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Module name: Introduction to Health and Social Care

Module code: LCHS4003_LON

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Ambulance services

Introduction: The London Ambulance Service is the UK's busiest emergency healthcare provider, serving more than nine million residents and visitors across 620 square miles. Operating 24 hours a day, every day of the year, it evolved from London's earlier municipal ambulance services and became part of the National Health Service in 1948, later forming the current trust in 1996. Today, it employs around 10,000 staff, volunteers, and students, handling approximately two million 999 emergency calls and two million 111 urgent care calls annually while responding to over 3,000 emergencies each day. Its integrated system dispatches ambulances, rapid response vehicles, motorcycles, bicycles, and air ambulance support to provide prompt care. However, the service faces significant challenges, including increasing demand, staff shortages, and extreme heatwaves, which raise emergency call volumes, prolong response times, increase pressure on frontline crews, and create health and operational risks while supporting safe, high-quality patient care.

History: The National Health Service Act of 1948 was the result of post-war reorganisation. As part of this, ambulances had to be available for everyone in need for the first time. A more recognisable service was starting to emerge by this point. The London County Council's ambulance service relocated to its headquarters at Waterloo Road in the 1950s, although it was clearly obvious that this would not be sufficient. It was decided to construct a new headquarters further up Waterloo Road by the early 1960s. If you were hurt in the 1890s, the police, firefighters, and even taxi drivers had to staff a fleet of wheeled stretchers known as "litters" to transport patients to the closest hospital or doctor's office. This may be difficult to imagine nowadays. London did not prove a full-time ambulance service until well before the start of the 20th century.

Horses first pulled the ambulance fleet. The first gasoline-powered ambulance debuted in 1904 and had a top speed of 15 mph when carrying a single stretcher. By 1930, county authorities oversaw the ambulance service. As the Second World War approached, an auxiliary ambulance service was set up as part of the Government's civil defence service. There are some amazing tales of bravery and exceptional service to Londoners during this time, and it was primarily composed of women. (London ambulance service NHS trust, 2025)



Function: The strategic evolution of modern ambulance services centres on transforming the delivery model from reactive treatment to proactive, patient-entered prevention, actively working to eliminate unwarranted clinical variation and deep-rooted health inequalities. By embedding robust clinical navigation and validation frameworks directly into the triage process, services can significantly expand "hear and treat" and "see and treat" protocols, ensuring patients receive the most level of care at once. This is seamlessly coordinated through Single Points of Access (SPOA) and "call before convey" mandates, which prioritise safe referrals to community-based alternative services and drastically reduce avoidable hospital conveyances. Structurally, operations are optimised by utilising advanced NHS England demand and forecasting tools to align workforce rotas with real-time patient needs and fine-tune the fleet mix. Underpinning this entire operational shift is a profound recognition of the ambulance. (London ambulance service NHS trust ,2025)

Challenge of the service

Heatwave: The NHS faced winter-level pressures during May's heatwave, with paramedics handling 832,089 incidents—their third busiest month ever. Despite this severe strain, the health service managed 1.86 million hospital attendances within the four-hour target, marking the highest volume for any May in a decade.

For the first time, experimental data on "corridor care" was released, showing that an average of 2,241 patients daily were treated in emergency department corridors, with another 669 in alternative temporary hospital spaces. The issue is highly concentrated: just 20 trusts accounted for over half of emergency department corridor care, and 20 trusts handled more than two-thirds of corridor care elsewhere. In response, NHS England is collaborating with these heavily affected organisations to deploy targeted improvement plans and on-site specialist teams to end the practice.

Beyond emergency care, the overall elective treatment waiting list stands at 7.22 million, with 65% of patients waiting under 18 weeks. Conversely, diagnostic services hit a historic high, delivering a record 2.5 million tests in April.

Professor Francesca Swords, National Medical Director for the NHS, praised staff for rising to the challenge of record heatwave demand but firmly stated that corridor care is entirely unacceptable. The NHS has launched a 7-point plan alongside targeted support to eradicate it. Acknowledging that upcoming industrial action will create further complications, Swords reassured the public that frontline services are still open, urging patients to call 999 in emergencies

And utilise NHS111 for all other medical needs. (NHS England 2026)

Challenge of the service

Staff shortages:

Achieving a high-quality, sustainable NHS is currently hindered by major workforce problems. Staff are the most significant element of NHS expenditure¹ and its most important asset in providing care for NHS patients. Still, stewardship of the workforce is not optimised at the policy or service level. Based on knowledge of the field, the literature, and listening to patients and staff, we show three key interlinked areas in which action is urgently needed: configuring the workforce, improving conditions and working environments, and enhancing career and training pathways. We propose what might be done to tackle the current challenges, emphasising that workforce stewardship needs to be highly intentional about diversity, inclusion, and equity and needs to be done collaboratively with staff, patients, and the public. (NHS England 2023)

Conclusion: Ambulance services are an essential part of the healthcare system, providing rapid emergency medical care and safe transport for patients. Over the years, they have evolved from simple transport for the injured to highly advanced emergency medical systems equipped with modern technology and staffed by trained professionals. Their effective functioning depends on rapid response, skilled medical staff, appropriate equipment, and strong coordination with hospitals and emergency agencies. However, challenges such as traffic congestion, limited resources, staff shortages, high operational costs, and delayed access in rural areas continue to affect service delivery. Addressing these challenges through increased investment, improved infrastructure, regular staff training, public awareness, and better emergency planning will enhance the quality and efficiency of ambulance services. Overall, a well-organised ambulance service plays a vital role in saving lives, reducing complications, and improving public health outcomes.



A paramedic is extricating a patient from the ambulance transport compartment for transfer to the emergency department."

Community Disability Services

Introduction: Community Learning Disability Services (CLDS) provide specialist multidisciplinary support to enable people with learning disabilities to live independently, maintain their health and wellbeing, and participate fully in their communities. The development of services for people with learning disabilities in the United Kingdom reflects a significant shift from institutional care towards community-based support, influenced by changing legislation, policy reforms, and evolving understandings of human rights. Since the establishment of the NHS in 1948, successive inquiries and government initiatives have sought to improve the quality of care, promote independence, and reduce discrimination. Policies such as *Valuing People* and the *Equality Act 2010* have strengthened the principles of inclusion and person-centred care. This section critically examines the historical development of Community Learning Disability Services (CLDS) and evaluates how effectively these services function within contemporary health and social care systems.

Origin of the service and historical context that shaped its development:

In 1948, the NHS became responsible for hospitals that cared for people with learning disabilities. At that time, about 55,000 people were living in these hospitals across England and Wales. Also in 1948, the Universal Declaration of Human Rights confirmed that every person has the right to life, freedom, and personal safety. During the 1950s and 1960s, investigations found that many hospitals had poor living conditions. Studies by Professor Jack Tigard showed that people with learning disabilities achieved better outcomes when they lived in small homes within the community rather than in large institutions. Dr Wolf Wolfensberger also encouraged society to treat people with disabilities equally and to provide them with the same opportunities as everyone else.

Although the Mental Health Act 1959 supported the development of community care, many people continued to live in hospitals. Reports such as the Ely Hospital Report (1969) exposed neglect and poor treatment of patients.

In the 1970s, the government published Better Services for the Mentally Handicapped (1971), which recommended expanding community-based services. The Jay Report (1979) supported the idea of “normalisation,” meaning people with learning disabilities should live ordinary lives and be fully involved in their communities.

During the 1980s and 1990s, many long-stay hospitals closed, allowing people to move into community-based housing. The NHS and Community Care Act 1990 introduced personalised care plans and Direct Payments, giving people greater control over the support they received. In the 21st century, the Valuing People (2001), and Valuing People Now (2009) policies promoted rights, independence, choice, and inclusion. The Equality Act 2010 provided stronger legal protection against discrimination. After the Winterbourne View abuse scandal in 2011, further changes were introduced to improve safeguarding and raise the quality of care for people with learning disabilities. (*Social History of Learning Disability* 2020)

Critically evaluate how the service functions today: Community Learning Disability Services (CLDS) in the UK today operate within a complex and pressured system, and both national policy ambitions and persistent structural constraints shape their effectiveness. Although DHSC's strengthened evaluation strategy promotes better evidence, improved guidance, and more transparent monitoring, recent NHS data show that community provision remains insufficient to prevent long-term hospitalisation for many people with learning disabilities and autistic people. The continued presence of large numbers in inpatient settings, often for several years, highlights weaknesses in early intervention, discharge planning, and community capacity. Regional variation further undermines equity, with some areas offering robust multidisciplinary support while others struggle with workforce shortages and limited specialist provision. CQC's "Right Support, Right Care, Right Culture" framework sets clear expectations, yet implementation is inconsistent. Overall, CLDS fulfil essential roles but function today with notable gaps in accessibility, coordination, and long-term outcomes. (Department of Health and Social Care 2026)

Conclusion: In summary, the evolution of Community Learning Disability Services (CLDS) demonstrates a major shift from institutional care towards a rights-based, community-centred approach that promotes independence, inclusion, and person-centred support. Legislative reforms, public inquiries, and government policies have significantly improved the quality of care and strengthened legal protections for people with learning disabilities. Nevertheless, the critical evaluation shows that considerable challenges remain, including inconsistent service provision, workforce shortages, regional inequalities, and insufficient community resources, which continue to contribute to avoidable hospital admissions and delayed discharges. Addressing these issues requires sustained investment, effective policy implementation, stronger multidisciplinary collaboration, and continuous evaluation to ensure equitable, high-quality care.

References:

- London Ambulance Service NHS Trust (2025) *Our history*. Available at: <https://www.londonambulance.nhs.uk/about-us/our-history/> (Accessed: 10 July 2026).
- NHS England (2026) *A&Es 'bore the brunt' as heatwave piled pressure on NHS*. 11 June. Available at: <https://www.england.nhs.uk/2026/06/aes-bore-the-brunt-as-heatwave-piled-pressure-on-nhs/> (Accessed: 10 July 2026).
- NHS England (2023) *NHS boosts emergency care workforce before winter with hundreds more paramedics and call handlers*. 14 December. Available at: <https://www.england.nhs.uk/2023/12/nhs-boosts-emergency-care-workforce-before-winter-with-hundreds-more-paramedics-and-call-handlers/> (Accessed: 10 July 2026).
- Langdon Down Museum of Learning Disability (2020) *Social history of learning disability*. Available at: <https://www.langdondownmuseum.org.uk/social-history-of-learning-disability/> (Accessed: 10 July 2026).
- Department of Health and Social Care (2026) *DHSC evaluation strategy 2026*. Available at: <https://www.gov.uk/government/publications/dhsc-evaluation-strategy-2026/dhsc-evaluation-strategy-2026> (Accessed: 6 July 2026).