

Chapter 2

United Kingdom

Befitting the UK's status as an advanced capitalist society notwithstanding the current problems of national debt and cost-cutting of public services in particular, there are a wide range of local, regional, and national initiatives from agencies that are rooted in altruistic beliefs (see Table 2.1 which sets out the key social and economic indicators of the UK). We shall consider these in terms of the following themes:

- Aging
- Disability and other health issues
- Community development, governance, and institutions
- Emergency services and public health provision

Aging

Cook and Halsall (2011, p. 4, 29) provide an overview of aging in the UK. As they note, drawing on Rowland's (2009) United Nations (UN) data, the UK has had an aging society for many decades, reaching the commonly accepted 7% cut-off point for the proportion of those aged 65 or over by 1930. By 1950, the UK was 4th globally in the list of countries with an aging population at 10.7%. This percentage rose to 14.0 by 1975, then 15.8 in 2000, with forecasts of 21.9% by 2025, and 27.3% in 2050 when the country is forecast to be 28th in the global list of older populations. It is not just about numbers, however, and Cook and Halsall (2011, p. 29) cite Dorling and Thomas (2004, p. 30) who suggest that the proportion of the UK's oldest residents is likely to increase disproportionately, giving rise to a range of issues including pension provision, pressures on the National Health Service (NHS) and the welfare system in general, as Cook and Halsall (2011) cite. Such issues are exacerbated by public sector cutbacks, including those in the NHS and from 2012, there have been increasing concerns over extraordinary pressures on Accident and Emergency (A&E) services, which began during the long hard winter of 2012–2013. For example, in Wales extra funding was announced for A&E departments on 5 December 2012, due to the fact that:

Table 2.1 UK summary data. (Britannica World Data [2014](#))

Population, millions	64.2 (2013)
Percent age of aged 60 or over	22.7 (2011)
Male life expectancy	78.1 (2008–2010)
Female life expectancy	82.1 (2008–2010)
Top three causes of death per 100,000 population	312.6 diseases of circulatory system 261.8 malignant neoplasms (cancers) 132.4 diseases of respiratory system (2008)
Gross national income per capita	US \$ 38,250 (2012)
Population per physician	365 (2012)
Population per hospital bed	349 (2011)
Further information	www.ons.gov.uk/ons/index.html

A bigger than expected increase in emergency hospital admissions for patients aged 85 and over was putting a ‘significant strain’ on services. (BBC [2012](#))

In England, A&E services have a target of a 4 h waiting time for patients, but by March 2013, these services were under such a pressure that many were unable to meet this target. For example, in the county of Shropshire, (BBC [2013a](#)) the two main hospitals failed to treat and discharge 95 % of patients within this 4 h period, in part due to high demand, with 290 patients per day since the start of the year seeking treatment in A&E. Two patients were left on trolleys for over 12 h.

Such stories were repeated across the country, and by May the issue had become a full-blown crisis (BBC [2013b](#)) The UK Government stated that there had been an increase in use of A&E services of 1 million patients in the last few years since they came to power. In part, this was attributed to the rising numbers of older people in the population who were seeking out such services, but there were also issues identified over the lack of General Practitioner (GP) visiting out-of-hours at evenings and weekends, a lack of funds for A&E services, which meant a shortfall in staff availability, plus the failure of the NHS helpline service that was originally intended to reduce demand for emergency services. Hospitals received less funding per patient when numbers rose above those for the benchmark year 2008–2009, and as this British Broadcasting Corporation (BBC) link shows, this was estimated to be costing hospital trusts ‘millions’ in lost revenue, given the deficit between funding per patient and the cost of patient treatment. Further, it was estimated that non-emergency patients accounted for between 15 and 30 % of those attending A&E, and so, ideally, these patients would be directed to local treatment centres such as GP surgeries or ‘walk-in’ centres.

Negative news stories such as these were compounded by a report by Macmillan Cancer Support (MCS) in June 2013 which forecast that 47 % of the UK population will get cancer by 2020, compared to the level of 44 % in 2010 and 32 % in 1992 (BBC [2013c](#)). The forecast increase was due to people living longer and thus becoming at higher risk of contracting this disease the impact of which is severe in terms of physical health and emotional wellbeing. The chief executive of MCS,

Ciaran Devane, argued that this projected increase meant that the NHS would not be able to cope:

Without a fundamental shift towards after-care, without more care delivered in the community, and without engaging cancer patients in their own health. (BBC 2013c)

But even within this gloomy prognosis, there were signs of progress because survival rates had increased from 21 % in 1992 to 35 % in 2010 and a forecast of 38 % by 2020. Up to a quarter of cancer cases could be avoided via lifestyle changes including cutting down or stopping smoking, keeping physically active and maintaining a healthy weight.

MCS is one of the longest established charitable organisations involved in cancer amelioration and treatment, famously in the UK via their Macmillan nurses. Their website Macmillan (2013) details their historical development from the founding more than 100 years ago, in 1911, as the Society for the Prevention and Relief of Cancer. Table 2.2 is based on their website, which provides further information concerning their aims and objectives.

As Table 2.2 shows, there can be little doubt about the success of this charity, which has grown to national recognition, partly of course due to the contemporary seriousness of cancer as an illness in the UK. Thus, they appointed their first Macmillan nurse in 1975 and reached their 1000th cancer nurse in 1993, with their 2000th being appointed in 2000. They have been engaged in national fundraising campaigns that have raised millions of pounds sterling, including a major TV campaign in early 2014. Although very much associated with Macmillan nurses who support those with cancer, as Table 2.2 indicates, they now have a multiplicity of activities designed to support not only cancer patients, but their families, who also have to deal with the trauma of this illness.

Another illness that strikes fear into people, due to its dramatic impact, is dementia. 'Dementia is a word used to describe a range of symptoms. These can include the gradual loss of memory, communication skills and the ability to think and reason clearly' (Alzheimer's Research UK n.d., p. 5). One of the main causes of dementia is Alzheimer's, which causes about two-thirds of dementia cases (Alzheimer's Research UK n.d., p. 5), but there are others too, including vascular dementia, dementia with Lewy bodies and frontotemporal dementia (Alzheimer's Research UK n.d., p. 5). In brief, Alzheimer's (named after the German neurologist Alois Alzheimer) sees 'plaques' or 'tangles' of proteins build up in the brain; these interfere with normal brain cell activity and kill off brain cells in a progressive deterioration that also involves chemical change in the brain (Alzheimer's Society 2011). Vascular dementia is caused by reduced blood flow to the brain, after a stroke, for instance, dementia with Lewy bodies is caused by build-up of protein within nerve cells, and frontotemporal dementia is similar in that abnormal proteins develop in specific parts of the brain (Alzheimer's Research UK n.d., pp. 12–13). Whatever the cause, dementia is an illness that is very much associated with old age, and the vast majority of people with dementia in the UK are aged over 65, about 92 % according to estimates. At particular risk are people aged over 80 with a one in five chance of contracting the disease (Alzheimer's Society 2008, p. 1). In all, about 820,000

Table 2.2 Macmillan Cancer Support (MCS) historical development (key milestones). (Adapted from Macmillan 2013)

1911
Douglas Macmillan establishes the ‘Society for the Prevention and Relief of Cancer’, providing information on recognising, preventing, and treating cancer to patients, doctors, and members of the public
1924
Becomes a benevolent society and changes name to ‘National Society for Cancer Relief’, providing practical help to patients and their families
1930
The first paid member of staff is appointed
1969
Begins to support in-patient care, making first contributions towards building hospices.
1975
First Macmillan nurses are appointed, plus first Macmillan cancer care unit established
1980
£ 2.5 million spent to expand Macmillan nursing teams throughout the UK. Educational programme launched to train doctors, nurses and students in advanced pain control and cancer care
1986
First Macmillan doctor is appointed
1989
Name changed to ‘Cancer Relief Macmillan Fund’
1993
1000th Macmillan nurse is appointed
1994
‘10 minimum standards of care’ publicised as part of a nationwide campaign about breast cancer
1997
Name changed again to ‘Macmillan Cancer Relief’. Information Line opened in December
1999
Macmillan launches ‘a voice for life’ to give people with cancer the chance to have their voices heard and successfully lobbies The Oxford English Dictionary to change its inaccurate definition of cancer
2000
2000th Macmillan nurse appointed
2001
Macmillan merges with Cancerlink, a national charity providing support to people affected by cancer, particularly those in cancer self-help and support groups. Finds a mobile Macmillan cancer information centre and completes 100th building project, a day centre at Craigavon in Northern Ireland
2002
Macmillan CancerLine is launched, integrating the existing Macmillan Information Line and Cancerlink’s information services

Table 2.2 (continued)

2003
Implements a social care strategy, focusing on supporting carers and helping people financially
2004
Macmillan Benefits Helpline, offering advice by telephone for people with cancer across the UK who need help to access benefits and other kinds of financial support, is established
2005
Number of Macmillan health professionals rises to more than 3,500 and includes nurses, doctors, radiographers, dieticians, occupational therapists, and other specialists to provide more integrated care to people with cancer
2006
Name changed once more to Macmillan Cancer Support to help people better understand what they do
2008
Merged with Cancerbackup, to provide high quality, expertly developed information about cancer, and make it available to everyone who needs it
2009
Integrated phone service is launched, allowing people affected by cancer to call just one number for medical, financial, practical, and emotional support

people in the UK are estimated to have dementia, but it is not necessarily that obvious an illness to identify and can be slow to progress.

Typical symptoms in the early stages of Alzheimer’s are shown in Table 2.3 and include memory loss, disorientation, mood swings, and so on. One of the hardest things for relatives and friends to cope with is the fact that patients can completely forget who their relatives or friends are, while the patients themselves can exhibit distressing behaviour. Not surprisingly, therefore, given the social impact of this disease, a major charity has grown to help people deal with the consequences of this condition, namely the Alzheimer’s Society (2013).

Related to the Alzheimer’s Society is the research organisation whose work is cited here, namely Alzheimer’s Research UK which according to their publication *All about dementia* is the UK’s leading dementia research charity. Their website is

Table 2.3 Typical symptoms of early Alzheimer’s disease. (Alzheimer’s Research UK n.d., p. 8)

Regularly forgetting recent events, names and faces
Regularly misplacing items or putting them in odd places
Confusion about the time of day
Disorientation, especially away from your normal surroundings
Getting lost
Problems finding the right words
Reduced judgement, for example, being unaware of danger
Mood or behaviour problems such as apathy, irritability, or losing confidence

Table 2.4 Lifestyle factors that may reduce the risk of dementia. (Alzheimer’s Research UK [n.d.](#), p. 16)

Regular exercise
Not smoking
Achieving and maintaining a healthy weight
Controlling high blood pressure
Controlling blood glucose level if you have diabetes
Eating a healthy balanced diet with high amounts of fruit and vegetables and low amounts of saturated fat
Only drinking alcohol within recommended limits

www.alzheimersresearchuk.org where more information can be found, but we note here that they have ‘funded tens of millions of pounds of pioneering research across the UK to promote the development of new treatments for dementia’ (Alzheimer’s Research UK [n.d.](#), p. 19). Given people’s worries about dementia, it is worth noting that their research shows that an active lifestyle that includes a range of interests and hobbies may be beneficial in reducing the risk of dementia, as shown in Table 2.4. They warn, however, that some potential ameliorations such as consumption of oily fish or B vitamins are as yet unproven, as are taking of anti-inflammatory drugs such as aspirin or ibuprofen, or hormone replacement therapy (HRT), while ‘There is also no evidence that turmeric, ginkgo, ginseng, statins or coffee can protect against dementia’ (Alzheimer’s Research UK [n.d.](#), p. 17).

Given the social, sometimes antisocial, nature of dementia, it is clear that the social response will become increasingly important in order to support immediate family members in particular. One charity that performs an important role in this process of providing respite to dementia carers is Personal Social Services (PSS). They have a Dementia Befriending Service in which trained volunteers are paired up with people of similar interests who have dementia, for example, those with an interest in football (soccer), swimming, shopping, or whatever, and then those volunteers (who must obtain police clearance and references in order to prevent abuse of vulnerable people) gradually meet up with their allotted person with dementia with a view to taking them out to various agreed activities. This not only provides friendship to the person with dementia but also acts as a respite for the immediate carer who can have some time off to catch up with essential tasks or just to have some time to themselves without the responsibility of the role of carer as the need arises (see Person Shaped Support [2013](#)).

Disability and Other Health Issues

In the past, in the UK as in other countries, disability was poorly dealt with and the word ‘spastic’ became a common term used against those who suffered a range of physical disabilities, while ‘mad’ or ‘lunatic’ were used for those with mental problems. Today, in the UK, we have come a long way in terms of responding to

disability and the success of those such as Professor Stephen Hawking or the British Paralympic Squad show dramatically how disability can be overcome in a range of ways. But there is much work still to do, and charitable organisations can play a big part in educating people to be more caring in their response to disability. For example, in 1963 a Women's Royal Volunteer Service (WRVS) officer, Joan Brander, saw firsthand the problems faced by those with severe physical disabilities, including their need for a break from regular routine. Further:

Joan also witnessed the plight of family carers, whose devotion to their loved ones without any kind of support or respite was taking a devastating physical and emotional toll. Joan realised that these families were in desperate need of support—and she set about providing it. (Vitalise 2013, p. 8)

Ms. Brander became the founder trustee of 'The Winged Fellowship' which began to provide holiday breaks for disabled people and their carers. Joan Brander died in 2004 by which time the organisation had gone from strength to strength, and changed its name to Vitalise that same year. Two of the current authors live in Southport, Merseyside, where the Sandpipers centre is one of three major centres run by the charity. The statistics in the Vitalise (2011–2012) annual report are impressive, and include total income of just under £ 8 million which includes £ 1.2 million of fundraising, generating a small surplus of £ 114,000 after 3 years of a deficit (Alzheimer's Research UK *n.d.*, pp. 24–25). In all, Vitalise provided 4,838 weeks of 'life-enhancing breaks' for those with disabilities and their carers, assisted by 4245 weeks of time given by volunteers, 83% of whom were aged between 16–25 years old (Alzheimer's Research UK *n.d.*, pp. 6–7). As a link to the Alzheimer's topic discussed in the previous section, 133 weeks of breaks were devoted to supporting couples dealing with the impact of Alzheimer's/dementia on their lives. Further information on this worthwhile work is available at Vitalise (2013). But of course, not all charitable activity is without its problems. As noted above, the charity lost money for 3 years from 2008–2009, which we would attribute to the impact of the beginning of the recession. This loss prompted difficult decisions that have included the closure of the Kendal, Cumbria, office when its lease ended in 2012, and consolidation within the London office. Once again the organisation is in surplus and is in a position to realise its revised aims, which include provision of short breaks, non-centre breaks, investment in facilities, and to further develop the volunteering programme, one of whom is the young Philip Bembridge, 18, who volunteered at Sandpipers in order to gain an insight into social care before beginning his degree in medicine and the sprightly Joy Bone, 82, who has devoted an average of 13 weeks per year to volunteering since 1990!

A different type of emphasis on wellbeing is provided by the Reader Organisation, founded by Jane Davis who then lectured in continuing education and English at the University of Liverpool. She is now director of this charity whose mission is to build a 'Reading Revolution...in which everyone has access to literature and in which personal responses to books are freely shared in reading communities in every area of life' (The Reader 2014). A key element in their work is the concept of shared reading, led by reading facilitators trained by the charity. These facilitators lead small reading groups, often with people who have a range of mental problems

or alcohol and drug dependency for instance. The therapeutic dimension of this shared reading is considerable and potentially life transforming. Jane Davis herself has had an interesting and varied life, eventually transformed by her growing love of literature, and more information can be found about her at the Ashoka website linked to the Reader Organisation website itself.

Another important UK charity that deals directly with mental health issues is Mind, whose website is: <http://www.mind.org.uk>. This charity campaigns against the stigma of mental health, giving a voice to those who suffer from mental ill-health. As their website notes, there are local branches throughout England and Wales, offering support to 250,000 people. 'Their services include supporting housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending' (Mind 2014a). The charity has been operating for over 60 years and has had noted successes in promoting more positive attitudes to mental health, including a campaign against two major supermarket chains, Asda and Tesco, that were promoting derogatory Halloween masks mocking mental ill-health in September–October 2013. The masks were withdrawn following public concern, in response to their publicity. Ecotherapy works is one of their major current campaigns, launched in late 2013. Sometimes known as 'green care' or 'green exercise', ecotherapy involves a range of outdoor or indoor green activities such as gardening, conservation, and helping to look after animals. These types of activities are shown to promote good mental and physical wellbeing, aiding recovery from or response to mental problems (Mind 2014b). These charities and many others typify those working voluntarily in the UK, and help explain why David Cameron launched the 'Big Society' campaign in 2010. Such organisations do not, however, operate in a vacuum, and are affected by the same stresses and strains within British society that the 'age of austerity' has brought. And so, for example, some have struggled to ensure that donations keep up with the increased demand for their services at a time when public sector funding has been cut. Many charities have amalgamated over time, and difficult decisions have been made to close branches ('branch plants'?) to ensure survivability. We wonder if such closures are in part an issue of corporate size—is there an optimum size for a charity? In similar vein, is there a point at which the original aims of the charity are professionalised to such an extent that working for such organisations becomes little different to working for public or private sector organisations, i.e. 'our' professionals talk to 'their' professionals? But such questions are related to questions of governance and it is to this that we now turn.

Community Development, Governance and Institutions

Social scientists have had a long fascination with governance and institutions (North 1991). There has been a contemporary fascination with governance. Many scholars have reframed the concept of governance as 'Global Governance.' Sinclair (2012) has noted that global governance has commanded a new authority within the context

of globalisation and this theoretical debate will continue. Interestingly, Weiss (2013, p. 2) has had a critical insight into global governance whereby arguing:

The essence of the problem of global governance is that the evolution of inter-governmental institutions, and the forms of collaborative in which they engage, lags well behind the emergence of collective problems with trans-border, especially global, dimensions.

One of the most prominent scholars on institutions is Anthony Giddens (1987). In his book of 1987, Giddens argues that institutions have two contributing factors which are: (1) agency and (2) structure. As (Halsall et al. 2014, p. 169) have noted, 'Agency is the sense of individuals of making their own choices and structure in the impression of pattern arrangements which influences or limit choices and opportunities available.' Similarly, Dunia (2011, p. 22) has provided a contemporary definition on institutions:

According to perhaps the most formal approach, institutions are tightly structured entities—such as parliaments, courts, trade unions, firms, and various sorts of associations—whose parts relate to each other in clearly and often officially prescribed ways. We can think of institutions as highly organised spaces.

In the context of the UK, there are two interpretations of institutions. Firstly, institutions can be defined in central and local government and secondly, the voluntary sector. Within the British society, social commentators and scholars have had a profound interest in the welfare state. The origins of the welfare state were born from the Beveridge Report (1942). As Cook and Halsall (2012, p. 21) have noted 'The main aim of the Welfare State is to bring together a number of agencies and institutions to deliver a sustainable social welfare programme.' Since the setting up of the welfare state past governments have been obsessed in changing the system to make sure the most vulnerable people in society are protected (Patton 2006; Klein 1995).

The general election of 1997 saw a significant change in British politics. The election of New Labour saw a new emphasis placed on how communities function at a local level. As Imrie and Raco (2003, p. 4) state 'The Labour government came to power in 1997 with a commitment to regenerate Britain's cities by recourse to social inclusion, neighbourhood renewal and community involvement.' Local communities across the UK experienced a new level of investment and a greater focus on the statutory and voluntary sector. Since this time local communities across the country have encountered a greater level of public participation. One area of policy that New Labour developed when they were in power (1997–2010) was 'Active Citizenship'. The New Labour government of time perceived 'Active Citizenship' as a tool for residents to engage in their local community, thus, creating community empowerment and contributing to 'Civil Renewal' (Recknagel and Holland 2013). In this period of time, communities saw an integrated relationship between different institutions, namely, central/local government and the third sector. However, since the economic downturn from 2008, the level of investment for local communities has declined. Due to the economic downturn and the recession of 2009 onwards, the previous Labour and the current coalition governments have cut back government spending, thus having an impact on local communities (Hastings et al. 2014).

Research carried out by Mayo et al. (2013, p. 234–235) concluded that the success of community development in the UK relies upon:

Public resources can still make a difference, when provided through democratically accountable partnership, whether these are resources for community-university research, and/or for the promotion of active citizenship and community development more generally.

In recent years, there has been a critical focus with regard to institutions failing people in British society. The most prominent case to date is the Steven Lawrence murder of 1993, which was racially motivated. A public inquiry was undertaken in 1999 ‘The *Macpherson* Report’. The report was highly critical of the conduct of the police. There are other examples whereby a number of public institutions have failed members of the public. The most contemporary examples to date are the Jimmy Saville and Cyril Smith cases (Furedi 2013; Danczuk and Baker 2014), Asian Grooming (Cockbain 2013), and the murder of *Daniel Pelka* (Coventry Partnership 2014). It is therefore our argument that there needs to be a more critical focus placed on why institutions are failing the British public.

Emergency Services and Public Health Provision

The landscape of pre-hospital care and the health service delivery changed drastically after the coalition government’s highly controversial spending review announced in October 2010 which set broad limits on public spending through to 2014–2015. These proposals became part of the Health and Social Care Act 2012. The impact of these cuts has been far reaching given that the total cuts amounted to £ 67 billion and spread across all government departments (HM Treasury 2010). It was estimated that this could lead to cutting 500,000 jobs, costing the government around £ 4.6 billion in lost tax revenues and £ 6.1 billion in extra benefits (UNISON 2010). There were far reaching implications for the design and delivery of the emergency ambulance services. Radical structural reforms initiated by the coalition government have been transforming the architecture of emergency pre-hospital care. These include incorporating the changes into the commissioning structures from abolition of the primary care trusts (PCTs) in 2013 and transferring those responsibilities to the new clinical commissioning groups (CCGs) along with the abolition of the NHS direct service. The scale of these NHS reforms is significant. Radically transforming urgent and emergency care services including ambulance services is central to achieving the government’s objectives to improve outcomes delivered by the NHS, alongside delivering greater efficiency and productivity (NHS Confederation 2012).

There have been few notable aspects of these reforms impacting the future direction of travel of the emergency ambulance services. Each of them has been discussed in some detail.

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