce need to be taken into account.

A significant external factor is the cost of fuel, particularly diesel. The ambulance services' primary function and core business is responding quickly to patients. As a result, significant quantities of diesel are purchased. As the number of incidents the ambulance service responds to, and journey distances are increased, due to the transformation of acute hospitals and speciality hospitals, the cost of operating vehicles has increased. This is also compounded when the cost of oil or duty is increased.

These costs can be reduced, but not significantly by bunkering fuel or using fuel cards. Having a means of storing and refuelling vehicles at our own estate means that diesel can be purchased in bulk, and therefore purchased at a reduced cost per litre compared to the commercial forecourt price. Using a fuel card can also mean discounted rates of fuel. A fuel card company will apply a discount to the fuel bill, as they will have negotiated discounted rates with the petrol station companies. This discount is not currently as big as when fuel is bought in bulk by an ambulance service.

As well as vehicle fuel costs, energy to operate control rooms, ambulance stations, response posts and headquarters' buildings also rises with cost implications. Increased costs in energy to run estate can have significant cost implications, especially during long spells of cold weather when heating is used more extensively.

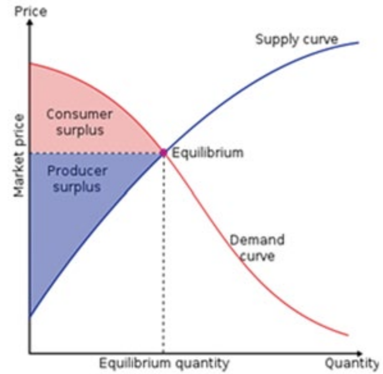

Fig. 11.2 Neoclassical economic theory—supply and demand curve. (Pilkington 2013)

Value of the Ambulance Services

The current commissioning arrangements for ambulance services mean that service providers are paid for the activity they should experience. Each UK taxpayer contributes towards the ambulance service. For example, in 2012, the residents of the West Midlands contributed roughly £ 31.88 per person towards the ambulance service. (This figure is derived by dividing the cost of West Midlands Ambulance Service; WMAS by the population of the West Midlands.) In comparison to other services, for example, considering that a car owner might pay in the region of £ 90 per year for vehicle roadside assistance, the potential life-saving service a resident may receive from the ambulance service makes the £ 31.88 seem proportionally low.

There is a philosophical and perhaps ethical question around the value people place in the ambulance service. Value, as considered here, is demonstrated in the neoclassical economic theory at the equilibrium point below. To put the graph into context, it is worth considering the supply and purchase of plasma TVs. Initially, the new TVs had been very expensive and were not sold in great numbers. This was because the public did not equate the price to the value of the TV. As the price of the TVs came down, they reached a point where they sold in great numbers. This was where the value of the TV matched its price (Fig. 11.2).

If the 'Market Price' axis was replaced with 'Contribution to Ambulance Service' and used the 'Quantity' axis to measure the amount of people, it is interesting to note where the 'Equilibrium' point might be? Perhaps it would be higher than £ 31.88.

Does Commissioning Need to Change?

Currently, local clinical commissioning groups (CCGs), which include the local clinicians, have great powers and responsibility for making commissioning decisions on behalf of their patients and population. It is possible that in times of austerity,

there is a need to change the commissioning arrangements to increase value for money. Ethical commissioning is looked at in detail in Chap. 5; however, there are options other than the arrangements in place today which could be considered.

One new approach to commissioning could involve awarding the entire out-of-hospital care for a single patient to one healthcare provider. The job of that provider would be ultimately to keep that patient out of hospital to contain overall costs of medical care.

Currently, a patient may require several healthcare providers to support them. For example, a patient could have healthcare workers going in several times a day for support; he or she may call upon the ambulance service several times a week, and they may also require a district nurse to attend. In the long term, this is expensive; also, because there are so many agencies involved and often they will not be communicating with each other regularly, patients can end up in emergency departments more frequently because the provider is unable to, for whatever reason, solve the current problem in the community and has to resort to calling for an ambulance.

An example of how this approach could work is that Patient A over a period of 12 months costs the NHS £ 300,000 to care for. If a single provider were to be given £ 150,000 to care for that patient, then they would certainly have to think outside the box to achieve the necessary level of care without overspending and reducing possible surplus.

It is, therefore, possible with some restructuring that an ambulance service could become the specialist care provider for out-of-hospital patients. To do this, an ambulance service would need to co-ordinate other community providers to deliver the whole care package. With an array of other professionals at the ambulance services disposal, the incidence of a patient being admitted to hospital should greatly be reduced. The ambulance service almost needs to be separated into two functions—that of dealing with life-threatening calls where the patient is rapidly transported to an acute hospital, and, secondly, dealing with primary care and wellbeing issues where joint working practices with local partners is essential.

Conclusions

There have previously been discussions which proposed that ambulance services should move away from the NHS and become part of the fire and rescue service (Knight 2013). There is, however, a very strong case which means that a modern ambulance service cannot be operated independently from the rest of the NHS.

The care of patients has to be integrated between agencies and hospitals. Removing the ambulance service away from the NHS could only serve to complicate and reduce interagency working. Whilst working closely with colleagues in the fire and rescue service and the police is essential at road traffic collisions and major incidents, these only represent a small percentage of the workload of an ambulance service. The need for improving relationships between the three blue services has been

recognised and the Joint Emergency Services Interoperability Programme (JESIP) is underway, which was the key discussion issue in Chap. 9.

Paramedics are required to liaise with other healthcare professionals. It could be the doctor or nurse they are handing over to at a hospital or a patient's GP. It could be that the paramedic has to refer a patient to a mental health team, emergency nursing team or other community support organisation. In order for that paramedic to be respected amongst other allied professionals, the paramedic role needs to be understood and should come under the same NHS umbrella.

It is possible that by investing more into pre-hospital care, costs could be reduced later on. Admission into a hospital is extremely expensive and should always be avoided if feasible and possible. In order to achieve this, pre-hospital provision needs to evolve. By improving the assessment skills of paramedics and widening their treatment options, more people would be successfully managed in the community. This could go hand in hand with ambulance services being able to take more of a co-ordination role with other community health providers such as nursing and mental health teams. Combining the skills of some of these healthcare professionals could develop a technically less expensive workforce which is well placed to increase their community care roles.

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