Health and Social Care

Consultation Paper 139

Spring Conference 2019

Background

This consultation paper is presented as the first stage in the development of new Party policy in relation to health and social care. It does not represent agreed Party policy. It is designed to stimulate debate and discussion within the Party and outside; based on the response generated and on the deliberations of the working group a full policy paper on immigration, refugees and identity will be drawn up and presented to Conference for debate.

The paper has been drawn up by a working group appointed by the Federal Policy Committee and chaired by Tamora Langley. Members of the group are prepared to speak on the paper to outside bodies and to discussion meetings organised within the Party.

Comments on the paper, and requests for speakers, should be addressed to: Christian Moon, Policy Unit, Liberal Democrats, 8 - 10 Great George Street, London, SW1P 3AE. Email: policy.consultations@libdems.org.uk

Comments should reach us as soon as possible and no later than Sunday 31st March 2019.

Further copies of this paper can be found online at www.libdems.org.uk/policy_papers

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1. Introduction

Dear fellow member,

In November, our group published a Request for Evidence on the party website. You'll see in this paper, that we've outlined four key areas we would like to focus on. Health and Care is a huge policy area, so we're concentrating on NHS and Care Staff; Starting Well and Keeping Well; Intensive Users of Services; and, Mental Health.

Even these four areas cover a lot of ground. A further complexity is that to improve public health we need to work across government, because the largest drivers of health inequality are economic or environmental: poor housing, air pollution and unemployment.

In January, the NHS published the NHS Long Term Plan. Much in the plan makes sense: aiming to spend a larger share of the NHS budget in the community rather than in expensive hospitals; improving treatment of some of the common long-term conditions; and making more use of technology.

However, even the authors of the plan say that progress depends on social care 'doing its bit'. And we know local authorities have faced huge cuts and reduced social care even while demand is rising. Health leaders also point out that chronic staff shortages in the NHS, made worse by Brexit, mean there is not the workforce to deliver all the improvements needed. A further challenge is cuts to public health services, which stores up problems for the future.

So our proposals seek to address some of these omissions. If you have ideas in these areas, they would be especially welcome.

Already we have received evidence and ideas from dozens of health and care experts: charities, health and care providers, professional bodies, academics and think tanks. Many of our best ideas have come

from individual members, including members who've volunteered to participate in the working group. We will keep developing our thinking through the spring, and invite you to share your ideas at our consultation session at spring conference.

Best wishes,

Tamora Langley, Chair

2.   NHS and Social Care Staff

2.1   Why do we care about this?

2.1.1   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.

2.1.2   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.

2.1.3   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.

2.1.4   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.

2.1.5   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.

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

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

2.1.8   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.

2.1.9   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.

2.1.10   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.

2.2   What's the problem?

2.2.1   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.

2.2.2   Social care staff, doing some of the hardest jobs in the system, remain some of the least well-paid individuals in the country, with an average pay of £8.12 an hour. 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.

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

2.2.4   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.

2.2.5   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.

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

2.2.7   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.

2.2.8   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.

2.2.9   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.

2.2.10   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.

2.2.11   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.

2.3   Policy ideas on which we are seeking views

2.3.1   Developing a comprehensive workforce strategy that:

(a)   Creates more training places to match forecast needs, and makes the training pathway into health and care services more attractive and accessible.

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

(c)   Attracts and supports talented professionals from countries that it is ethical to recruit from, in particular from EU member states, encouraging them to once again come and work in our public services.

2.3.2   Prioritisation of public funding of training places and bursaries, and how we can ensure that workforce planning is long-term.

For instance, the Royal College of Physicians has called publicly for an increase in the number of medical school places, while the Royal College of Nursing has called for £1 billion investment in training and support for nursing. Our party currently backs reintroduction of the nursing bursary, which succeeded in supporting more nurses to study. We are seeking views on alternative or additional approaches: for example, 'forgivable loans' that are repaid by government in return for nursing services, potentially supplemented with a non-means-tested maintenance grant, targeted at nurses working in particular areas with staff shortages (such as community and mental health nursing). In particular, we need measures that will persuade nurses to work later, countering the trend of earlier retirement, including helpful changes to pensions that could help here.

2.3.3   Setting as a cross-cutting objective 'parity for social care staff'. The aim being to put social care staff on an equal footing with NHS staff, where the work they undertake requires an equivalent level of skill and training. 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. Public attitudes towards social workers are less favourable than attitudes towards doctors and nurses. To address this and boost 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 would likely involve increasing training budgets for care staff, and developing career pathways across public services, including supporting networks across the sector. We see an enhanced role for Skills for Care in developing enhanced career paths for care workers, and propose allocating equivalent training budgets (per head) for social care staff as those received by healthcare staff. The CQC would have an increased role in regulating care homes, for instance ensuring a new requirement for professional regulation of care home managers, who would also be required to have a relevant qualification. We would set a target for 70% of care staff to have an NVQ level 2 or equivalent (currently levels are around 50%).

2.3.4   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 seek views on 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).

2.3.5   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, so we are seeking members' views on improving flexible working for NHS staff. We would reduce the requirement for 26 weeks of continuous service to qualify for the right to request flexible working, instead embedding flexible working from the outset.

2.3.6   To counter the negative impact of the Government's Brexit policy, we are seeking views on funding an EU recruitment campaign. The aim of the campaign would be to encourage qualified doctors and nurses from EU member states, 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, to protect the rights of our current, and future, EU NHS and care staff, and their families. Bureaucratic restrictions such as visas and charges should be waived for NHS and social care workers.

2.3.7   We oppose the government's suggested annual salary threshold of £30,000 to restrict people from other countries coming to work in Britain, which many care workers, nurses and junior doctors could fall below, and note that this threshold is unsuited to the health

and care sector, where financial reward is not a good proxy for skill level.

2.3.8   We would 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.

2.3.9   If you would like to propose other policies for empowering NHS and care staff, we would like to hear from you.

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.

3.1.2   However, 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.

3.1.3   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.

3.1.4   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.

3.1.5   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.

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

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

3.2   What's the problem?

3.2.1   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 also 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 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. 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 support 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   Policy ideas on which we are seeking views

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. In the near-term we would 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.

3.3.2   In the medium term, we would 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.

3.3.3   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. We would enable local government further by introducing powers allowing councils to prevent fast food outlets or their 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.

3.3.4   We need to improve accountability in public health. Improvements in population health and reducing health inequalities can only be achieved sustainably in a place by organisations working together. Health and Wellbeing Boards must be the leading accountable body to deliver improvements in population health. They are best placed to understand their communities, and engage and collaborate with NHS partners, social care providers, the voluntary and community sector, and Local Health Watch, following the principles of openness and transparency. They are required to produce a health and wellbeing strategy, based on the local joint strategic needs assessment, which gives them the evidence for the priorities they set, following consultation with partners. The health and wellbeing strategy sets out the priorities for which local health and care commissioners are held to account for delivery by the Board. Part of the strategy is to identify the

workforce requirements within commissioning plans, and take steps to address gaps. Health and Wellbeing Boards are thus accountable for public health, and the social determinants of health, and can provide the leadership needed to make the most of contributions from the community and wider public services.

3.3.5   To support adults to live healthy active lives, we need to build more physical activity into our daily lives. We need also to support people to understand their own health indicators better, and support them to take action to mitigate any particular risks they may have, such as high blood pressure. To this end we would develop the 'Health Check' offered at 40 into a 'health programme' comprising appointments every five years with health advisers. We will give people ownership of their own health records, accessed through a user-friendly interface; health and activity data collected through health apps should be incorporated, turning medical records into health records. Better information would support more informed conversations with health advisers and medical professionals. We would also ensure they are equipped to make appropriate decisions and plan for later life.

3.3.6   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 should have targets supporting 'healthy work' – jobs designed to support employees' physical and mental health. Guidance on how to improve the design of jobs and workplaces should help employers understand how small changes can impact on staff health, and in turn improve productivity. For instance, flexible lunch hours that enable a lunchtime walk outside helps counter vitamin D deficiency and enables regular activity. Health and care employers, including the NHS, should lead by example here.

3.3.7   A new healthy eating policy: a guiding principle behind our healthy eating policy would be that cost of food and drink should better reflect the 'whole costs' of products (taking into account their costs to

our health and wellbeing). In reality, we do not choose food based on 'rational' factors like healthiness, cost or taste. We opt for food that's attractive, cheap and/or convenient. This means that food labelling alone, or informative 'public broadcast' style campaigns, can only have a limited impact.

3.3.8   We need to counter a range of factors that push us in the opposite direction from a healthy balanced diet. Evolution drives us to enjoy calorific and sweet foods. Also, some marketing and advertising strategies encourage us to choose unhealthy foods. We believe overcoming this then will entail extensive reshaping of the market. The policy would not be punitive for individuals, but would aim to make healthy choices easier, more desirable and more affordable. Based on the gap between our current diets and a healthy balanced diet, we need to increase our consumption of vegetables and fibre, and reduce our consumption of saturated fat, salt, alcohol and sugar. Our current ideas include:

> (a)   Increasing the soft drinks levy by 10p per litre for each band, expanding it to incorporate juice and milk-based drinks that contain added sugar. We would use the proceeds to extend the free fruit and veg schools programme beyond infants, to run through the whole of primary and secondary schooling, and to fund the 'wellbeing hour' in schools (see below).

> (b)   Consulting on expanding the soft drinks levy to a wider sugar tax, covering foods.

> (c)   Revising labelling to make sugar content clearer, for example representing sugar content visually in pictures showing the equivalent number of sugar cubes.

> (d)   Increasing the number of public drinking fountains, so free drinking water is available across the country's cities and towns. We will introduce a 'free tea' scheme in parks and

commons, to support local walking groups and year-round outdoor exercise.

(e)   Restricting 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 should not be (HFSS) products. In smaller retailers we would consult on the idea that 50% of products within five metres of the point of sale should not be HFSS.

(f)   Working 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 restricting alcohol promotions; both in-store and online.

(h)   Encouraging healthier eating in the food service (out of home/restaurant) sector, including mandatory food labelling on restaurant and takeaway menus. We would work with the restaurant sector to ensure every meal served out of home includes at least one portion of vegetables.

3.3.9   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. Our current ideas include:

(a)   Promoting healthy eating through the curriculum, teaching primary school children to prepare and shop for healthy food as part of the national curriculum, involving parents through after school cookery clubs.

(b)   Introducing 'veg in pregnancy' vouchers, to ensure pregnant women increase their intake of vegetables.

(c)   Giving all families access to 'eating in pregnancy' and 'healthy weaning and childhood nutrition' classes through maternity services.

3.3.10   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.

3.3.11   We would improve children's understanding of balanced diets, their cooking skills and levels of physical activity by introducing a new 'wellbeing hour' in schools. This would give universal access to a 'wellbeing hour' at the end of every academic school day, consisting of physical activity (sports, dance, etc.), food science/cooking and strategies to improve psychological wellbeing, such as mindfulness. This would be delivered by support staff, not teaching staff.

3.3.12   We need to 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. We think this is short-termist, and delays identification of potentially vulnerable children. We favour a preventative approach to supporting early years. We would put early help services on a statutory footing, preventing further closures of children's centres, and supporting community-based

services for the most vulnerable children. We support better coordination between the NHS, local authorities and schools, including more flexible funding arrangements. Over time we expect this new way of working to create efficiencies, these efficiencies should be redirected into early help services to increase the overall funding envelope.

3.3.13   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.

3.3.14   Currently, even when children are assessed as needing support, they often do not get it. There are 2,060 children in 2018 who have education, health and care plans (EHCs) setting out their needs, but who receive no support at all. This problem requires concerted effort from a range of public services. We will ensure the health service does its part, by putting the Health and Care elements of the Education Health and Care plan on a statutory footing. Parents report that their children's special needs are often not assessed until they are excluded from school. We will introduce a maximum referral to assessment time of eight weeks for assessment of any child referred by their GP or teacher for a special needs assessment.

3.3.15   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.

3.3.16   Working in partnership with Trans communities, we will review the design of medical systems and records to make sure that the binary recording of gender does not lead to trans people being put at risk - for example, by them being excluded from sex-specific screening or checks that they might benefit from.

3.3.17   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 providing drug testing at festivals and clubs.

3.3.18   Excessive consumption of alcohol has a direct cost to the NHS of £3.5billion 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 (based on experience from Scotland expected later this year), improve labelling requirements of units and include health harm messages, while ensuring universal access to addiction treatment.

3.3.19   If you would like to propose other policies for starting well and keeping well, we would like to hear from you.

4.   Intensive Users of Services

4.1   Why do we care about this?

4.1.1   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.

4.1.2   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.

4.1.3   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.

4.1.4   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.

4.1.5   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.

4.1.6   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.

4.1.7   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.

4.1.8   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.

4.1.9   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.

4.1.10   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.

4.1.11   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.

4.1.12   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.

4.2 What's the problem?

4.2.1   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.

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

4.2.2   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.

4.2.3   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.

4.2.4   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.

4.2.5   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.

4.2.6   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.

4.2.7   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.

4.2.8   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.

4.2.9   We note the continued problem of under-funding of social care. Adult social care services face a £1.5 billion funding gap by 2019/20, and a £3.5 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.

4.2.10   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.

4.2.11   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.

4.3   Policy ideas on which we are seeking views

4.3.1   How to improve commissioning, aiming to reduce the costs incurred through siloed procurement and commissioning, and move increasingly 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 should be encouraged. In the NHS the number of CCGs has been quietly decreasing, while a new model – the Integrated Care System – is gaining favour. The risk in these changes is a loss of democratic local accountability. Given the continued existence of Health and Wellbeing

Boards, and Sustainability and Transformation Partnerships, and the lack of appetite for new structures, we need to develop and increase oversight of the emerging new structures. 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. We believe that public services should be democratically accountable as locally as possible. Currently health services sit outside the group of most local public services which are run or commissioned by councils, the uniquely locally democratically accountable bodies. In particular we wish to consult on:

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

> (b)   Introducing 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)   Our suggestion that the Chief Officer of the Council should be the Chief Accountable Officer of each local system.

> (d)   Whether the commissioning functions on CCGs should become a responsibility of local county or unitary councils, alongside local government's other commissioning responsibilities for local public services.

> (e)   How to ensure accountability when budgets are pooled.

4.3.2   We note that the social care funding crisis will undermine progress in the NHS if it is not addressed. We need to give social services a sustainable funding basis. Under current plans, a £3.65 billion shortfall in social care funding is forecast by 2025. In this context, it is unsurprising that best practice approaches set out in the Care Act, developed by Liberal Democrats in government, have not been fully implemented. 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 still valid, but is not always followed. 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.

4.3.3   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 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.

4.3.4   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, and it 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 6 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.

4.3.5   Integrated multidisciplinary teams (MDT) and rapid response teams (RRT) based in the community can offer access to specialist recovery, rehabilitation and continuing support services. This helps keep people out of hospital, and involves the input of a range of professionals to address a range of needs (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 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 – a good example of cross-sector, multi-disciplinary working, that could be more widely adopted.

4.3.6   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 invite views on other unmet needs, and how to guarantee access to mobility aids that support independence, including whether a new statutory duty is desirable, e.g. every area should have provisions for short term wheelchairs in line with long term wheelchair provision. We would increase support for people with a range of multiple long-term conditions, with a focus on supporting their rehabilitation and independence. We are interested in views as to whether personal budgets could be extended to support this.

4.3.7   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 to 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). We are interested in allowing self-referral into social prescribing schemes, exercise and weight management programmes.

4.3.8   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, and many play key roles in the leadership of community and voluntary groups. The NHS and local government should develop a strategy to involve this group in addressing loneliness and social isolation; working with the voluntary sector to find ways to better connect them with isolated older people in the community (e.g through help with shopping, park walks and companionship).

4.3.9   The quality of care for people with learning disabilities deserves greater prioritisation than it currently receives. 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.

4.3.10   Addressing 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 1 year, each year. We would support those who advocate for people with learning disabilities so they can better access the healthcare to which they are entitled.

4.3.11   Every person with a learning disability would 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.

4.3.12   Respite and additional support for carers should be developed (statutory guarantee of respite, monthly outreach from NHS to check any additional support needed, free leisure centre access to keep them healthy).

4.3.13   Making better use of the highly skilled, but under-utilised pharmacy workforce, with a particular focus on community pharmacy. Public funding to train independent community pharmacists to prescribe (those working in under-doctored areas and/or areas with severe health inequalities). Developing MURs, to better target them where they can have the greatest impact, for instance on people leaving hospitals with several long-term conditions. Involving pharmacists in MDTs, supported by write-access to health records with appropriate safeguards. Developing the range of services that pharmacists can perform, for instance trialling health checks with the pharmacist, considering the need for training as relevant.

4.3.14   If you would like to propose other policies for Intensive Users of Services, we would like to hear from you.

5.   Mental Health

5.1   Why do we care about this?

5.1.1   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.

5.1.2   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.

5.1.3   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.

5.1.4   In government, we legislated to give mental and physical health equality under the law. We introduced the first 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.

5.1.5   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.

5.1.6   We believe that early, effective interventions are critical to preserving good mental health.

5.1.7   Preventing poor mental health is key to preventing mental and physical suffering and distress, and averting wider social consequences and costs.

5.1.8   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.

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

5.2   What's the problem?

5.2.1   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.

5.2.2   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.

5.2.3   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.

5.2.4   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.

5.2.5   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.

5.2.6   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.

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

5.2.8   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.

5.2.9   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.

5.2.10   Young lesbian or bi women, and young gay or bi men are groups particularly prone to eating disorders.

5.2.11   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.

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

5.2.13   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.

5.2.14   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.

5.3   Policy ideas on which we are seeking views

5.3.1   Making 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. Many of the conditions that currently receive free prescriptions were placed on the list in the 1960s, when asylums were commonplace and before modern medications were available to treat conditions in the community. Many of those most in need of free prescriptions experience extra barriers due to their mental health in accessing support with payments or prepay certificates. Forcing patients to skimp on their medication leads to costly preventable, and sometimes involuntary, admissions, a false economy that could be prevented by expanding the provision of prescriptions to those with enduring mental illnesses.

5.3.2   Ensuring that insurance policies for health, income-protection and travel, do not unfairly discriminate against those with mental health problems. We would work with the insurance industry to ensure there is greater consistency and clarity in their policies and the questions they ask those who sign up with their services.

5.3.3   Doing more to support college and university students to stay mentally healthy and access services, including:

> (a)   Improving the visibility of students in the 'university' setting, and ensuring appropriate priority is given to those residents, despite the fact they are not resident in that location all year round.

> (b)   Providing university students with information about local mental health resources, beyond crisis, and how to access them at the beginning of every term, moving beyond the purely academic view of the role that universities play.

> (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.

5.3.4   Increasing 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.

5.3.5   Introducing waiting time standards for all mental health services, in particular children's services, and services for people with eating disorders, and bipolar conditions.

5.3.6   Making more hospital beds available to ensure patients don't wait for more than 24 hours in A&E, and reduce waiting times for services where standards already exist:

(a)   Ensuring that 50% of children and young people with diagnosable conditions get NHS treatment by 2020, and 100% by 2025.

(b)   Ensuring 7 in 10 people get access to treatment by 2022, and with the aspiration that everyone who needs treatment receives it by 2025.

5.3.7   Ensuring equal access to talking therapies for older people and BAME patients by 2020.

5.3.8   Removing the rigid and arbitrary 25-year age boundary between children's and adult's care – and accept that needs are variable.

5.3.9   Increasing facilities so that no children or young people are forced to travel unreasonable distances away from their homes, with a special priority for young people coming out of care; and introducing a bursary scheme so that close friends or family can visit young people who are being treated out of area, helping maintain their support networks.

5.3.10   Developing a model for rewarding employers who invest in the mental wellbeing of their employees. For example, piloting reduced business rates for employers who support employees' mental wellbeing.

5.3.11   Introducing 24-hour services including mental health liaison teams in all hospitals and ensure that physical and mental health care is fully integrated.

5.3.12   Removing 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.

5.3.13   If you would like to propose other policies for mental health, we would like to hear from you.

6.   Post-script: on funding

6.1   Changes in lifestyles, the availability of new treatments and increasing longevity all combine to drive up the costs of health and social care more quickly than the general rise in prices across the economy. Historically the NHS budget has grown at about 4% in real terms, however in recent years it has received much less than this.

6.2   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, even to maintain services at current levels. Meanwhile, there is continuing strong public support for a publicly-funded NHS, and as a party we too are wholly committed to this.

6.3   So Liberal Democrats have committed to match this latest increase for the NHS. Additionally, we would raise a penny on the pound in income tax for the NHS and Social Care, generating over £6 billion a year. This would lift the average growth rate above inflation to 4%. Our party has also committed previously to restoring student nursing bursaries, additional to the 1p in the £.

6.4   We have already committed to reversing cuts to public health budgets, funded from within the £6 billion. We have also ear-marked funds for improvements in mental health services – an area where Liberal Democrats have long led the fight for parity of esteem.

6.5   In the longer term, we recognise that both the NHS and social care need to be put on a sustainable financial footing. Our party has previously committed to establishing a cross-party commission to set a realistic long-term funding settlement for the NHS and social care, and to introducing a dedicated Health and Social Care tax. However, neither of these things could be implemented immediately. In the meantime, a large deficit remains, particularly in local authorities' social care budgets.

6.5   Some proposals in this paper would be self-funding. For instance, this paper includes a suggestion for raising more taxes (through taxing unhealthy foods) to fund free sports and cookery classes in schools. Other proposals (such as restoring early help to families), will need to be funded. As we progress our proposals, we will work with our Treasury team to further identify the costs and implications of these suggestions.

6.6   If you have ideas on ways we could either save money elsewhere, or raise more revenue to boost health and care spending in the short to medium term, then please do share suggestions on this.