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Save the NHS and Social Care by Stopping Brexit

Policy Paper 137

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1. Introduction

The NHS and the Social Care systems are vital public services which we all depend on. More than 1.6 million people work in the NHS, delivering our babies, saving lives and helping us manage our long-term conditions as we age. 1.5 million more work in social care, looking after elderly people, supporting children from troubled families and helping adults with disabilities to live independently.

Shamefully, under the Conservatives these critical public services have been underfunded, and the staff who keep them going have been taken for granted. Dangerous levels of vacant posts mean the hard-working professionals who look after us when we are most in need, are under tremendous stress. The prospect of Brexit presents an even greater threat. Since the referendum, it has been harder to recruit EU doctors, nurses and care workers. Many have returned to their home countries, leaving the NHS short-staffed and over-stretched. And this is even before Brexit has actually happened.

If Brexit goes ahead, the effects will be devastating. 63,000 EU nationals work in the NHS in England and 104,000 work in the adult social care sector. One in ten NHS doctors, seven per cent of nurses and seven per cent of social care workers are EU nationals. Losing even a small fraction of these professionals would make it impossible to cope with the needs of our people.

If there were a no-deal Brexit, things would be even worse. The damage could include:

Barriers to workforce recruitment – Proposed new immigration rules would affect the UK's ability to recruit doctors, nurses and care workers from the EU. Under EU rules there is mutual recognition of qualifications – if these rules change, it could be harder to fill the growing number of vacancies.

Delays to getting medicines – In the short term, there could be delays in importing medicines. The creation of a new medicines' approval

regime could lead to further delays. The UK could be excluded from partnerships like the European Rare Diseases Network, so treatments that aren't commercially viable for the UK market alone may not reach UK patients.

Patients in the UK missing out on medical research funding and trials – We would no longer have the right to take part in Europe-wide research collaborations. Medical researchers in the UK would no longer be able to get funding from EU research schemes, which have traditionally funded medical research in the UK to the tune of hundreds of millions of pounds.

Losing membership of Euratom – This would remove the guarantee of consistent and timely access to radioisotopes. The result could be delays in cancer tests and treatment, and could also restrict the UK's ability to benefit from sharing expertise in radiation research.

Half-a-billion-pound NHS bill – UK nationals living in the EU, including tens of thousands of pensioners living in Spain and France, could lose their right to free healthcare under the S1 scheme. The potential cost for the NHS has been estimated at up to £500m.

No more free healthcare for British tourists – The European Health Insurance Card, which allows tourists from the UK to access the same level of state-provided emergency treatment as a resident of the country they are visiting, could also be invalidated.

Risks to Public health – the UK's ability to respond to pandemics could be undermined as we lose membership of key EU bodies, such as the European Centre for Disease Prevention and Control.

In the longer term, Brexit would hurt health and social care further, by damaging our economy, leaving us with less money available for public spending. There is a clear need for increased spending on the NHS and Social Care to meet the needs of an ageing population. Brexit will make it more difficult, if not impossible, to find the necessary funds. Most economists estimate that Brexit uncertainty has already cost between

1.5 and 2.5% of GDP since 2016. Government itself has estimated that Brexit could cost up to 9.3% of GDP over a 15-year period.

If the Brexiters' vision of a series of independent UK Free Trade Agreements were to be realised, this would give our negotiating partners the opportunity to demand concessions such as access to the UK health and care 'market'. Donald Trump has already said he wants the NHS 'on the table' in trade talks. This would mean the end of the NHS as we know it, fragmenting services and destroying the important principle of health care being free for all. It could restrict the freedom of government to regulate for public health reasons and limit access to cheaper generic drugs. Liberal Democrats will fight this every step of the way.

For all these reasons, our most urgent priority when we look at health and social care policy is to stop Brexit.

Both Labour and the Conservatives are consumed by infighting over Brexit. They have forgotten their most important responsibility is to look out for those who are sick, disabled or in crisis. We demand better. Only the Liberal Democrats are clear in our opposition to Brexit. We want to end debate over this divisive issue, and look positively to the future. We want to restore economic stability and make Britain a welcoming outward-looking country again. We will ensure the public continue to own the NHS, and that it never becomes a bargaining chip in international trade deals. We will welcome European doctors, nurses and care workers back into our NHS and local care services, and we will invest in our NHS, public health and care services.

Even before Brexit derailed the normal business of government, there were very serious issues facing the NHS and Social Care. Funding for the NHS has not kept up with rising demand. While the government's recent additional funding announcement was helpful, it was not enough to fill the gap. Liberal Democrats will invest an additional £6 billion (1p on income tax) in these essential public services.

This is needed, because Conservative cuts to local government funding have created a crisis in social care, with many local authorities now on the verge of bankruptcy. The NHS cannot improve if hospital beds are filled with people who would be better off in their own homes, but can't go home because the support isn't there for them.

Proven interventions like stop smoking services and sexual health clinics have also been axed. We would reverse these cuts, and ring fence public health budgets.

Most importantly, we will invest in children and new parents, and in mental health. Early intervention is key to healthy long lives. We will improve the mental wellbeing and resilience of our children and young people, working with schools, parents and communities.

Liberal Democrat MP Norman Lamb introduced the first ever maximum waiting time standards for mental health in 2014. We will keep fighting to make a reality of parity of esteem for mental health, improving children and adolescents' mental health services and ending out-of-area placements, and outdated practices that keep people detained in institutions for too long.

This paper sets out in detail our plans, looking at:

- Starting well and staying well.
- Mental Health.
- Intensive users of services.
- NHS and Social Care staff.

2. Executive Summary

To guarantee continued access to medicines and treatments, to reverse the loss of key staff, to create the economic conditions in which Health and Social Care services can be properly funded, and to prevent the NHS being sacrificed on the altar of international trade negotiations, Liberal Democrats will:

- Save the NHS and Social Care by Stopping Brexit.
- End the waste of public money on no-deal Brexit preparations by stopping Brexit.

Changes in lifestyles, the availability of new treatments and increasing longevity all combine to drive up the costs of health and social care. Historically the NHS budget has grown at about 4% in real terms, however in recent years it has received much less than this. The latest funding settlement announced by the government, from now until 2023/24, amounts to a headline average increase of 3.4% per year. While an improvement, this does not match the needs of the NHS, and does not tackle the funding crisis in social care.

- As a short-term measure, in addition to the Government's recent spending announcement, we would raise a further 1p on the £ from income tax, around £6 billion a year, and use this to meet immediate priorities in social care, reverse cuts to public health, and boost spending on mental health beyond the government's current plans.
- In the medium-term, we will establish a cross-party commission to set a realistic long-term funding settlement for the NHS and social care, and introduce a dedicated Health and Social Care tax to fund it.

We believe prevention is better than cure. Every child deserves a healthy start in life, so we will support families and schools to eat healthily, be more active and develop their skills and resilience we will:

- Reverse the cuts to public health grant funding to local authorities since 2015, and ring-fence the public health allocation.
- Introduce a new statutory requirement for public health interventions evaluated as cost effective by NICE to be available to qualifying people, within three months of publication of guidance.
- Make healthy choices easier, more desirable and more affordable. We will extend the 'sugar tax' to include juice and milk-based drinks that are high in sugar. We think that only healthy products should be allowed within 5 metres of the point of sale/till of supermarkets.
- Give councils greater powers to prevent fast food outlets or HFSS advertising from being within 500m of a school, and new traffic management powers to tackle air pollution, support the 'daily mile' and encourage safer outdoor play.
- Guarantee that every child who is eligible for free school meals has access to at least an hour a day of free activities to improve their health and wellbeing. We will fund our new 'Wellbeing Hour' via a public health grant to local authorities. Local authorities will deliver the 'Wellbeing Hour' by helping schools to subsidise and widen access to after-school clubs.
- Aim to make England the safest country to have a baby in, granting every family a single maternity health professional by 2025 for continuity of care. Building on our policy of shared parental leave, we will ensure all fathers/partners have paid leave to attend pre-natal appointments, scans, and training on spotting signs of postnatal depression.
- Restore funding of early help services for children in need, and establishing ACE ('Adverse Childhood Experience') Hubs. These hubs will provide rapid and emergency support to families, in times of crisis.

- Introduce a maximum referral to assessment time of twelve weeks for assessment of any child referred by their GP or their teacher for a special needs assessment.

We will help people to access practical and professional advice swiftly. We will support people to make more informed decisions about their health:

- In place of the current 2-week waits for advance GP appointments, we will guarantee a same day phone or video appointment with a healthcare professional at your local GP practice, following morning triage.
- We will develop the 'Health Check', currently offered at 40, into a 'health programme' comprising of appointments every five to ten years with health advisers (aligned with screening programme target ages).

To deliver our goal of parity between mental and physical health care, we will:

- Make prescriptions for people with chronic mental health conditions available for free on the NHS, as is already the case for conditions such as cancer or diabetes.
- Introduce further mental health maximum waiting time standards, starting with children's services, services for people with eating disorders, and bipolar conditions.
- Increase mental health services and facilities so that no one is forced to travel unreasonable distances away from home. We would prioritise in the first year young people coming out of care, and set out and fund a plan to ensure that no one will have to travel out of area for all but the most specialist mental health services.
- Support college and university students to stay mentally healthy, requiring universities to make mental health services accessible to their students, and ensuring the quality of those services.

- Bring forward legislation to implement the recommendations of the Wessely review of the Mental Health Act. We will apply the principle of 'care not containment', while ensuring an emergency mental health bed is always available if needed.

To create a joined-up system of care which meets the needs of those who are long-term or intensive users of services, we will:

- Allocate funding from our proposed additional 1p in the £ on income tax to meet the immediate pressures on local care budgets.
- Ensure there is always local accountability for commissioning decisions by applying the principle of local government leading on the commissioning of both health and care services, where these are currently commissioned by CCGs.
- Give every person with a learning disability the right to a named advocate to help them navigate public services and access health, care and advice services.
- Extend the work of the Learning Disabilities Mortality Review Programme (LeDeR), underpinning this with a national target for the gap in life expectancy to be reduced by one year, every year.
- Introduce a statutory guarantee of regular respite breaks and a package of carer benefits including free leisure centre access and self-referral to socially prescribed activities and courses.

To tackle the recruitment and retention crisis, and improve NHS and Social Care staff wellbeing, we will:

- Target extra help for nursing students, starting with bursaries for specialties where shortages are most acute such as mental health, linked to clinical placements in geographies that are under-staffed.

- Fund an EU recruitment campaign and end the Government's inflexible £30,000 earnings threshold for overseas workers, which rules out many care workers.
- Recognise the equally important contribution of social care staff through a new professional body for care workers and improved training and career development.
- Adopt the lead employer model for junior doctors, to grant them access to shared parental leave and minimise costly repeats of mandatory training.
- Improve access to flexible working for NHS and social care staff – scrapping the requirement of 26 weeks of continuous service to qualify for the right to request flexible working – instead embedding flexible working from the outset.
- Support the mental wellbeing of NHS and Care staff through mental health first aid training in all health and care settings, and a dedicated mental health support service giving confidential advice and support 24 hours a day.
- Introduce a new statutory duty upon the Secretary of State for Health and Care, making them responsible for producing an annual workforce report and plan, that meets the changing, growing needs of the population.

3. Starting well and keeping well

3.1 Why do we care about this?

3.1.1 We believe that everyone should have the opportunity to live a healthy (both physically and mentally) and a long life. The poorer you are, the worse your health outcomes. This is unfair, but also wasteful: preventing ill-health driven by social and environmental hardship will take pressure off health services.

3.1.2 We believe that people and communities are experts in their own health and that the things they do to start and stay healthy should be celebrated, shared and supported.

3.1.3 We believe that education and information lead to better outcomes, but education alone will not change behaviours. The healthy choice has to be the easier and more affordable choice too.

3.1.4 We believe government has a duty to protect us from the things beyond our control that can harm our health, such as air pollution or poor housing.

3.1.5 We believe that early interventions that help build healthy habits, support parents and identify early those children at risk of harm, are essential.

3.1.6 We believe that every child deserves a healthy, happy start in life, and the support to achieve their full potential.

The Price of Brexit:

Loss of co-ordination between the UK and reduces our capacity to deal with serious cross-border health threats, such as pandemics, infectious diseases, safety of medicines and contamination of the food chain. If we have to negotiate new Free Trade Agreements from a position of relative weakness, there is a high risk we will fail to protect our existing strong standards in areas such as food safety and regulation of medicines and devices. EU legislation is currently a cornerstone of environmental protection in fields such as water and air quality which are crucial to human health. All this is at risk if we leave the EU.

3.2 What's the problem?

3.2.1 Developing healthy habits is key to staying well as we age. However, seven in ten adults in England do not meet government guidelines in relation to two or more risk factors including poor diet, physical inactivity, excessive alcohol consumption and smoking. These risk factors are linked to ill health and premature death related to cancer, heart disease and diabetes.

3.2.2 The UK also has the highest rates of childhood obesity in western Europe. The largest cause of childhood admission to hospital is tooth decay: 40,000 children a year are admitted.

3.2.3 Physical inactivity is responsible for one in six UK deaths (an impact on health that is equal to smoking) and is estimated to cost the UK £7.4 billion annually.

3.2.4 Poor health outcomes are patterned by social deprivation: the poorer you are, the more likely you are to suffer chronic ill-health and die early. This is true for those in the middle as well as the very poorest.

3.2.5 Studies have shown that life expectancy differs substantially between different BAME groups. This is particularly marked when considering the disability-free life expectancy (the average age that an individual is expected to live free of disability), which ranges from 67 years for Chinese women to 55.1 years for Pakistani women.

3.2.6 Trans, non-binary and intersex people can fail to access services, because of poor system or service design. For example, missing out on potentially life-saving health screening, because of inflexibility in the way medical data is recorded.

3.2.7 Most of us would benefit from eating fewer products that are high in fat, sugar or salt (HFSS), and replacing these with vegetables and food that is high in fibre. The nutritional information contained in food labelling is not easy to use and act upon and needs to be simplified to support healthy behaviour changes. We support measures to reduce consumption of unhealthy products across the population, such as the

sugar tax and minimum unit alcohol pricing, but do not advocate a punitive approach. Our approach is to make healthy choices easier, more attractive and more affordable.

3.2.8 We are concerned that proven public health interventions like stop smoking services, sexual health services, drug and addiction treatment services and early years interventions (both universal and targeted) have been cut in many areas, as local authorities' budgets have been slashed.

3.2.9 In many parts of the country legal air pollution limits are being exceeded, exposing people to unsafe levels of particles and other pollutants linked to lung disease and other illnesses.

3.2.10 We need a whole system approach – not just via health and care services, but also through schools, homes, workplaces, parks, transport and public services – all geared towards supporting healthier behaviours.

3.2.11 We are particularly concerned that the most vulnerable children in our society are not being given the opportunity to lead a healthy, happy life. Although the negative effects of experiencing adverse events in childhood are well-known (ACE), policy responses are limited and siloed. Preventative services like Children's Centres and early help have been cut by 80%, and 15% of children starting school are behind where they should be developmentally.

3.3 Public health

3.3.1 For years politicians and health service leaders have talked about the need to prevent ill-health, so that the NHS becomes less of a 'sickness' service, and more of a 'wellness' service. If we can extend the number of 'healthy life-years' people have, there will be returns in productivity and tax revenues. Nevertheless, the proportion of both the NHS and local councils' budgets that is spent on prevention remains tiny compared to sums spent on acute care and social care respectively. Public health grant funding to local authorities has been cut by over £600 million between 2015/16 and 2019/2020, undermining councils'

ability to improve the public's health and to keep the pressure off the NHS and social care.

3.3.2 In the near-term we will reverse these cuts, and ring-fence the public health allocation. We would also set targets for reducing waiting times for effective public health interventions, for instance ensuring prompt access to stop smoking services.

3.3.3 In the medium term, we will introduce a new statutory requirement for public health interventions evaluated as cost effective by NICE to be available to qualifying people, within three months of publication of guidance.

3.3.4 To tackle the social and economic drivers of poor health and health inequality (poor housing, poor environment, poor education), we would introduce a cross-government target to reduce health inequalities, with supporting targets for departments, addressing the contributing factors.

3.3.5 We will support local government further by introducing powers allowing councils to prevent new fast food outlets or HFSS advertising from being within 500m of a school. Planning policies need to be improved to enable councils to prevent the proliferation of take-aways and gambling places in some, usually economically deprived, areas, and to take into account the views of local residents.

3.3.6 We will give local authorities more power over traffic management and enforcement of traffic laws, so that health factors carry greater weighting in traffic management decisions. Building on the success of 20mph speed limits introduced by Liberal Democrats in Portsmouth, we will support local authorities to further innovate; tackling idling near schools; supporting initiatives like 'school streets' that create car-free zones outside schools during drop-off and pick up times; supporting the 'daily mile' by making it safer and more enjoyable to walk to school and supporting outdoor play by improving the safety of residential streets.

3.3.7 To live healthy active lives, most of us need to build more physical activity into our daily routines. Increasing numbers of people have recognised the value of walking more, and staying active. Taking greater responsibility for own health, includes understanding our own personal risks and taking part in targeted screening programmes. To this end we would develop the 'Health Check' currently offered at 40, into a 'health programme' comprising of appointments every five to ten years with health advisers (aligned with screening programme target ages).

3.3.8 We will give people ownership of their full health records, which they can choose to access on their mobile phone. We will support a cultural change that encourages people to record and interact with their own health and activity data, collected through health apps or diaries. Getting swift medical advice from a professional can avert an A&E attendance, so in place of the current unsatisfactory system of 2-week waits for advance GP appointments, we will guarantee a same day phone or video appointment with a healthcare professional at your local GP practice, following morning triage (by phone or at the practice).

3.3.9 Employment is one of the most significant drivers of health. Being unemployed is generally bad for your health, but poor-quality work is not good for it either. The Department of Work and Pensions will be tasked with supporting 'healthy work'; jobs designed to support employees' physical and mental health. Guidance on how to improve the design of jobs and workplaces will help employers understand how small changes can impact on staff health, and in turn improve productivity. For example, flexible lunch breaks with an expectation that staff leave their desks for a lunchtime walk or jog. Health and care employers, including the NHS, would be expected to lead by example.

3.3.10 As suggested by the British Lung Foundation, we would introduce a national system of air pollution alerts with health advice. People across the country should be able easily to see what air pollution levels are like in their local areas, so they can take steps to protect themselves and their families, such as choosing cleaner travel

routes or avoiding exercise outdoors on days when pollution levels are very high. We would develop a cross-sector strategy to reduce air pollution and revise legal limits for particulate matter (PM). PM comes from a range of sources including vehicles, wood burning, industry and farming, and UK limits are set lower than the WHO recommends. A fuller statement of policies that would reduce air pollution, such as encouraging the use of electric vehicles, is set out in Policy Paper 139 *Tackling the Climate Emergency.*

3.4 Healthy Eating

3.4.1 We will create a new healthy eating policy. A guiding principle is that the cost of food and drink must better reflect the 'real costs' of products (taking into account their longer-term costs to our health and wellbeing). The result will be that food and drink products which keep people healthy, will be cheaper than highly processed unhealthy products, in every situation. However, cost is not the only factor in food choices. Time/convenience, taste and visual appearance are all important. So nutritional labelling alone, or informative 'public broadcast' style campaigns, will only ever have a limited impact. To change behaviour we need to make healthy choices the easy, affordable, convenient and tasty choice. Our policies will not be punitive for individuals or producers. We aim to gradually change the market and incentives to make healthy choices easier, more desirable and more affordable. There is still a considerable gap between the average UK diet and a healthy balanced diet: most of us need to increase consumption of vegetables and fibre, and reduce consumption of saturated fat, salt, alcohol and sugar. Our healthy eating policy would create incentives to make this change more attractive, cheaper and more desirable. Healthy food is also usually better for the environment (see Policy Paper 139 *Tackling the Climate Emergency*). To this end we will:

a) Increase the soft drinks levy by 10p per litre for each band, expanding it to incorporate juice and milk-based drinks that contain added sugar. The primary objective of this policy is to

change the behaviour of manufacturers and consumers, and we would therefore be happy if it did not raise revenue; however any revenue would be used to fund public health measures, in particular to promote healthy eating.

b) Consult on expanding the soft drinks levy to a wider HFSS tax, covering foods.

c) Revise labelling to make clear the nutritional content of food and drink in a readable font size and make the sugar content of products easier to understand, by representing sugar content visually in pictures showing the equivalent number of sugar cubes.

d) Increase the number of public drinking fountains, so free drinking water is available across the country's cities and towns, making these ideas tangible through funding local government to deliver this. Alongside this we will encourage 'free tea' schemes in parks, commons and seafronts, to support local walking groups and year-round outdoor exercise.

e) Restrict how high fat, salt and sugar (HFSS) products are marketed and advertised by multiple retailers. For instance, specifying that products within five metres of the point of sale in supermarkets should not be (HFSS) products. In smaller retailers and the food service sector we would consult on the proposal that 50% of products within five metres of the point of sale should not be HFSS.

f) Work with retailers to ensure that promotions and free gifts, including in the growing online sales market and through home delivery services, promote healthy options through their pricing and digital marketing strategies.

g) Further restrict alcohol promotions; both in-store and online.

h) Encourage healthier eating in the food service (out of home/restaurant) sector, including mandatory food labelling on restaurant and takeaway menus.

3.4.2 With rising rates of childhood obesity, we need a particular focus on children, and support for healthy diets in pregnancy and the first years of life. This will include:

a) Promoting healthy eating through the curriculum. As part of our 'curriculum for life' to help children navigate the modern world, our independent Education Standards Authority will support and strengthen teaching on healthy eating and wellbeing.

b) Following the recommendation of the London Assembly Health Committee, we will establish the ambition for all schools to become 'sugar free' by 2022. Our new light-touch schools inspectorate, when evaluating pupil welfare, will consider whether schools are encouraging pupils to live a healthy lifestyle. Supporting this, we will update School Food Standards to support healthier choices, updating requirements on how nutritious foods such as wholegrain and oily fish can be served, and restricting HFSS foods such as cakes, sweetened yoghurts and fried foods. We will extend the free fruit and veg schools programme beyond infants, to run through the whole of primary and secondary school.

c) Introducing 'veg in pregnancy' vouchers, to ensure pregnant women increase their intake of vegetables. We will review the Healthy Start Voucher scheme to i) address the problem of poor uptake among eligible families and ii) increase access to advice on diet and exercise from health visitors and other professionals to maximise benefit. We will give all families access to 'healthy eating in pregnancy' and 'breastfeeding, healthy weaning and childhood nutrition' classes, through NHS maternity services.

d) Supporting people expecting their first child, to learn about nutrition for their new families. We will provide local free classes

for both fathers and mothers in the final weeks of pregnancy. Through this, we will identify families who could benefit from programmes that help parents establish healthier behaviours, such as Henry (Health, Exercise, Nutrition for the Really Young). This supports parents in setting boundaries for their children and taking a firm stance on issues such as healthy eating, alongside practical skills like preparing nutritious meals. We will support healthy behaviours further through children's centres and nurseries, involving the voluntary sector.

e) Addressing the existing advertising rules designed to protect children from marketing and advertising of junk food, which are not being properly implemented. Many children watch TV online, or watch popular 'family entertainment' shown between 6pm and 9pm, when advertising restrictions do not apply. We believe children should be protected from junk food adverts across all media they are exposed to, with a 9pm watershed on adverts for HFSS foods served across all media.

3.4.3 We will guarantee that every child who is eligible for free school meals has access to at least an hour a day of free activities to improve their health and wellbeing. We will fund our new 'Wellbeing Hour' via a public health grant to local authorities. Local authorities will deliver the 'Wellbeing Hour' by helping schools to subsidise and widen access to after-school clubs. However, we will allow for local councils to take into account local circumstances, and partner with other organisations to deliver activities outside of schools where needed. As well as ensuring that all schools deliver a broad and balanced curriculum through our education policy, our new light-touch schools inspectorate will ensure that the funding delivers good outcomes, by evaluating pupil welfare in each school and council area. This will be further supported by our policy of reversing school cuts.

3.5 Health in Childhood

3.5.1 We want to make England the safest country to have a baby in, by improving our maternity care. This will entail reducing stillbirths,

neonatal deaths, maternal deaths, brain injuries, sudden infant deaths and preterm births, so that we match the best performing countries in the world by 2025. To achieve this we would establish an expert maternity task force in every region of the country to work with services which are identified as performing poorly by the Care Quality Commission. We would give every family a single maternity health professional by 2025, so they have continuity of care throughout their pregnancy and birth, prioritising those with a higher risk of poor outcomes. We would give expecting families a personal budget and free guidance to enable access to pregnancy and new-born resources and services, so that families who cannot afford privately provided advice and services have equal access to essential information and support.

3.5.2 We will enable fathers to play an increasingly equal role in the care of their children, building on the Liberal Democrats' policy of 'shared parental leave'. This would include guaranteeing fathers and partners paid time off during pregnancy to attend scans, prenatal checks and family nutrition courses. We will create a 'family friendly' quality mark and award scheme for employers, and write family-friendly HR policies into public sector contracts.

3.5.3 We will restore funding of 'early help' services. Reductions in local government budgets have led to these services being cut, although statutory duties in relation to protecting vulnerable children have protected services for the most vulnerable. Limiting early help to this extent is short-termist, and it delays the identification of potentially vulnerable children. We favour a preventative approach to supporting early years. We would strengthen the statutory footing of preventative children's services, investing in them (as set out in our policy paper, A Fairer Share for All) to re-open children's centres and support community-based services for the most vulnerable children. We support better coordination between the NHS, local authorities and schools, including more flexible funding arrangements, which should save money in the long-term to be reinvested into early help services.

3.5.4 We would support the development of ACE ('Adverse Childhood Experience') Hubs to interface with the increased CAMHS support outlined within the NHS Long Term Plan, as well as policing and education services. These hubs will provide rapid and emergency support to families to ensure patients and families health and care needs are met in times of crisis. The services would link into local early help provision, ensuring there is an agreed early help plan in place before discharge. This follows the lead of the ACE hubs in Scotland and Wales, and we would match their ambition to develop effective ways to mitigate the effect of Adverse Childhood Experiences, improving vulnerable children's life chances.

3.5.5 We will stop the scandal of children with special educational needs or a disability waiting months for an Education, Health and Care Plan (EHCP). We will establish early help panels to encourage intervention as soon as need is noticed. Many children are not assessed until they are excluded from school, or until their parents have spent many months battling the local authority, often through the courts, for an assessment. We will strengthen the enforcement of the existing statutory timeline so that all ECHPs are in place within 20 weeks of the date they were requested. We will look to introduce a new target so that no parent waits more than 12 weeks for the outcome of their child's assessment. As set out in Policy Paper 135, *Eradicating Race Equality*, we would remove the financial disincentive for schools to refer their own pupils for an EHCP assessment by providing additional funding for students with an EHCP.

3.5.6 Currently, even when children are assessed as needing support, they sometimes do not get it. An estimated 2,060 children in 2018 who have EHCPs setting out their needs receive no support at all. This problem requires a concerted effort from a range of public services, not just schools, and we will ensure the health and care service plays its part. EHCPs should be properly maintained and enforced, with tailored, precise support for the child specified in each plan.

3.6 Trans Communities

3.6.1 Working in partnership with trans, non-binary and intersex communities, we will ensure everyone has the option of a streamlined and simplified process which does not lead to people being put at risk, for example, by them being excluded from screening or checks that they might benefit from based on recorded gender by reviewing the design of medical systems and records.

3.7 Addictions

3.7.1 Across government, we need a more consistent approach to tackling addiction (whether tobacco, alcohol, gambling or illegal drugs). Since addiction is primarily a public health challenge, it requires a public health-first (not criminal justice) policy response. 'Harm reduction' should be the guiding principle underlying all departments' addiction policies, leading to support for innovative effective policies such as drug treatment rooms, and permitting drug testing at festivals and clubs.

3.7.2 Excessive consumption of alcohol has a direct cost to the NHS of £3.5 billion annually: contributing to more than 50% of A&E attendances, and an array of lifestyle diseases and cancers. Wider impacts and costs are borne by the criminal justice system, and felt by children (alcohol abuse being a commonly cited reason for children being taken into care). To address these problems we would introduce minimum unit pricing (learning from experience in Scotland as it emerges), improve labelling requirements of units and include health harm messages, while ensuring universal access to addiction treatment.

4. Mental Health

4.1 Why do we care about this?

4.1.1 As Liberal Democrats we care deeply about fairness and freedom. For centuries mental health was a taboo subject. Poorly understood mental health conditions were denied the care and attention they deserved, and people were left to suffer in silence or locked up in institutions.

4.1.2 Thanks mainly to the work of the mental health charities, most people today better understand that mental illnesses are real, and just as deserving of research, treatment and understanding as physical illnesses.

4.1.3 We believe that mental health is just as important as physical health. Indeed, the two are intertwined, so looking after mental health leads to better physical health.

4.1.4 In government, we legislated to give mental and physical health equality under the law. We introduced the first maximum waiting time standards for access to treatment for mental health. We introduced the crisis care concordat, which dramatically reduced the number of people who end up in police cells because of a mental health crisis; and we secured more money for children and young people's mental health services.

4.1.5 These changes were welcomed, but they are not enough. Government needs to do much more still to put mental health on an equal footing with physical health. We believe that early, effective interventions are critical to preserving good mental health. Preventing poor mental health is key to preventing mental and physical suffering and distress, and averting wider social consequences and costs.

4.1.6 Any one of us can experience a mental health crisis, at any time in our lives. Wherever it is safe to do so, we believe it is critical to support the right of people with mental illnesses to live where they choose and enjoy the freedoms and rights that the rest of us enjoy. We

will keep on fighting for quality treatment and support for everyone who needs it.

4.2 What's the problem?

4.2.1 Mental health is a key cause of disease burden worldwide, as well as a key driver of disability worldwide, causing over 40 million years of disability in 20 to 29-year-olds.

4.2.2 Major depression is the second leading cause of disability worldwide. It is also a major contributor to the burden of suicide and ischaemic heart disease.

4.2.3 In the UK, it is estimated that one in six people in the past week experienced a common mental health disorder (CMD); and rates of CMD have steadily increased amongst women since 2000.

4.2.4 Evidence suggests that 12.7% of all sickness absence days in the UK can be attributed to mental health conditions, so the potential gains to the economy of helping people stay mentally healthy and supporting them in work, are significant.

The Price of Brexit:

We urgently need to recruit more specialist staff to meet maximum waiting time targets and make mental health treatment available without patients having to travel unreasonable distances. Some specialists such as child psychiatry face particular difficulties, and Brexit will make it more difficult to get these essential staff. The stress caused to many families by uncertainty over the status of EU citizens in the UK is also likely to contribute to mental health problems among people who have contributed to our national health and wellbeing, working as doctors, nurses and care staff in this country.

4.2.5 Young women are particularly at risk of common mental health disorders, with high rates of self-harm, post-traumatic stress disorder (PTSD) and bipolar disorder.

4.2.6 In 2017, 5,821 suicides were recorded in Great Britain: 3 out of 4 were male. Suicide is the most common cause of death for men aged 20-49 years in England and Wales.

4.2.7 Delayed diagnosis in BAME communities is common, and treatment rates are particularly low among the black community.

4.2.8 Young black men can face a double barrier, in having to break through the social stigma of seeking support for a mental health condition in the first place, then many can face discrimination within the system and fall out before treatment can begin to help.

4.2.9 People who are unwell can get 'stuck' in expensive mental health beds, when they may be better supported at home and prefer to be in familiar surroundings. A siloed funding system creates perverse financial incentives, and the failure properly to fund community services leads to further discharge delays and poor use of public money.

4.2.10 Some people seeking support to treat their eating disorders are subject to strict BMI requirements which prevents them accessing a service; effectively being told they aren't sufficiently underweight.

4.2.11 We know swift interventions can avert crises and help people get well faster, returning to normal life and work. However, maximum waiting time targets are not being met.

4.2.12 Mental health conditions are not treated as equivalent to physical conditions by insurers, nor are people with mental health conditions fairly considered in respect of prescription charges.

3. Services for children and young people are inadequate: more than 1,000 children and young people with serious mental illnesses were sent out of their local area in 2017-18 for a mental health bed, some as far as 285 miles, increasing the likelihood of social isolation and reduced contact with families, friends and carers.

4.3 Reducing Unfair Costs

4.3.1 We will make prescriptions for people with chronic mental health conditions available for free on the NHS, as is already the case for conditions such as cancer or diabetes. Those most in need of free

prescriptions find it harder due to their poor mental health to access support with payments or prepay certificates for medicines. When people with chronic mental health conditions do not take their medicines, the result can be costly, preventable, and sometimes involuntary, admissions. We will end the false economy of prescription charges for these people, and expand free prescriptions to people with enduring mental illnesses. We reaffirm our existing policy of reviewing the entire schedule of exemptions for prescriptions charges, which has not been fully updated since 1968 and contains many anomalies.

4.3.2 We will ensure that insurance policies for health, income-protection and travel, do not unfairly discriminate against people with mental health conditions. We would work with the insurance industry to ensure there is greater consistency and clarity in their policies, and fair questions are asked of applicants

4.4 Mental Health in Education

4.4.1 We would improve young people's mental health through a 'whole school' approach, following the example of Liberal Democrats running local government in Richmond, working through the South West London Health and Care Partnership. They have created mental health support teams that will work with schools, children and young people and their parents, with the aim of ensuring they are well equipped to have healthy and honest conversations about emotional wellbeing – and connecting them to local services. A whole school approach includes services such as online peer support for young people, mental health first aid training for teachers and courses to empower parents to talk to their children about emotional wellbeing. We reaffirm our commitments in Policy Paper 128 *Every Child Empowered* (2018), including investing in mental health counselling in schools and colleges, screening for trauma and neglect in early years settings and primary schools, and ensuring that teaching staff have the training to identify mental health issues.

4.4.2 We will support college and university students to stay mentally healthy, requiring universities to make mental health services

accessible to their students, and ensure the quality of those services, including:

a) Requiring universities to check that their students have access to a local primary care service, and that this service links to the student's 'home GP'. Rather than students switching between GP lists with the risk some fall through the cracks, or cannot access their GP during holiday time (if they register with a university practice and return home for holidays), we will establish a home/away network arrangement between practices. This should include provision of an out-of-hours telephone/video service.

b) Providing university students with information about local mental health resources, beyond crisis, and how to access them at the beginning of every term.

c) Requiring that all on-site counsellors be accredited.

d) Introducing a Mental Health Lead on University Boards – a designated senior lead on each student and university body, to ensure oversight and reporting of campus mental health services and use of those services.

e) Making available peer-training, so young people are able to spot symptoms in themselves and others, and provide appropriate support and signposting.

4.5 Boosting Mental Health Services

4.5.1 As part of our vision to give mental health the priority it deserves and end its status as a 'cinderella' service, we will:

a) Increase mental health staffing by 35,000 by 2023 and 70,000 by 2028, including 2,000 new psychiatrists by 2023 and 4,000 by 2028, and ensuring all GPs receive core mental health training.

b) Introduce further mental health maximum waiting time standards, starting with children's services, services for people with eating disorders, and bipolar conditions:

   i) Ensuring that 50% of children and young people with diagnosable conditions get NHS treatment by 2020, and 100% by 2025 (currently only 35% do).

   ii) Ensuring 7 in 10 adults get access to treatment by 2022, and setting an ambition that everyone who needs treatment receives it by 2025 (currently only 4 in 10 do).

c) Bring forward legislation to implement the recommendations of the Wessely review of the Mental Health Act, to modernise the law governing how mental health is legislated for. We will apply the principle of 'care not containment' to mental health, while ensuring an emergency bed is always available if needed.

d) Ensure equal access to talking therapies for older people and BAME patients by 2020.

e) Remove the rigid and arbitrary 25-year age boundary between children's and adults' care – and accepting that needs are variable.

f) Increase mental health services and facilities so that no one is forced to travel unreasonable distances away from home, with the risk they lose contact with their support networks. We would prioritise in the first year young people coming out of care, and set out and fund a plan to ensure that no one will have to travel out of area, for all but the most specialist mental health services.

g) Develop a scheme to reward employers who invest in the mental wellbeing of their employees, piloting reduced business rates for employers who support employees'

mental wellbeing and provide mental health first aid training to staff.

h) Improve awareness of eating disorders in the training of health professionals.

i) Remove barriers to integration and whole-system working: improving integration between mental health trusts, local authorities and hospitals, to promote a holistic approach to improving mental health services. We would work to make mental health services 24-hour, including mental health liaison teams in all hospitals.

j) Support public services to:

   i) Apply consistent standards to the monitoring of LGBT+ diversity characteristics of patients (using the Sexual Orientation Monitoring Information Standard), including gender identity, supported by training for staff, to identify inequalities in LGBT patient experience and outcomes, and develop targeted services and initiatives to address these.

   ii) Make LGBT-inclusive information and resources readily available for patients and service users.

5. Intensive Users of Services

5.1 Why do we care about this?

5.1.1 All of us hope for a long, healthy life, and more people today are living active lives into their sixties, seventies and beyond. However, our growing ageing population includes an increasing number of people living with more than one long-term condition.

5.1.2 Thanks to medical advances, people born with life-limiting conditions are fortunately living longer too. But the services they need around them, to provide a good quality of life, have become costlier and more complex.

5.1.3 Meeting these increasing needs demands service innovation and reform. It also requires sustainable funding, in place of the successive funding cuts that we have seen under Conservative-led governments. The risk of doing nothing, continuing as we are, is that services will not stay free, safe or sustainable. If we don't act in a joined-up way, progress in the NHS will be undermined by rising demands from the underfunded social care sector.

5.1.4 We see great potential for new digital technologies to help people and their carers manage their health better, and streamline how they receive care day-to-day. This should make it easier for individuals to focus on their quality of life, and free up care professionals to focus on care.

5.1.5 We believe that people should be able to lead the lives they choose, and have control over the support they need. We think government should make it safe and easy for people to share their personal health information with the team looking after them, to ensure care is better informed.

5.1.6 We believe that, with the support of their carers, families and friends, people can be experts in their own health and well-being. The things they do to remain independent and contribute to their communities should be celebrated, shared and supported.

5.1.7 As Liberal Democrats, we also believe there should be public accountability for how health and care resources are allocated, and that local communities need to be involved in making sure the most vulnerable in our society have the right to live a long, healthy life.

5.1.8 With more people living alone, we know that loneliness affects not just quality of life, but contributes to mental and physical ill health. We believe communities should be enabled to do more to reduce loneliness.

5.1.9 Caring for those with the greatest needs is the marker of a fair society in which everyone is valued. This is the society that Liberal Democrats want to help build, and support.

5.1.10 However, there remains a large gap in the life expectancy of people with learning disabilities, who are not getting the support they need to lead healthy, long lives. On average, women with learning disabilities die 20 years younger than women in the general population. We believe this inequality must be tackled, and that people with learning disabilities have an equal right to live a long, healthy life.

5.1.11 We recognise carers play a vital role in the health, well-being and quality of life of older people, people with learning difficulties, and those with life-limiting conditions. We believe carers must be properly supported and rewarded for their part in maintaining the fabric of society.

5.1.12 We believe government has a duty to create the conditions for sustainable health and care services, ensuring services are properly joined up, to minimise waste and improve the quality of care.

5.2 What's the problem?

5.2.1 The UK population is ageing rapidly, there will be:

- 51% more people aged 65 and over in England in 2030 compared to 2010.

- 101% more people aged 85 and over in England in 2030 compared to 2010.
- Over 50% more people with three or more long-term conditions in England by 2018 compared to 2008.
- Over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.

5.2.2 These developments will have a profound impact on a broad range of public services.

5.2.3 Researchers for the Lancet looked recently at elements of dependency including continence, cognition and self-reported activities of daily living in two cohorts of people aged over 65 – one cohort recruited in 1991 and the other in 2011. It found that men and women studied in 2011 were living, on average, an additional 2.4 and 3 years respectively with substantial care needs.

5.2.4 Currently, most support for dependent adults comes from informal family caregivers. Of six million people in the UK caring for an elderly relative, around two million are themselves aged over 65 and half a million are over 80. Many of these carers have their own health concerns that may be adversely affected by their caring role and few receive statutory help, despite government rhetoric about providing more support.

<u>The Price of Brexit:</u>

Brexit will make it more difficult, if not impossible, to find the necessary funds to give the NHS and social care the boost they need to meet the challenges of an ageing population. Most economists estimate that Brexit uncertainty has already costs between 1.5 and 2.5% of GDP since 2016. Government itself has estimated that Brexit could cost up to 9.3% of GDP over a 15-year period – more than the total NHS budget. A struggling economy will hurt these essential services, at the same time that many drugs and treatments that we export, will likely cost more and be harder to bring into the country.

5.2.5 3.6 million older people in the UK live alone, of whom over two million are aged 75+; 1.9 million older people often feel ignored or invisible; loneliness can be as harmful for our health as smoking 15 cigarettes a day.

5.2.6 Health and social care is too often fragmented, with services based on professional and institutional boundaries when it should be coordinated around the needs of the person. Our ageing population and the changing patterns of disease mean that growing numbers of people with multiple long-term conditions require services that are joined up. A number of policy initiatives in England over recent years have attempted to tackle this by promoting closer integration of health and care services. Despite this, integrated care remains the exception rather than the norm.

5.2.7 Accessing and navigating the different health and care services available from the many different local providers (GP, community pharmacy, community health trust, mental health trust, acute trust, local council) is challenging and confusing for most people. We believe access should be made more straightforward and thereby equitable to ensure everyone is able to access the joined-up care they need.

5.2.8 Community care poses another challenge. Around one in five older people who fracture their hip are transferred from the acute hospital to a community hospital for a period of further rehabilitation. Of people who were living independently beforehand, many move into residential care after a hip fracture. However, the historic and persistent divides between health and social care often prevent the effective coordination of rehabilitative care. These are compounded by cuts to community health and social care budgets that contribute to delays in transfers and long waits for community physiotherapy.

5.2.9 Public services – health, social care, benefits and housing – are not well integrated. Different budgets, cultures and performance frameworks point to inefficient use of resources, and a landscape that the people using these services find difficult to navigate.

5.2.10 We note the continued problem of under-funding of social care. Adult social care services face a £1.5 billion funding gap in 2019/20, and a £3.6 billion gap by 2024/25. This hampers progress being made in the NHS, because a lack of adequate, timely social care support leads to inappropriate (and costly) A&E attendance, or delays in discharge from hospital. This results in people who would far rather be supported in their own homes 'bed-blocking' in the NHS.

5.2.11 Cuts to local authorities' budgets have led to less support being provided to people living with disabilities and to older people who need support to live independently. The distinction between 'free' health services and paid-for social care is poorly understood by the public. They are often not then in an informed position when it comes to choosing a provider. There is wide variation across councils in the level and type of care services provided, which leads to a 'postcode lottery', depending on where you live.

5.2.12 Inequalities of outcome and experience are continuing: for example, treatable health conditions such as diabetes, obesity and poor dental care among adults with learning disabilities. On average, women with learning disabilities die 20 years younger than women in the general population. For men there is an average gap of 13 years.

5.3 Integration and Accountability

5.3.1 No one wants a major reorganisation. Nevertheless, it's important that we reduce the costs incurred through siloed procurement and commissioning. There are good examples of more joined-up working between the NHS and local government, for example in the Liberal Democrat-led London Borough of Sutton. We would speed up recent moves toward commissioning on the basis of the needs of the whole population, considering both health and social care needs. Integration is important to overcoming the silos between primary, community and tertiary services, and beyond these silos between local government and the NHS. Pooled budgets align incentives, and we will support and encourage them.

5.3.2 In the NHS the number of CCGs has been quietly decreasing, while a new model – the Integrated Care System (ICS) – is gaining favour over the Sustainability and Transformation Partnership (STP). The risk in these changes is further loss of democratic local accountability, as the public is understandably confused by the constant changes and new acronyms. We need to develop and increase oversight and public accountability. We believe that public services should be democratically accountable as locally as possible. To ensure there is always local accountability for commissioning decisions, we advocate the principle of local government leading on the commissioning of both health and care services, where these are currently commissioned by CCGs. Additionally we will:

a) Reform Health and Wellbeing Boards, to make them more accountable and effective.

b) Introduce a 'duty to cooperate', requiring the NHS, in particular Sustainability and Transformation Partnerships, to engage with Health and Wellbeing Boards to reshape and integrate health and care services that are genuinely locally agreed.

c) Make the Chief Officer of the Council the Chief Accountable Officer of each local system.

d) Make the commissioning functions of CCGs a responsibility of local county or unitary councils, alongside local government's other commissioning responsibilities for local public services.

5.4 The Funding Challenge

5.4.1 The social care funding crisis will undermine progress in the NHS if it is not addressed. We need to put social services on a sustainable footing. Under current plans, a £3.6 billion shortfall in social care funding is forecast by 2025. The result of this funding shortfall is that the best practice approaches set out in the Care Act, developed by

Liberal Democrats in government, have not been properly implemented.

5.4.2 Local government has been focused on how to meet their statutory duties within ever-shrinking budgets. For example, the important principle of involving beneficiaries in service development (co-developing services) is often sacrificed due to lack of resource. We would extend the number of Co-Production boards, as trialled in Oxfordshire, investing in a series of regional pilots to develop a best practice model for national adoption. We are committed to making up the shortfall in social care from the £6 billion raised by our 1p on income tax proposal.

5.4.3 Technology can be used to improve the quality of care we receive. For example full online records enable health and care professionals to see a patient's full medical history, recent assessments or test results. This is just as important in social care settings as it is in NHS settings. However, cash-strapped social care providers do not get equal support from government to invest in technology. Therefore, we propose a digital initiative for social care, equivalent to the NHS programme. For instance, NHS Digital's programme to provide Wifi in NHS hospitals should be replicated for social care settings. This brings efficiencies and improvements in quality, as staff can access patients' histories and past notes 'on the go', and so are able to spend more time supporting and helping those in their care.

5.4.4 Artificial Intelligence (AI) or machine-learning has exciting potential to improve the quality and efficiency of healthcare because of its capacity to analyse and spot patterns in data more efficiently than an individual clinician. The potential benefits of this include more accurate diagnosis and stratification of patients according to their profile, to enable personalised medicine. It is also being developed for use in triage of patients into their GP practice. Although healthcare professionals use a range of technology in their daily work, AI poses a unique ethical challenge when developers (or clinicians) say they do not understand how the decisions made by AI systems are made, or do not

agree with them. We must always have accountability, and there may be areas of health and care that AI is unsuitable for and should not be allowed to operate in. Liberal Democrats believe there must always be clear accountability for decision-making, and that a human being or organisation must always take responsibility for its actions. In response to the new ethical challenge posed by AI, we would establish a new ethics body, independent of industry, to consider these challenges and advise government to protect patients and the public interest.

5.5 Helping People Stay Independent

5.5.1 A key problem for people with care needs, is navigating the system to identify the support that is available. Particularly with the decline of Citizens Advice Bureaux, and reductions in core council staff, the case for early effective advice and navigation support has never been greater. This needs to incorporate the range of health and care (and ideally housing and benefits) services. For example, Kirklees Metropolitan District Council's 'Gateway to care', co-located with community health, is a multidisciplinary 'front door' which provides simple care packages for a rapid response, care navigation, assistive technology provision and safeguarding support. 'Care navigators', located in four community hubs, help to embed a strengths-based approach by building community capacity and supporting people to find solutions in those communities. The front door deals with the majority of contacts first time, with just six per cent going on to a full assessment. In 2017/18 almost half of those with eligible care needs achieved good outcomes through community support, saving the council over £1.9 million. We would encourage all areas to provide access to community-based 'care navigators', to help those with care needs identify support and relevant services.

5.5.2 Integrated multidisciplinary teams (MDT) and rapid response teams (RRT) based in the community would offer access to specialist recovery, rehabilitation and continuing support services. This is key to keeping people out of hospital, and involves input from a range of professionals (occupational health, physiotherapists, speech and

language therapists all come into play). Services such as stroke rehabilitation should be available to all patients across the country, ensured through population-based, strategic commissioning. Community teams should involve the voluntary sector more in connecting people with LTCs, helping them to navigate the wider system and understand their options. For example, the British Red Cross' involvement in a Reactive Emergency Community Team in Ipswich and Sussex is a good example of cross-sector, multi-disciplinary working, that could be more widely adopted.

5.5.3 Cost-effective interventions that support independent living and speed recovery should be guaranteed. For example, up to 4.3 million people across the UK with a mobility need could benefit from accessing a short-term mobility aid, such as a wheelchair. However, less than a quarter of NHS wheelchair providers currently loan short term wheelchairs. We would guarantee access to mobility aids that support independence, including a new statutory duty that every area should have provisions for short-term wheelchairs in line with long term wheelchair provision. We would increase support for people with a variety of multiple long-term conditions, with a focus on facilitating their rehabilitation and independence, extending personal budgets to support this.

5.5.4 British Red Cross research highlighted that loneliness isn't just experienced by older people, but affects people in key transitions, such as when they become a parent. Social prescribing to tackle loneliness or inactivity should be more widely available, so that health checks and conversations with professionals include discussions that pick up on isolation or loneliness. Social prescribing should undergo development, to include more activities that contribute to broader societal goals and cross generations (for instance gardening in community parks, involving older people in supporting new parents and linking up better with voluntary sector and community organisations). Self-referral into social prescribing schemes should be piloted, allowing more people access to these services without a visit to the GP.

5.5.5 The idea that all older people need help is a fallacy. Increasing numbers of people are retiring with decades of healthy life years ahead of them. The resources of this group are considerable. Many play key roles in community and voluntary groups, and care for family, neighbours or friends. We will develop a national strategy to involve more active older people in tackling loneliness and social isolation in their communities; working with the voluntary sector to find ways to better connect the 'active elders' with isolated older people in their communities (e.g through park walks, gardening groups and start-up grants for community groups like 'silver dancing' clubs that engage in outreach to isolated older people).

5.6 Learning Disabilities

5.6.1 The quality of care for people with learning disabilities deserves greater prioritisation than it currently receives. Too many people with disabilities spend too long confined in inpatient 'assessment and treatment centres', because community-based support for them to live independently is lacking. We need a more ambitious target for reducing the number of people with learning disabilities in assessment and treatment centres. We would bring forward the target date for a 50% reduction (benchmark of 2,300) in the number of people with learning disabilities in assessment and treatment centres, to 2021.

5.6.2 We will prioritise shortening the large and persistent gap between life expectancy of people with a learning disability and the rest of the population. We would extend the work of the Learning Disabilities Mortality Review Programme (LeDeR), underpinning this with a national target for the gap in life expectancy to be reduced by one year, every year. We would support charitable organisations that advocate for people with learning disabilities, helping them to better access the healthcare to which they are entitled.

5.6.3 Every person with a learning disability will have the right to a named advocate to help them navigate public services and access health, care and advice services. All health and care professionals will

be trained in learning disabilities, to make sure they understand the particular issues, know how to communicate effectively and involve people with learning disabilities and their families in decisions.

5.6.4 Respite and additional support for carers should be developed, to recognise the huge contribution carers make to our communities. We would introduce a statutory guarantee of regular respite breaks, and require councils to make regular contact with carers to offer support and signpost services. We will introduce a package of carer benefits such as free leisure centre access and self-referral to socially prescribed activities and courses (enabled through respite).

5.6.5 We will make better use of the highly skilled, but under-utilised pharmacy workforce, with a particular focus on community pharmacy. We will train independent community pharmacists to expand their role including prescribing, starting with those working in under-doctored areas and/or areas with severe health inequalities. We will develop Medicines Use Reviews, to better focus them so they have the greatest impact – for example focusing on people leaving hospitals with several long-term conditions. We will involve pharmacists in MDTs, supported by write-access to health records, with appropriate safeguards. We will develop the range of services that pharmacists can perform, for instance trialling health checks by pharmacists, supported by pharmacist training as needed.

6. NHS and Social Care Staff

6.1 Why do we care about this?

6.1.1 Health and social care staff are currently experiencing unprecedented pressures of increased workload, reduced pay and fewer resources to do their jobs well. This is having a devastating impact on the morale of the workforce, affecting both recruitment and retention of staff in critical roles.

6.1.2 The uncertainty over Brexit, and the failure of the current government adequately to reassure European nationals working in our health and care services, has made matters worse. Essential staff have returned to their home countries, others are considering leaving and the number of applications from European countries has plummeted.

6.1.3 We believe that it does not have to be this way. Liberal Democrats welcome staff from neighbouring European countries who want to come and work here, and we will protect and defend their rights. We believe it is morally unacceptable to poach doctors and other professionals from developing countries, where health systems are weak.

6.1.4 We believe that all health and social care staff, wherever they are from, should feel valued, and have the opportunity to enjoy and develop their career.

6.1.5 We believe that the primary and community care workforce needs radical attention, if it is to ensure its sustainability and viability moving into the future.

6.1.6 We believe more can be done to support the medical professions, particularly in local areas when it comes to medical indemnity and liability.

6.1.7 We believe we need a robust recruitment and retention strategy, to boost morale.

6.1.8 We believe that the social care workforce needs to be much better supported, to enable the development of careers, improve the retention of staff and improve overall care outcomes.

6.1.9 Government has a duty to help maintain and manage this large and complex workforce, so that staff develop and grow, adding value and quality to our public services. Government must improve its workforce planning. There needs to be innovation in the roles and responsibilities of different professionals, and the use of technology, so that we have the right kinds of staff in the right numbers, better matching the changing needs of our population.

6.2 What's the problem?

6.2.1 Overall, the healthcare workforce is growing; we now have over 40,000 more clinicians substantively employed than in 2012. However, some professions have seen a reduction in numbers, including District Nurses and GPs.

6.2.2 Social care staff, doing some of the hardest jobs in the system, remain some of the least well-paid individuals in the country. They are not employed by the NHS but by a variety of private and not for profit organisations; training, terms and conditions are highly variable, and rarely desirable.

6.2.3 NHS vacancy rates are at an all-time high; currently vacancies for nurses, midwives and allied health professionals are almost 42,000. 10%

The Price of Brexit:

63,000 EU nationals work in the NHS in England. One in ten NHS doctors and seven per cent of nurses are EU nationals, while seven per cent of social care workers are from the EU. There are 1,400 fewer midwives and nurses from EU countries working in the NHS since the referendum. The social care workforce includes around 90,000 EU nationals and could face a shortfall of as many as 70,000 workers by 2025/26 if net migration from the EU is halted after Brexit. Social care staff are typically less highly qualified and paid less than their NHS colleagues. With earnings in sterling, settling or remaining in the UK is becoming less attractive.

of mental health posts are vacant. In adult social care there is a vacancy rate of 8%, equivalent to around 110,000 vacancies at any given time.

6.2.4 High vacancy rates lead to staff being overworked and stressed, affecting their health and wellbeing. The shortages are then an important factor explaining why highly-trained professionals leave the public sector for the private sector, work abroad, retirement early or change career. Fatigue is a particular issue, leading to potential errors in decision-making, and affecting the mental and physical health of staff.

6.2.5 NHS retention rates have been dropping; the percentages of nurses leaving the NHS for other reasons than retirement have been increasing. Across all nurses, the most common reasons for leaving, apart from retirement, is dissatisfaction with working conditions, and an inability to deliver care of the right standard. Increasing numbers of junior doctors are deciding not to continue their training and are leaving the NHS.

6.2.6 The number of applications to train as a nurse or midwife have fallen dramatically since the Conservatives scrapped the nurse bursary in 2017.

6.2.7 The current GP, nursing and critical hospital specialties workforce is ageing. We face a 'retirement bubble' that will place the primary care system under even greater strain and add to the recruitment and retention crisis within primary care.

6.2.8 There is anecdotal evidence that Trusts are not adhering to the WHO Global Code of Practice on the International Recruitment of Health Personnel, and are recruiting staff from countries with weak healthcare systems. The recent NHS Long Term Plan advocates increasing recruitment of staff from overseas, which threatens to worsen the 'brain drain' of healthcare professionals from lower income countries.

6.2.9 These workforce issues are compounded by ever increasing pressures on the health and care system. For instance, primary care is

under unprecedented strain: nationally, demand for appointments has risen about 13% over the last five years; recently there has been a 95% growth in the consultation rate for people aged 85-89.

6.2.10 Costs of NHS litigation are increasing. We believe that anyone who is the victim of negligence should have a right to redress, but the current process for addressing claims needs improvement. It creates unintended consequences that are detrimental to improving medical practice, and too often fails to deliver satisfactory outcomes for patients.

6.2.11 Meanwhile care workers do not have the training, qualification and career progression that other caring professions enjoy. Alongside this is the lack of a recognised pay structure or union support, and no professional body. This lack of recognised professional status can leave carers demoralised, looking for alternative employment. The result is poor staff retention, which impacts further on the quality and training of new staff. There is wide variation in training; a care worker could be looking after a vulnerable person with complex needs within a few hours of receiving some basic training.

6.3 Workforce Strategy

6.3.1 Our workforce strategy will plug the gaps in both the NHS and social care and make it easier for nurses and care workers to move between the two reflecting the integrated nature of these services and the equal value the two bring to our society. Our workforce strategy will:

a) Create more training places to match future staffing needs, and make the training pathway into health and care services more attractive and accessible.

b) Improve working conditions in areas such as flexible working, and ensure staff across health and social care have a clear career pathway.

c) Attract and support talented professionals from countries with developed health systems that are ethical to recruit from, in line with WHO guidance. in particular we will look to attract staff back from EU member states, encouraging them to once again come and work in our public services.

d) Support improved mental wellbeing among NHS and care staff, through mental health first aid training in all health and care settings, and a dedicated mental health support service, giving confidential advice and support 24 hours a day.

6.3.2 After years of minimal funding and a lack of planning, we will prioritise the training and education of health and care staff through a stable financial settlement for Health Education England and Skills for Care. We will target extra help for nursing students, starting with bursaries for specialties where shortages are most acute such as mental health, linked to clinical placements in geographies that are under-staffed. Equally important is the retention of staff who are already trained. We would review urgently the perverse financial incentives that encourage medical professionals to work fewer hours, and ensure pensions schemes do not penalise staff for going part times towards the end of their careers.

6.4 Valuing Care Staff

6.4.1 Public attitudes towards social workers are less favourable than attitudes towards doctors and nurses. For too long staff working as carers for adults with learning disabilities or complex needs, with vulnerable children or older people with dementia, have been treated as 'second class' compared to NHS workers. We believe in 'parity for social care staff', and will support this through policies that put social care staff on an equal footing with NHS staff. We recognise that nursing work in the care sector often requires the same level of skills and training as nursing work in the health sector. To boost care staff morale and the attractiveness of a career in care, we would develop a workforce strategy to improve the quality and status of social care work. This will involve increasing training budgets for care staff, and

developing career pathways across public services, including supporting networks across the sector.

6.4.2 We will support the creation of a new Professional Body for Care Workers, to advocate for care workers. This would promote clear career pathways with ongoing training and development, and improved pay structures. We see an enhanced role for Skills for Care in developing these enhanced career paths for care workers. Addressing the gap in training budgets per head between social care and health care, we will review training budgets for social care staff, to ensure these are adequate.

6.4.3 To address poor care in some care homes, we will introduce a new requirement for professional regulation of all care home managers, who would also be required to have a relevant qualification. For care staff, we will set a target that 70% of care staff should have an NVQ level 2 or equivalent (currently levels are around 50%).

6.4.4 Commissioning of care services is variable in different parts of the country, so alongside our existing commitment to make up the shortfall in social care funding, we see a need to strengthen the oversight of local authority commissioning of social care. Additionally, we recognise the public benefit of care services that are provided by charitable organisations, as any profits are reinvested in the provider organisation rather than taken out of the business in the form of shareholder dividends. To support charitable providers, we propose giving charitable providers preference in the award of local authority contracts, by including in procurement the principle of 'where comparable, choose charitable' (where bids are broadly of a similar standard, favouring the charitable provider).

6.5 Work Life Balance

6.5.1 Poor work-life balance was cited as the top cause of job dissatisfaction (ranked above their pay) for doctors aged 18-45 and nurses under the age of 35. We want to improve access to flexible working for NHS and care staff. We will:

a) Require all NHS job adverts to make clear whether and in what ways a job can be done flexibly

b) Review Agenda for Change rules to ensure that seeking a part time role does not entail a banding downgrade.

c) Identify a board-level flexible working champion in every NHS and Care body, to lead and drive a culture change supporting flexible working

d) Scrap the requirement of 26 weeks of continuous service to qualify for the right to request flexible working – instead embedding flexible working from the outset.

6.5.2 We will adopt the lead employer model for junior doctors, to reduce the problems both they and employers face with short term contracts and aim to improve the accuracy of pay, avoid emergency tax code use and minimise costly repeats of statutory and mandatory training. This would also tackle current problems of some junior doctors not qualifying for shared parental leave because of short-term repeated contracts, which fuels the gender pay gap. This would bring the NHS in England into line with the other nations in the UK.

6.5.3 Rates of sickness absence and stress from overwork are high among NHS and care staff. We will ensure all health and care staff are trained in mental health first aid, so they can support colleagues and spot signs of stress and 'burn-out'.

6.6 Repairing the Damage of Brexit

6.6.1 To counter the negative impact of the Government's Brexit policy, we will fund an EU health and care staff recruitment campaign. This will encourage qualified doctors and nurses from EU member states to work in our health and care system, with the aim of attracting applications in the numbers we were seeing before the Brexit referendum. Liberal Democrats will continue to fight for a People's Vote, with an option to remain in the EU. We oppose the government's suggested annual salary threshold of £30,000 to restrict people from

other countries coming to work in Britain. Many care workers, nurses and junior doctors could fall below this. This threshold is particularly unsuited to the health and care sector, where financial reward is not a good proxy for skill level.

6.6.2 The lack of coordination of workforce planning and uncertainty for overseas staff has persisted for too long. Vacancy rates are undermining the NHS at every turn. Cancelled operations and delayed treatment are resulting in increasing costs in damage awards paid out by the NHS, besides the pain and anxiety experienced by patients enduring long waits. We will introduce a new statutory duty upon the Secretary of State for Health, making the SoS responsible for producing an annual workforce report and plan, that meets the changing, growing needs of the population.

Save the NHS and Social Care by Stopping Brexit

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This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 8.4 of the Federal Constitution.

Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom.

The Party in England, the Scottish Liberal Democrats, the Welsh Liberal Democrats and the Northern Ireland Local Party determine the policy of the Party on all other issues, except that any or all of them may confer this power upon the Federal Party in any specified area or areas.

The Party in England has chosen to pass up policymaking to the Federal level. If approved by Conference, this paper will therefore form the policy of the Federal Party on federal issues and the Party in England on English issues. In appropriate policy areas, Scottish, Welsh and Northern Ireland party policy would take precedence. Health and Social Care is an England-only competence.

Working Group on Health and Social Care

Note: Membership of the working group should not be taken to indicate that every member necessarily agrees with every statement of every proposal in this paper.

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Baroness Jolly

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Stephanie Bell (until May 2019)

Nicholas Bromley

Dr Peter Carter

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