

# Executive Summary

Our proposals are designed to ensure that the NHS is fair, empowering for patients, accountable, efficient and ready to meet the challenges of the 21<sup>st</sup> Century.

**Fairness:** Liberal Democrats believe that every person matters. The NHS must deliver high quality health services to all, irrespective of income. It must be fair. We propose:

- Introducing a 'Care Guarantee', entitling elderly people to a personal care payment based on need not the ability to pay and setting out the entitlements both of people in need of care and of their carers. For carers this would include freedom from discrimination, a statutory right for carers to be treated as partners in care, improved mechanisms to challenge unacceptable standards of care whether in a care home or provided as domiciliary care and access to information and advice.
- Appointing a Secretary of State for Public Health - in place of the current Secretary of State for Health - to make public health a priority across all government departments.
- Protecting the health of all children and ensuring healthy eating and regular exercise are learnt at an early age by investing in school nurses.
- Ensuring much fuller integration of the work of councils and Primary Care Trusts on public health initiatives under a jointly appointed local director of public health. This will allow health promotion and prevention to be fully integrated into local community plans.
- Reviewing of the basis on which the National Institute of Clinical Excellence (NICE) arrives at its judgements on the cost-effectiveness of treatments and holding regular reviews of the implementation of NICE technology appraisals to ensure trusts are fulfilling their legal responsibilities.
- Enshrining NICE's independence in statute so that there can be no risk of political interference in the objective assessment of any particular technologies and treatments.

**Empowering Patients to Improve Quality of Care:** Liberal Democrats believe in giving power to citizens to take control of their lives. This is as important in terms of health care as in any other sphere of life. We propose:

- Piloting a network of Patient Advocates dedicated to providing information, guidance and support to patients and carers in navigating the health and social care systems and in providing support in how best to use direct payments and individual budgets.
- Replacing Labour's national targets with a system of universal entitlements enshrined in a Patient's Contract between the NHS and the individual patient outlining minimum standards of access to primary (including dental treatment), secondary and tertiary care services.
- Establishing a Constitution for the NHS enshrining its core principles.
- Expanding the use of direct payments and individual budgets in the provision of social services and introducing the concept into specific areas within the NHS.
- Pilot publishing 'Patient Reported Outcome Measures' which measure real patient experiences and assesses whether the treatment has actually benefited their physical and mental health.
- Expanding and developing expert patient initiatives. Radically reducing the government's politically motivated and clinically distorting national targets.
- Ensuring the greatest possible choice and flexibility in the delivery of local health services by giving local health boards the power to develop innovative mechanisms for service delivery in defined areas of care.

**Local Democratic Accountability and Devolved Decision-making:** It is extraordinary that local communities have no effective say in how their health services are run. This has to change. We propose:

- Replacing centrally-appointed boards of PCTs with directly-elected boards, supported by professionals, and renaming Primary Care Trusts as Local Health Boards.
- Because we strongly believe that a national model should not override local innovation, the commissioning role could alternatively be passed to the local social services authority if local people indicated their support in a referendum.
- Establishing a new, light-touch regional body made up of representatives from Local Health Boards to take responsibility for planning tertiary services such as specialist medical units.
- Ending the central imposition of Independent Sector Treatment Centres and allowing Local Health Boards to decide how to finance capital projects, in particular whether or not to use PFI for capital projects.
- Enabling local Health Boards to negotiate adjustments to the tariff with local providers. In a decentralised system, there should not be an inflexible national tariff.
- Encouraging the development of 'Public Benefit Organisations'.

**Efficient Use of Public Resources in Delivering High Quality Services:** In delivering high quality health services it is incumbent on government to ensure the best achievable outcomes for patients, but also the most efficient use of tax payer's money. We propose:

- Placing a statutory duty on both Health Boards and Social Services Authorities to integrate health and social care, breaking down the current organisational divide, developing and commissioning joint services and establishing joint budgets.
- Creating an independent 'NHS Funding and Advisory Commission' to allocate funding independently to individual Local Health Boards and determine the needs-based funding formula on which the allocation would be based, within an overall framework of objectives and resources agreed by Parliament.
- Making Local Health Boards subject to a statutory duty to demonstrate efficient use of resources – value for money – and have regard to quality and equity.

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# 1. Introduction

- 1.0.1 Liberal Democrats have always had a strong, unswerving commitment to the National Health Service. Created in 1948, the NHS had its origins in the Social Insurance and Allied Services Report written six years earlier by the Liberal, William Beveridge. Despite the enormous challenges it has faced over the last half century the NHS still retains strong public support, and any government which fails to exercise effective stewardship of the NHS pays a heavy political price.
- 1.0.2 However, today we find ourselves in the remarkable situation that, despite record investment, doctors, nurses and other health professionals have lost confidence in the Government's handling of the NHS. So too have the public. If, as the NHS approaches its sixtieth birthday, we are to sustain it into the future we have to ensure that it is fit to meet the needs of today's patients effectively. The NHS has to be capable of adapting to new challenges presented by medical science and increasing life expectancy, as well as the rising expectations of patients.

## 1.1 The Conservative Record

- 1.1.1 The NHS suffered many years of chronic under-investment. In 1997, as the Conservatives left office, the UK spent 6.8% of GDP on health (public and private provision) compared with 9.1% for the rest of the EU. The cumulative impact of this neglect was there for all to see – and suffer. People often waited in pain for years for operations. There was a serious shortage of doctors, nurses and other health professionals. Not enough staff were being trained. The state of hospital buildings was also a disgrace. Critically, health outcomes were poor compared to other countries with similar levels of income per head of population. The Conservatives had been guilty of almost criminal neglect.

## 1.2 The Case for Extra Investment

- 1.2.1 The Liberal Democrats were at the forefront of arguing the case for boosting investment in the NHS. We supported the Government when it acted on Derek Wanless' recommendations and raised the percentage share of GDP spent on health to the European average. In the financial year 2007/8, spending on health stands at 9.4% of GDP. The UK has one of the highest levels of public spending on health in Europe.
- 1.2.2 Yet despite the dramatic increases of the last few years, we have seen large numbers of Primary Care Trusts and Hospital Trusts suffering significant deficits. Even after a year of cutbacks to bring the NHS as a whole back into balance, the cumulative deficit of those trusts in debt at the end of 2006/07 was approaching £1 billion. Many trusts have borrowed heavily to tide them over. No-one ever imagined that this would be the position when the extra resources started to flow. The issue now is clearly how the money is being spent rather than the overall level of spending. We need to use the available funding more efficiently so that better outcomes can be achieved. We should also avoid lurching from one extreme to another. After all the cutbacks of the last two years, it is bizarre that in this financial year the NHS is in surplus. We should, of course, never be complacent about the importance of maintaining adequate levels of funding. The UK must not be allowed to again fall behind the rest of the EU as it did under the last Conservative government.

## 1.3 Labour's Stewardship of the NHS

- 1.3.1 First, it is fair to say that the extra investment has resulted in some progress in the NHS since the dark days of the 1990s. Waiting lists have come down significantly. New hospitals and

health centres have been built and the NHS now employs thousands more doctors, nurses and other health professionals. However, so much more could have been achieved.

- 1.3.2 Labour's record overall can be characterised as inconsistent, confused and incompetent. Before taking office the Labour Party promised to abolish the internal market. Instead it has extended it. Labour created primary care groups, then abolished local health authorities and established 303 primary care trusts. Just 3 years later their number was reduced to 152. Community Health Councils were scrapped, with Patient and Public Involvement Forums taking their place. They only lasted three years. Now LINKs (Local Involvement Networks) are being established. Each change leads to a loss of morale amongst staff, enormous redundancy and early retirement costs and a destabilised service.
- 1.3.3 The NHS IT system is running behind schedule and billions of pounds over the original budget; the grossly mishandled doctors' contracts with costs running hundreds of millions of pounds over budget; the new centralised computer system for doctors' recruitment – MTAS was introduced without proper piloting which caused chaos. These are all examples of where the Government has rushed headlong into new projects and in the process has wasted money and pushed the NHS into disarray.
- 1.3.4 The Government has also so far failed to get to grips with the future challenges. The UK has an aging population yet the organisational divide between health and social care has made the delivery of integrated services and long term care much more challenging.
- 1.3.5 The use of PFI to fund a substantial building programme – with no capital planning or budgeting of the on-going costs – has resulted in the creation of a straitjacket of expensive, serviced accommodation for perhaps 30 years into the future. The Government's failure to negotiate break clauses into the early contracts was particularly incompetent. Yet the Government has proceeded with PFI at the very time when it is also telling us, rightly, that we have to be able to adapt the delivery of our health services to new demands.
- 1.3.6 The common thread in this catalogue of failures is central direction from Whitehall. This Labour Government has mistakenly sought to manage this vast organisation with a remarkable degree of central control which is, ultimately, unsustainable. The National Health Service is now the world's fourth largest employer after the Chinese People's Liberation Army, the Indian Railways and Wal-Mart. It employs over 1.33 million staff. In a frank assessment of the state of the NHS at the end of her tenure Patricia Hewitt admitted that the "NHS is four times the size of the Cuban economy and more centralised". The centre thinks it knows best and frequently fails to listen when local and regional concerns are raised. Consequently, when things go wrong, they go spectacularly wrong because the same wrong solution has been imposed across the whole country.
- 1.3.7 In the summer of 2007, the Government embarked on an exercise of listening to staff and patients in order to help shape future direction. This bid for strategic direction comes after 10 years of holding office. However, morale amongst staff is very low. A top priority has to be to rebuild trust and to get professional and support staff re-engaged.
- 1.3.8 The UK has also experienced growing health inequalities between the wealthiest and the poorest members of our society. Although these inequalities are largely caused by social and economic factors beyond the control of the NHS, weaknesses in the health service tend to have a disproportionate effect on the most disadvantaged of our communities. As a party committed to fairness, Liberal Democrats will not complacently accept growing health inequalities. Tackling them must be a top priority.

## 2.0 The Way Forward

- 2.0.1 What then are the principles which should guide Liberal Democrats in developing the right way forward for the NHS? We believe that there are four key principles – fairness, patient empowerment, local accountability and efficiency in delivering high quality health care.
- ***Fairness***  
Every person matters. The NHS must deliver high quality health services to all, irrespective of income. It must function on the basis of fairness: we cannot tolerate second rate services, and the most disadvantaged must not be excluded from high quality health care. But we recognise that the priorities in one geographical area may be different to those in another.
  - ***Empowering Patients to Improve Quality of Care***  
Liberal Democrats believe in giving power to citizens to take control of their lives. This is as important in terms of health care as in any other sphere of life. We cannot any longer justify a view of patients as passive recipients of care. Instinctively, we have a particular concern for those without power, those who are most vulnerable. The challenge is to ensure that everyone is valued, that everyone plays an active role in the decisions relating to their care. Citizens should know what entitlements they have from the NHS and should also be aware of their responsibilities.
  - ***Local Democratic Accountability and Devolved Decision-making***  
It is extraordinary that local communities have no effective say in how their health services are run. Primary Care Trusts, which are responsible for commissioning – or buying - health services, are accountable to Strategic Health Authorities, which, in turn, are accountable to the Secretary of State. This has to change.
  - ***Efficient Use of Public Resources in Delivering High Quality Services***  
In delivering high quality health services it is incumbent on government to ensure the best achievable outcomes for patients, but also the most efficient use of tax payer's money.
- 2.0.2 In applying all of these principles, it is important to reassert the case for engaging clinicians in the decision-making process at all levels. Clinicians have to be seen as key to improving care, not barriers that need to be overcome as the Government seems to believe.

## 3.0 Fairness

- 3.0.1 It is a shameful failure of public policy that we have actually experienced growing health inequalities under Labour. This must be challenged. The impact of these inequalities is stark; there are significant differences in life expectancy between better off communities and the most disadvantaged. For example, in East Dorset the life expectancy for men is just over 80 years but in Manchester it is less than 72 years, while infant mortality amongst the most affluent is just 2.9 infant deaths per thousand live births compared to 8.9 deaths at the bottom end of the income scale.
- 3.0.2 Access to services is also unequal. In 2004 there were 62.5 GPs per 100,000 of the population in the most affluent PCT areas compared with only 54.2 in the most impoverished despite those areas being most in need of these services. Ethnic minority communities may also suffer worse access to health services. Many of the root causes of health inequalities sit well beyond the scope of the NHS. However there is a direct link between health outcomes and access to services. Therefore policies relating to the NHS and its work with other Government departments can serve to significantly aggravate or alleviate health inequalities.

### 3.1 Funding of Personal Care

- 3.1.1 The 2006 Wanless review highlighted serious inequities within adult social care, revealing that there are half a million older people whose needs were not being met and that every year at least 50,000 older people have to sell their home in order to fund their long term care. Indeed a 2005 Health Select Committee report into NHS long term health care funding concluded that "some of our most vulnerable populations have been unjustly denied continuing care under the NHS resulting in suboptimal care and financial hardship". As it stands, older people needing care and support currently face a 'hit and miss lottery' thanks to tightening council budgets and variations around the country in where the health/social care divide lies.
- 3.1.2 There are also huge differences in the care that older people receive from social services, in part due to local eligibility criteria and their application and in part to local charging regimes. Over the last ten years the number of households receiving domiciliary care from local authorities has declined by 25% as eligibility criteria have been progressively tightened and charges have escalated. Liberal Democrats do not believe this is fair (although we do recognise that inadequate financial settlements from central government have placed many local authorities in an impossible budgetary position).
- 3.1.3 Liberal Democrats have argued for free personal care for the elderly and in partnership Government in Scotland have introduced it – a policy that has been fairer than the iniquitous means-tested system for care costs which still operates in England and Wales and is also popular. Indeed the Joseph Rowntree Foundation has concluded that Scotland's policy of providing free personal care for older people at home and in residential and nursing homes has created a fairer system without undue extra public spending; older people using care services and their families felt that the arrangements introduced in 2001 were more equitable and an improvement on the past, as did social care managers in Scottish local authorities and care home providers.
- 3.1.4 However, the same study also raised concerns about the sustainability of such a package and the limitations of the Scottish model, including arguing that elderly people in many parts of Scotland had experienced delays before receiving their care as local authorities struggle with competing demands on their resources; this can be distressing and disempowering for those

in urgent need of care and makes it difficult for them to plan for their future. The Scottish Executive has now commissioned Lord Sutherland to review its personal care system.

- 3.1.5 There is also evidence that care home fees increased following the introduction of the personal care payment. This, combined with the fact that the personal care payment has been frozen at the same rate throughout (£145 a week), means that, in reality, the payment has amounted to a contribution towards the cost of care home fees with families having to top up their care costs with their own savings. In Scotland in 2004 care home fees averaged at £427 per week (leaving £282 to pay by the individual). Even taking into account the £65 contribution to nursing costs for those who are eligible this means that the weekly cost to the individual in an average care home was £217 a week – more than half the cost.
- 3.1.6 Concern has also been expressed that because payments to those in care homes are capped, whilst payments to elderly people living at home are not, there is a perverse incentive for local authorities to encourage people to move into a care home, rather than staying at home.
- 3.1.7 In looking to the future we must learn all the positive lessons from these experiences in Scotland whilst also acknowledging the concerns. We should apply the following fundamental principles:
- Fairness in the allocation of funding and the way it is raised.
  - Sustainability – recognising that any system has to be workable with an aging population and with increasing numbers living with disabilities or long term conditions such as dementia.
  - Promoting dignity and independence. We should empower individuals to determine their care priorities and enable people to stay in their own homes if they wish to.
  - Securing the highest quality of care through the most efficient use of the available resources.
  - Providing an incentive for preventive forms of care.
  - Avoiding disincentives to save for older age and encouraging family and personal responsibility both in terms of providing informal care and in using private resources as a contribution to overall care costs.
- 3.1.8 First, it is important to be clear that more needs to be spent on social care. In the latest spending review, social care received a real terms increase of 1% compared to 4% for the NHS. Over the last decade these figures are 14% and 70% respectively. This is not sustainable.
- 3.1.9 Secondly, in order to achieve a sustainable and fairer solution, we believe that the funding of personal care must be a shared responsibility between the state and the individual. Neither central nor local government can provide for the full extent of care and residential costs that many elderly people face, but they should provide a basic level of care (according to assessed need) and then encourage individuals to top up with their own contributions.
- 3.1.10 Liberal Democrats would introduce a 'Care Guarantee', entitling elderly people to a personal care payment based on need not the ability to pay and setting out the entitlements both of people in need of care and of their carers. The Personal Care payment would be based on Derek Wanless' partnership model, which would guarantee older people payment to cover the great majority of care they need. Individuals could then 'top up' their care package by making private contributions which would be matched by the state – pound for pound – until the maximum benchmark is reached. People on low incomes would have the additional contributions made through the benefits system. The payment would vary according to assessed need.



- 3.1.11 By having a universal payment and slashing existing charges, this system would help many more people to take up care and improve the quality of their care relative to the current situation. Those who currently receive care free would continue to do so.
- 3.1.12 It is important that for those receiving a payment for domiciliary care, there should be as much flexibility as possible so as to meet the needs of the individual. For those who wish to receive support in the form of a direct payment, advice and guidance must be available in order to enable the individual and any informal carer to make an informed decision about how best to use the available funds - chapter 4.2 outlines our proposals for Patient Advocates.
- 3.1.13 There should be as much freedom as possible to enable the individual to determine their own priorities such as, for example, respite care, daily support or help with the garden or with shopping. However, for many elderly people, a direct payment may not be appropriate. The local authority should then be required to offer an individual budget of the available funds to give the person a full say, if they wish, in how that money is spent. Others may simply wish to receive local authority commissioned services. Even then, there should be full discussion about options before decisions are reached.
- 3.1.14 In order to ensure equitable access to services and fair treatment for carers the Care Guarantee will also set out carers' entitlements. This would include freedom from discrimination, a statutory right for carers to be treated as partners in care, improved mechanisms to challenge unacceptable standards of care whether in a care home or provided as domiciliary care and access to information and advice. We will also consult on the level of Carer's Allowance and on means of enhancing the employment rights of carers so as to help facilitate continued work.
- 3.1.15 In the longer term we will consider the viability of extending the coverage of the personal care payment to those under the age of 65 with long-term personal care needs.

## **3.2 Health Inequalities**

- 3.2.1 Tackling health inequalities is a major challenge for policy makers, particularly in the field of public health. We will be developing further proposals to focus attention on the big public health challenges, such as obesity, alcohol consumption and smoking in order to meet our commitment to reducing health inequalities. However, we also believe that there is much that can be done within the structure of government to promote and facilitate effective means of tackling health inequalities. We propose in this paper to establish an independent commissioning authority as part of a package of measures to decentralise the NHS radically by establishing local control through locally-elected Health Boards. As a consequence of these proposals the Secretary of State for Health would be liberated from the day to day interference with the operation of the NHS.
- 3.2.2 We would therefore replace the Secretary of State for Health with a Secretary of State for Public Health whose task would be to make public health a priority across all government departments. Despite the importance of tackling obesity, alcohol abuse and smoking – and the clear impact on tackling health inequalities - money for public health budgets has too often been drained away to plug deficits elsewhere. The task of the Secretary of State for Public Health would be to work with locally elected health boards and local authorities in order to ensure that public health and health inequalities are priorities.
- 3.2.3 Effective implementation of public health initiatives also depends on local engagement between a range of NHS and local government services. The Director of Public Health must always be a joint appointment between the NHS and local authorities. Health promotion and

prevention must be fully integrated into local community plans. Directors of Public Health would then be in a position to lead positive action in a number of areas including:

- Strategies that empower people to improve their lives.
- Community development to increase the capacity of local communities to resolve their own problems.
- Community initiatives which identify and address health challenges.
- Engagement with schools to ensure that health promotion is incorporated into the curriculum.
- Integrated transport policies that support increased physical activity and improve access to health care services.
- Regeneration initiatives that address deprivation and that measure impact on health.
- Use of development control powers to improve environments, including in housing and which promote sustainability.

3.2.4 Liberal Democrats also recognise that material deprivation and disadvantage are linked to health inequalities; factors such as poor housing, poor diet and other social and environmental factors are all associated with worse health outcomes and, to a greater extent, with low income and poverty. The 1998 Acheson Inquiry and the 2004 Wanless Report both called for action to address long-term material inequalities and their influence on health care.

3.2.5 We brought forward proposals in policy paper 80 Freedom from Poverty, Opportunity for All (2007) to reduce poverty and improve housing in order to tackle health inequalities. However, the path towards poor health outcomes and poor life style habits emerge early in life. Indeed the most significant public health challenge facing England today is the growing threat of obesity. A recent report found that obesity will cost £45 billion a year by 2050 if the epidemic is not brought under control. Yet the latest Government proposal to make a one-off payment of £190 to all expectant mothers smacks of little more than a gimmick.

3.2.6 To help secure the health of all children, particularly those in deprived areas, and to ensure healthy eating and regular exercise are encouraged at an early age, we believe the money the Government proposes to invest in this one-off payment should be invested in school nurses – whose numbers were massively depleted under the Conservatives – to visit schools on a regular basis providing health services and teaching children and parents about the merits of a healthy lifestyle.

### **3.3 Access to GP Services**

3.3.1 In order to redress inferior access to GPs in deprived communities, the Government has announced the creation of more GP practices serving those communities. However, the GP contract also discriminates against practices in deprived communities. This must be remedied. We propose abolishing the ‘minimum practice income guarantee’ payment to GP practices. This element of their funding is based on historic funding levels – which have tended to be lower in deprived areas. We also propose reform of the Quality and Outcomes Framework (QOF) incentive payment scheme for GP practices to address the absurdity that payments under the scheme have tended to be lower to practices in deprived areas.

### **3.4 From Incapacity Benefit to Work**

3.4.1 An area deserving of particular attention is the question of how to help those on Incapacity Benefit back to work. The 2006 Layard Report highlighted the extraordinary waste of human talent of the one million people with mental health problems stuck on incapacity benefits with little access to the psychological therapies which could massively improve their lives

and help them back into employment. The cost to the economy is significant; Lord Layard estimated that the total loss of output as a result of depression and chronic anxiety is some £12 billion a year – 1% of national income – yet people are still not getting the help they need.

- 3.4.2 NICE guidelines on therapies which should be offered to those suffering chronic anxiety and depression cannot be implemented due to a sheer lack of therapists; only one in four sufferers are receiving treatment of any kind. So whilst the economy is losing billions in lost output and the taxpayer is funding benefit payments, the Department of Health is failing to invest in training sufficient therapists to comply with NICE guidelines which would help people back to work.
- 3.4.3 We must break this ludicrous silo approach to Government.
- 3.4.4 The Government decision in October 2007 to commit £170 million to expanding psychological therapy services is welcome but long overdue. Furthermore, there is no guarantee that the extra funding will deliver the quality of service or the speedy access which is required; it needs to be matched with an entitlement to NICE approved therapies within a specified period for those who would clinically benefit. In policy paper 80 Freedom from Poverty, Opportunity for All (2007) the Liberal Democrats committed to implementing the recommendations of the Layard Report.
- 3.4.5 The same goes for investment in physiotherapists and other allied health professions. Half a million people on incapacity benefit have muscular/skeletal injuries and yet access is very patchy and many physiotherapists are unemployed upon graduation. Liberal Democrats would commit to cost-effective investment in physiotherapy services.
- 3.4.6 Liberal Democrats would also investigate mechanisms to encourage better joint working between Government departments. This could include the NHS receiving a payment from the Department of Work and Pensions if an individual is helped back to work through access to therapies. Employment support providers could also have the right to commission these services outside the NHS if the individual was experiencing unacceptable delays.

### **3.5 Access to Medicines**

- 3.5.1 NICE has come under criticism for focusing too much on the costs and benefits of treatments to the NHS, rather than to society as a whole. It has, for instance, been accused of failing to take into account the burden on carers of having to look after patients denied drug treatment, and of not fully taking into account the benefits of treatments for the economy or to the individual, if they are successful at enabling patients to return to work.
- 3.5.2 Liberal Democrats would order a review of the basis on which NICE arrives at its judgements on the cost-effectiveness of treatments, and aim to arrive at a new system assessing costs and benefits as widely and as objectively as possible.
- 3.5.3 We believe that access to medicines and treatments must be fair, unbiased and independently assessed. Currently the National Institute of Health and Clinical Excellence (NICE) plays a central role by assessing treatments and determining which should be available on evidence based and independent assessment. However, since NICE's inception, there has been a perception that NICE has been subject to political pressure.
- 3.5.4 We believe that while the framework in which NICE operates should be set by Parliament we must ensure that NICE cannot be placed under pressure over particular high profile cases. Consequently Liberal Democrats would enshrine NICE's independence in statute so that there can be no risk of political interference in the objective assessment of any particular

technologies and treatments. We also would require greater transparency on the part of NICE in the assessment process.

- 3.5.5 Recommendations made under NICE technology appraisals are in theory mandatory, with trusts having a legal responsibility to enforce them. But in practice, trusts often ignore their legal responsibilities, with obesity surgery, for instance, continuing to be denied to patients in many parts of the country. Part of the problem is that NICE has an insufficient budget to track the implementation of its guidance, while patients are often unaware of their legal entitlements.
- 3.5.6 Liberal Democrats would initiate regular and thorough reviews of the implementation of technology appraisals, and would publish information on which health trusts were failing to meet their legal responsibilities in order that trusts could be held democratically accountable for their decisions.
- 3.5.7 Liberal Democrats also acknowledge that implementing NICE guidance is already putting a growing strain on the budgets of Primary Care Trusts and hospitals. If trusts are to have the flexibility to spend money in ways that will benefit their local populations, it will not be feasible to impose more and more funding requirements on them from the centre. We will therefore look at ways of allowing technology appraisals not only to make mandatory, legally enforceable recommendations, in high priority areas, but also to make some non-mandatory recommendations. Trusts would be regularly assessed by the Healthcare Commission on their compliance.

## 4. Empowering the Patient

- 4.0.1 Individual empowerment is a fundamental Liberal Democrat principle and central to our vision for healthcare. We believe all citizens must be empowered to make the best decisions for their own health – therefore we cannot dismiss the concept of choice in health services. However, we also believe that choice is only one component of empowering patients. The Labour Government has claimed to champion ‘choice’ yet in reality their version of choice is largely confined to a choice of hospital.
- 4.0.2 Liberal Democrats also believe that patients should be truly empowered to make decisions about their health care by having the right to be involved in the decision about which specialist they are referred to and about the type of treatment they will get. These are decisions for the patient and the patient’s rights should not be constrained or restricted by the Government simply to meet waiting time targets.
- 4.0.3 We believe that choice does not have to lead to greater inequality; instead choice and empowerment can have a real impact on reducing inequity in access to services, therefore reducing inequalities of health outcomes. In order to empower patients to take control of their own health, Liberal Democrats recognise that choice must be coupled with information and advocacy to ensure that every citizen has the tools to make informed choices.
- 4.0.4 The London Patient Choice Project clearly demonstrated how providing choice reinforced by reliable and tailored information can empower disadvantaged communities and individuals. Patients were supported in choosing which hospital to attend by Patient Choice Advisers and given the option of free transport. However since the ‘choice agenda’ has been rolled out nationally patients have not been given the same personalised guidance in making decisions on their healthcare. An IPPR study concluded that, in these circumstances, ‘choice is likely to increase inequality’.

### 4.1 Information

- 4.1.1 In order to empower patients it is essential that reliable information is readily available in order to allow them to make rational decisions about their treatment and services. It is also vital in achieving better accountability and improving overall quality of care.
- 4.1.2 Developments in the type of assessments made by the Healthcare Commission, along with attempts to make this data more accessible (such as making regular reports available on the internet) have improved public access to information about their hospitals. Though a positive step, such information has limitations for a patient trying to work their way through the maze of services and all the different options about which they probably have little prior knowledge. More is needed to help the patient make a truly informed choice.
- 4.1.3 There is real scope for empowering patients – and guiding PCTs in their commissioning - by providing better quality information about hospital and GP care. Outcome data currently focuses on mortality and readmission but that excludes the vast majority of hospital admissions. We would pilot publishing ‘Patient Reported Outcome Measures’ (PROMs), which measure real patient experiences and assesses whether the treatment has actually benefited their physical and mental health. BUPA successfully developed the use of PROMs in measuring the quality of outcomes in their hospitals (prior to sale). For both organisations and patients this sort of information can be invaluable in driving up the quality of care and empowering patients. Patient reporting could also be a powerful force in the drive to improve patient safety in the NHS. Websites such as that run by ‘Patient Opinion’ where

patients can post comments about their care (good or bad), and trusts have the opportunity to respond, can also be very effective in giving patients a voice and in improving standards.

- 4.1.4 As well as information on standards in health care, there is scope for providing people with accessible information on value for money in the NHS. Programme Budgeting – first introduced in 2002 – maps PCT and SHA expenditure showing where NHS money is going and what patients are getting for the money invested. It allows patients to compare, on-line, expenditure on particular medical conditions such as mental health, cardio vascular disease and cancer in different areas and then compare health outcomes. We believe Programme Budgeting should be further developed and used across the country in order to give individual citizens the power to hold their local health board to account, and to give health boards themselves a vital tool in ensuring that they apply their resources to best effect.

### **4.2 Patient Advocates**

- 4.2.1 Despite information becoming much more readily available many patients are still left bewildered by the sheer complexity of the health and social care systems, by the divide between health and social care, by their entitlement to benefits as well as by how to choose a hospital. We also recognise that some patients face additional barriers to being able to access and effectively interpret the information they need, as for example being unable to access a computer or having language or literacy barriers.
- 4.2.2 Liberal Democrats understand that in order to ensure all patients are empowered to take control of their own health and well-being we must make proper support and guidance available to patients, particularly to the most vulnerable. With their increasing workloads and management responsibilities GPs do not always have the time to spend on guiding their patient beyond an immediate referral, neither are medical professionals always best placed to give guidance and support.
- 4.2.3 We propose piloting a network of Patient Advocates dedicated to providing information, guidance and support to patients and carers in navigating the health and social care systems and in providing support in how best to use direct payments and individual budgets.
- 4.2.4 We believe that Patient Advocates who are embedded within their local communities and able to develop long term relationships with patients and carers would provide vital pastoral support and guidance, and would be of particular benefit to those managing or caring for someone with a long term condition and the most vulnerable patients. It is vital to ensure that Patient Advocates are easily accessible and able to engage in outreach work within the community, consequently local health boards in partnership with local authorities are best placed to determine where this service is best located such as in pharmacies, local GP surgeries or voluntary sector locations. Patient Advocates would be independent and employed by or on behalf of the PCT, local health boards would have a responsibility to ensure proper provision but could choose to commission this service from the voluntary sector. Patient Advocates would be available for face to face consultation, and by both telephone and email to give patients maximum flexibility and support.

### **4.3 Patient Records**

- 4.3.1 In addition to information about health and social care services, patients are often lacking information about their own medical history. Only 28% of respondents in a 2004 survey said they could access their medical records – despite the fact that all patients have a statutory right of access to do so – but according to Picker Institute research nearly two thirds of patients would want to be able to access their records. We would ensure that all patients are given a copy of their medical records when they register with a doctor.

## **4.4 Self Management**

- 4.4.1 A recent study of five developed countries ranked the UK worst at involving patients in healthcare choices. The 2002 Wanless Report highlighted the absolute importance of developing self care particularly for those with long term chronic conditions. In fact the report estimated the cost of failing to involve patients in their own healthcare as potentially being as high as £30 billion a year by 2022.
- 4.4.2 Taking clear and positive action to empower patients to make decisions about their health and social care would both help people to take control of their own lives and improve productivity in the NHS. Liberal Democrats believe that the Labour Government's failure to do so is wholly unacceptable. We propose to further expand and develop expert patient initiatives as a cost effective way of facilitating enhanced self care. Regular medicine reviews undertaken by pharmacists should also be developed further. The use of direct payments and individual budgets can also be enormously empowering for those needing care. Those with long term conditions should be able to determine their own priorities in making use of the available resources as proposed in this paper.
- 4.4.3 People with long-term conditions should also be entitled to an agreed Personal Care Plan, setting out their course of treatment, where and when they will be treated, and what other help, such as social care, they will receive.

## **4.5 Patient Entitlements**

- 4.5.1 Establishing confidence in the NHS and providing patients and the public with information about its performance is of fundamental importance. However, the creation of so many central and often contradictory political targets, which strive to allow ministers to 'prove' that the NHS is getting better, in practise distort clinical and financial priorities, waste money, and increase central control.
- 4.5.2 Ensuring national standards in NHS service is still vital, but we believe that this can be better achieved by establishing universal entitlements to care rather than through centrally imposed targets. Liberal Democrats propose to replace Labour's national targets with a system of universal entitlements enshrined in a Patient's Contract between the NHS and the individual patient outlining minimum standards of access to primary (including dental treatment), secondary and tertiary care services. It would also set out patient responsibilities.

The Patient's Contract would cover areas as:

- Rights to accurate and relevant information.
- Rights to advocacy and the right to make their own decisions about their healthcare with advice and support of health professionals.
- Rights with regard to redress.
- Condition specific maximum waiting times (which would apply in mental health as well) – patients being entitled to the right to treatment in a private hospital or from a private clinician if they have not had their operation or treatment within a specified timescale. This is based on the Danish system.
- Access to treatments recommended by NICE and access to core services such as sexual health services, drug and alcohol treatment and services for those with chronic conditions as defined from time to time by Parliament.
- Access to GPs.
- Out of Hours Care standards.

- 4.5.3 National entitlements would only be set after consultation with Local Health Boards. However in a decentralised system they will provide important reassurance that decentralised accountability and responsibility will not lead to loss of entitlement. The entitlement setting process will be open, transparent and democratically accountable. Agreed standards at every level will be published and made available to NHS staff and patients. Staff will therefore know what commissioning authorities expect them to deliver to patients, and patients will know what they can expect to receive. Informed choices can then be made, through the democratic process, about the costs and benefits of additional funding to address local health priorities.
- 4.5.4 Universal entitlements to care within a set period would vary according to the condition being treated. Maximum waiting times would differ from national targets in that the onus would be on the local health boards to ensure that patients received their treatment on time, by commissioning services in the private sector. Pressure would be put on hospitals in terms of potential loss of treatment (and thus payment), but they would not be chasing national targets on a day to day basis as meeting waiting times would be the responsibility of the local health board. This would minimise the distortion of clinical priorities in hospital care. It would also place more power in the hands of patients.
- 4.5.5 We would also aim to work with clinicians and patient groups to introduce new frameworks starting with the conditions where there are currently wide variations in the standard of care based on local pockets of bad practice as for example in sexual health and palliative care, and seek to evaluate the overall health effects on the population before any such new frameworks are agreed. We would also undertake a review of existing National Services Frameworks and publish the estimated costs of their implementation.
- 4.5.6 Liberal Democrats also propose to establish a Constitution for the NHS, enshrining its core principles. We will develop specific proposals for such a constitution, including the development of a transparent relationship between the management of the NHS and ministers.



## 4.6 The Role of Direct Payments and Individual Budgets

- 4.6.1 Direct payments have been successfully empowering social services users for years. Allowing the individual and their family to decide for themselves how their individual budget is spent can have enormous benefits. There is clear evidence that they lead to greater user satisfaction, better continuity of care, fewer unmet needs and to a more cost effective use of limited public funds as the recipient of the direct payment has the greatest vested interest in ensuring that every penny is spent as wisely as possible. Crucially, the direct payment gives control to the user in determining their care priorities.
- 4.6.2 The development of individual budgets has also been very successful. If the individual does not want the responsibility of handling the funds (as with direct payments), then they can still play a central role in deciding how the available resources are spent. Individual budgets have been pioneered by a number of local authorities and Mencap. Even where the individual wants directly delivered services, they should always have the right to a central say in decisions about their care.
- 4.6.3 Liberal Democrats will build on the positive experience of direct payments and individual budgets in the provision of social services and introduce the concept into specific areas within the NHS. There should be pilots in a number of areas such as services for those with long term conditions, mental health services, continuing health care and services for people with learning disabilities. We believe that this would help to end the idea of patients as merely passive recipients of care, and could help bridge the artificial divide between health and social care as patients would be able to pick treatments from both sectors. Enabling patients to take a more active role in their treatment and care would certainly lead to greater innovation in the development of services and would also lead to greater transparency and efficiency in the use of limited NHS funds.
- 4.6.4 A crucial issue with both direct payments and individual budgets is the availability of advice and support in order to help the individual make informed choices. This is particularly important with older people and those who are most vulnerable. Our proposal for patient advocates is central to the success of direct payments and individual budgets in terms of empowering those who at present often have no power. It is also important that people with chronic conditions receiving direct payments do not find themselves isolated from the support networks they need. It is vital for long-term well-being, and for maximising the chances of recovery, that they should be linked, via patient advocates and expert patients to a supportive range of mutual networks, community volunteering groups, time banks and others.

## 4.7 Other Options for Service Delivery

- 4.7.1 Liberal Democrats are keen to ensure the greatest possible choice and flexibility in the delivery of local health services by giving local health boards the power to develop innovative mechanisms for service delivery in defined areas of care. Eye care may provide a model which can be used elsewhere. Those entitled to NHS support can obtain glasses up to a specified value, with the NHS paying the optician. This gives the individual choice of glasses to purchase within a price bracket– and a choice of which optician to go to.
- 4.7.2 The same principle could perhaps apply to other services such as the supply of digital hearing aids. At present, there is a substantial waiting list and in parts of the country delays can stretch over two years. So if you cannot afford to get your hearing aid privately, you are left waiting unacceptably long. Private providers have argued that they could provide and fit digital hearing aids at a lower cost than the NHS and without lengthy delay. They could offer the service on the high street, accessible for most people. Already, anyone with money can

opt out of the waiting list and access this service. It should not depend on your income in this way. A local health board could commission digital hearing aid services from a number of providers able to meet quality and price standards. It is right to acknowledge that there are concerns about the potential impact on the viability of NHS audiology departments and this would need to be fully considered by the Local Health Board.

## 5. Local Democratic Accountability

- 5.0.1 At present Primary Care Trust (PCT) boards are appointed by the national NHS Appointments Commission and are accountable to Strategic Health Authorities (SHA) not to local people. Indeed few people have any idea who is on the board of their local PCT. The SHA board is also appointed centrally. Consequently, the line of authority and accountability for health services runs straight up to the Secretary of State. The only local democratic voice in the system is provided through a range of interactions with the local authority, most notably the Overview and Scrutiny Committee of the local authority.
- 5.0.2 For Liberal Democrats this is not enough. We believe that overbearing control from the centre has to be challenged; it creates a dependency culture where local managers, health professionals and citizens are not encouraged to take responsibility for tough but necessary priority decisions because they can blame the Government. If we do not like what is happening in our local health services all we can do is complain to the Government.
- 5.0.3 Liberal Democrats believe the answer is to establish proper local democratic accountability and a genuine devolution of decision-making so that local priorities can be addressed. We would focus on the body responsible for the commissioning of health services – the Primary Care Trust. This is where local people should have a say over what health services are secured for their area and in ensuring that we get value for money from providers. The importance of commissioning has been badly neglected by this Government. Many people have no real idea what a 'Primary Care Trust' does and the name does not, in any event, accurately describe its function as a commissioning body.
- 5.0.4 Liberal Democrats would rename PCTs 'Local Health Boards'. The board would be directly elected and supported by professionals providing financial acumen and health expertise. This would introduce genuine accountability to the local community without organisational disruption. However, we also strongly believe that a national model should not override local innovation. Therefore, the commissioning role could alternatively be passed to the local social services authority if local people indicated their support in a referendum. Such a model would have the benefit of integrating health and social care without requiring any further local elections.
- 5.0.5 With decentralised power and accountability, it would no longer be appropriate to retain Strategic Health Authorities in their current form. Responsibility for planning tertiary services such as specialist medical units which cannot be provided in every area would move to a new light touch regional body made up of representation from local health boards. This board would also be responsible for staff training, education and workforce planning.
- 5.0.6 As part of a fundamental shift of power away from Whitehall to local communities over the long term, we would switch taxation which funds local services from national to local income tax. We would give locally elected health commissioners some freedom to vary local income tax to spend on local health services. The potential local variation in local NHS spending would not be allowed to reduce access to NHS core services guaranteed nationwide by the NHS Patient's Contract.

## 5.1 Establishing Local Flexibility

- 5.1.1 Hand in hand with local accountability Liberal Democrats want to ensure that locally elected health boards have maximum flexibility to secure the best health services for their community. Consequently we would end the central imposition of Independent Sector Treatment Centres. Engagement with the independent and voluntary sectors should be a matter for local decision-making. Likewise decisions about capital projects should be the responsibility of local decision makers.
- 5.1.2 We believe Local Health Boards should decide how to finance capital projects, in particular whether or not to use PFI for capital projects. The Labour Government's obsession with PFI and its use without proper budgeting has been very damaging to the finances of the NHS. Local Health Boards could alternatively issue Health Bonds to raise funds for capital projects, subject to local referenda. In the USA, decisions of this sort are put to local communities by way of a 'proposition' on the ballot paper at election time. The community would be asked whether they approved the issuing of a Health Bond to raise funds for a particular capital project such as the building of a new hospital or health centre. Bonds would be secured against assets.
- 5.1.3 Where PFI is used there must be much more transparency about the financial package and real flexibility built into new contracts in respect of support services – allowing the capacity to adapt those services to changing circumstances with periodic break clauses. There should also be the option of traditional NHS capital funding methods of financing projects.
- 5.1.4 Local decision-makers should in addition have the right to vary the national tariff under 'payment by results'. This system - which provides for money following the patient - is still in its infancy. It has the potential to reward efficiency and it does introduce a more transparent rules based system by paying trusts for the work they do. However, a centrally imposed national tariff has created distortions in funding. Although the tariff is adjusted by the Government through a system called the 'market forces factor', it is crude and inaccurate. The Local Health Board should be able to negotiate adjustments to the tariff with local providers. In a decentralised system, there should not be an inflexible national tariff.
- 5.1.5 Liberal Democrats are also keen to build on the contribution that the voluntary sector makes to health services. 'Public Benefit Organisations', for instance, have enormous potential to deliver locally led services (more detail on the mutual structure of Public Benefit Organisations can be found in policy paper 53 *Quality, Innovation, Choice*). Around the country there are examples of neglected cottage hospitals being taken over by charitable trusts led by local people. This generates a strong local commitment to secure a hospital's future and substantial sums are raised by the town for the benefit of their hospital.
- 5.1.6 We would encourage the development of such 'Public Benefit Organisations'. It is, of course, essential that any voluntary sector organisation contracting with the NHS must demonstrate robust finances and sound clinical and corporate governance arrangements.
- 5.1.7 Ultimately, in a decentralised NHS, decisions about the shape of local health services are for the locally-elected Health Board. They must decide how to develop their services to ensure they are responsive to local communities. The great advantage of greater local control is that it allows for more innovation. However, even within the current centrally controlled system, new models of health care have been slowly emerging.
- 5.1.8 In Cornwall and the Isles of Scilly, for example, the Primary Care Trust has produced a blueprint for developing health services for local communities. They did this after extensive consultation with patient groups and the general public. Their plans are based on offering

more healthcare closer to where patients live. It is a fascinating pilot which has wide application elsewhere – both in rural and urban areas. They make the point that they can achieve maximum value for money for local patients, they can tackle inequalities – travel costs are a significant burden for low income households – and they can reduce their carbon emissions and promote sustainability. This is enlightened policy-making.

## **5.2 Health and Social Care**

- 5.2.1 Whichever route toward local democratic accountability is taken, our aim must be to end the divide between health and social care, as is the case in Northern Ireland. Structural divisions mean too often costs are shunted from one organisation to the other with judgements sometimes made on the basis of budgetary considerations rather than what is in the best interests of the patient. There are also potential savings to be made from bringing health and social care together into one board or local authority with one administrative hierarchy rather than two.
- 5.2.2 From the patient's perspective, the need is for a seamless service. In some areas in England there are good working arrangements between the NHS and social services. For example, in Herefordshire the unitary authority is effectively merging its organisation with the PCT in order to fully integrate local services. We also note the development of 'Care Trusts' in some parts of the country. One example is North East Lincolnshire where social workers have transferred their employment to the Care Trust so as to integrate services with NHS staff. Public health staff have, at the same time, transferred to the local authority so as to integrate their work with housing, community development and so on.
- 5.2.3 We would place a statutory duty on both Health Boards and Social Services Authorities to develop and commission joint services and to establish joint budgets. We would leave it to be a local decision as to which route towards integration is chosen.

## 6. Efficient Use of Resources

- 6.0.1 Despite five years of huge growth in NHS spending – averaging 7 per cent a year in real terms since 2002/03 – there is a widely-held view amongst health economists that resources have not been utilised efficiently and that significant efficiency gains are achievable. This is of central interest to Liberal Democrats because every penny wasted is money that is not going into patient care.
- 6.0.2 Liberal Democrats recognise that effective commissioning is critical to securing improved efficiency from providers. Under the Liberal Democrats Local Health Boards would become accountable – and responsible - to the communities they serve which would help to ensure money was not wasted. National audit must also play a vital role in assessing the performance of local health services both financially and clinically. Local health boards would be subject to a statutory duty to demonstrate efficient use of resources – value for money – and have regard to equity and quality.

### 6.1 Independence from Politicians

- 6.1.1 The NHS is currently a closed, secretive part of central government. Ministers and their officials meet in private, as do the Chief Executive and his top team, and minutes of their meetings are not available for public inspection. Some groups have called for this to be countered by creating an NHS free from political interference.
- 6.1.2 Liberal Democrats believe that elected representatives, locally and nationally, should be ultimately responsible for the NHS and so would resist any reform which created a new centralised and unaccountable body micro-managing health service delivery. Yet we also recognise that in a far more decentralised system there is a need to reform national decision-making structures to make them transparent and accountable.
- 6.1.3 We would create an independent ‘NHS Funding and Advisory Commission’ which would operate at arm’s length from the Secretary of State and have a board appointed by the Independent Appointments Commission. The Commission would operate within a broad planning and financial framework, which would be agreed by Parliament and embodied in a publicly available annual memorandum. This memorandum would set out the overall objectives and priorities for the Commission, for example giving high priority to tackling health inequalities. The Commission would be charged with independently allocating funding to individual local health boards and determining the needs-based funding formula on which the allocation would be based. This would remove political interference from the allocation of central NHS funding without interfering in decisions on the shape of local NHS services. Also by meeting in public and publishing its minutes and reports, it would introduce a level of openness sorely lacking in the current system. In addition, reforming the remit of the Department of Health would allow it to be slimmed down substantially and focus primarily on public health, workforce planning and training. In a far more decentralised system there is also a need to provide guidance on best practice in commissioning which this Commission would work with NICE to provide.

## 7. Concluding Comments

- 7.0.1 Liberal Democrats strongly believe in the core principles of the NHS - the challenge for us is to ensure that the NHS is sustainable. The big increases in funding have come to an end for the moment; therefore we must ensure that we achieve maximum value for money in order to achieve the best possible health outcomes for every citizen. We also believe that this cannot be achieved by top down, command and control. Our objective must be to empower local communities, health professionals and managers to secure responsive, local and high quality health and social care. We must work towards ending the divide between health and social care so that seamless services are provided to patients. And perhaps most important of all, we must empower individuals to be fully engaged in their own health care, not passive recipients of what is handed down to them. They should be clear about the core entitlements that every citizen should have within a National Health Service that everyone in Britain can be proud of.

## Empowerment, Fairness and Quality in Health Care

*This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 5.4 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 policy-making 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.*

*Many of the policy papers published by the Liberal Democrats imply modifications to existing government public expenditure priorities. We recognise that it may not be possible to achieve all these proposals in the lifetime of one Parliament. We intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next general election.*

### **Working Group on Better Governance**

*Note: Membership of the Working Group should not be taken to indicate that every member necessarily agrees with every statement or every proposal in this Paper.*

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