

# *Healthy Communities, Healthy People*

Health Policy Paper

Policy Paper 68





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# Summary

Liberal Democrats believe that health is more than just health services and choice is more than just where an operation is carried out.

People want to be able to live healthy lives, and if they need health services for these to be of high quality, close to home and responsive to them as individuals. This is in complete contrast to the Labour policy of choice for the few and the Tory plans of choice for the wealthy.

This health policy paper deals with the main areas that effect health and people's freedom to have control over their health. These main areas are:

- Tackling the causes of ill health - enabling all to have a choice.
- Enabling people to have real control over their own health.
- Freeing professionals and the NHS to support healthy choices and deliver quality services.

## **Tackling the causes of ill health**

- We will ensure that wherever possible national legislation maximises health through health impact assessment of legislation.
- We will tackle fuel poverty by strengthening home insulation programmes.
- We will create a healthier environment through improving air quality and reducing the use of harmful chemicals.
- We will give local communities an enhanced role in delivering healthcare and mutual support by strengthening the voluntary sector and by promoting community projects.
- We will enhance access to healthy food, for example through voluntary initiatives like school breakfast clubs, and through planning development so that communities have access to a wide range of food shops.
- We will recognise the importance of education in improving health by ensuring that the curriculum includes information on healthy living.

## **Enabling people to have real control over their own health**

- We will give individuals feedback on their current health status and advice on healthier choices through a targeted health MOT, which would guarantee every person access to appropriate health-screening tests.
- We will restore free eye and dental checks.
- We will provide clear information to support healthier choices, for example by ensuring there is simple 'traffic light' food labelling warning.
- We will provide more information on treatment options by developing systems for collecting and publishing information on treatment outcomes.

- We will expand the choice of treatment options to include Complementary and Alternative Medical therapies where clinically appropriate.
- We will improve the management of chronic diseases like diabetes, for example by supporting people to take control over their own treatment.
- We will increase the availability of healthy choices, for example by encouraging schools to open their leisure facilities to the wider community.

### **Helping professionals support healthy choices**

- We will remove central targets which interfere with clinicians' ability to do their best for individuals.
- We will drive up standards by giving a voice back to local people through making commissioning of health and social care a function of the Local Authority.
- We will make the NHS more of a health service, not a sickness service, enabling better decision-making through stronger advice on public health issues.
- We will cut out waste in the NHS by, for example, reducing Hospital Acquired Infections like MRSA through a package of measures, including strengthening the powers of infection control teams and stricter protocols on hospital hygiene.
- We will focus the Department of Health on making strategic decisions to improve the health of the nation.
- We will guarantee honest, long term funding of the NHS by earmarking National Insurance as the NHS Contribution.

*Federal/State Applicability Note: Most aspects of health policy are devolved and the great majority of the proposals in this policy paper relating to NHS services therefore apply to England only. Some of the wider policies on tackling the causes of ill health in Chapter 2 would however apply across the UK.*

# Introduction

## 1.1 Liberty, equity and accountability in health

1.1.1 In a liberal society people have responsibility for their own health; people have a right of self-determination over their body. That does not mean the State has no interest in securing the health of the nation. The role of Government is to remove the barriers and create the opportunities for people to make healthy choices to lead as healthy a life as possible. Government also has a responsibility to act when the actions of individuals or private interests harm the health and limit the liberties of others in society.

1.1.2 We have known for over 30 years the main causes of preventable disease and death: poverty, poor diet, lack of exercise, poor housing, and smoking. The NHS deals with the consequences of ill-health. It is not so good at tackling the causes. The NHS is part of the solution but if prevention is better than cure then we need to construct a health system fit for the task.

1.1.3 Health policy-makers have paid lip service to this while concentrating on building up NHS capacity to treat an ever-growing number of sick people. The cost of putting cure ahead of prevention is huge. By 2022 it has been estimated that unless people become more engaged with their own health the NHS will cost an extra £30 billion a year to run. Tackling the causes of ill health is essential to sustaining the NHS.

1.1.4 Liberal Democrats have a deep commitment to the NHS. The core values of the NHS are as relevant today as ever. A service based on a person's needs not on their means, a service free at the point of delivery regardless of age, sex or race. A common good funded by progressive taxation.

1.1.5 The NHS has successes every minute of every day, lives saved, and lives changed. The dedication and deep knowledge of the staff, doctors, nurses and managers is one of the greatest assets the NHS possesses. It is an asset no Government should neglect. Yet the current Government's addiction to political target setting sends a powerful signal that Ministers distrust

frontline NHS staff. The culture of targets and tick boxes, which has become the hallmark of Labour, stifles innovation and undermines the ability of staff to use their own judgement.

1.1.6 This paper sets out the case for an NHS free at the point of delivery with staff free to deliver the right service, at the right time, in the right place. We set out how we will deliver a more equitable and accountable health service. That means getting Whitehall off the backs of NHS staff and it means bringing healthcare closer to home. As long as the NHS remains accountable to a Secretary of State in Whitehall it will always have national must do's crowding out the needs of local people. That is why we want to make the NHS accountable locally, by giving local government the responsibility for commissioning healthcare. Local accountability is an essential reform of the NHS, but it is not sufficient to meet the health challenges facing this country over the next 50 years.

1.1.7 Investment in the NHS has concentrated on elective and critical care, diagnostic and curative services have taken the lion's share of resources since the inception of the service in 1948. Those with long-term medical conditions for which there is no cure have lost out. The success of the NHS has meant that more people than ever are living with rather than dying from a disease. This paper argues for a shift in the centre of gravity in the NHS, out of the acute hospital into the community, identifying health needs earlier and meeting them, developing a sustained relationship with people with long term medical conditions and care needs.

1.1.8 Liberal Democrats believe that people should exercise the maximum possible control over the decisions that affect their lives. We want people to have a far greater say about their health and how health and care are delivered. Health is not a commodity that the NHS can make - it is the result of a collaborative endeavour between individuals and society.

# Tackling the Causes of Ill Health

Liberal Democrats will tackle the root causes of ill health, not just the consequences. It is far more effective to prevent people from becoming ill in the first place whenever possible. Our key proposals include:

- We will ensure that wherever possible national legislation maximises health through health impact assessment of legislation.
- We will tackle fuel poverty by strengthening home insulation programmes.
- We will create a healthier environment through improving air quality and reducing the use of harmful chemicals.
- We will give local communities an enhanced role in delivering healthcare and mutual support by strengthening the voluntary sector and by promoting community projects.
- We will enhance access to healthy food, for example through voluntary initiatives like school breakfast clubs, and through planning development so that communities have access to a wide range of food shops.
- We will recognise the importance of education in improving health by ensuring that the curriculum includes information on healthy living.

## 2.1 Introduction

2.1.1 We have known the key determinants of ill health for decades. In the late 1970s Sir Douglas Black - following in the footsteps of Sir William Beveridge - reported to the UK Government on health inequalities. He argued that many of the causes of ill health and health inequality were the result of social and economic factors outside the scope of the NHS. Increases in life expectancy over the last century are more the result of better diets and improved sanitation than advances in medical treatments. Under Conservative Governments during the 1980s the Black Report gathered dust. The Conservatives were unwilling to fund the upfront costs of tackling health inequality. People were left to their own fate. Action to tackle the causes of ill health was stalled for almost two decades. When Labour took office in 1997 it commissioned Sir Donald Acheson to repeat the work of Sir Douglas Black. A year after the Acheson report a White Paper was published. It was vague on action, weak on deliverables: as a result implementation was patchy. It was not until the Wanless report, *Securing the Future of Health*, that public health again registered on the government's radar. This time the cost of doing nothing was put in stark

terms. By 2022 doing nothing will add £30 billion to the cost of healthcare.

2.1.2 The more recent Wanless report *Securing Good Health for the Whole Population* pointed out that whilst there is a lack of a complete evidence base for public health policies, this should not become an obstacle to taking action in the public health arena. One of the reasons public health has remained a low priority in Government is the long timescales involved in realising improvements in the health of the nation. Wanless also identified an absence of a clear overall responsibility for public health issues within government, and serious gaps such as the failure to replace the Health Education Authority (abolished in 2001). In addition to endorsing Wanless's key concerns about formal government structures, Liberal Democrats stress the importance of informal community support in preventing illness in the first place and in promoting recovery when people fall ill, with formal government structures being directed to advise, inform and support community actions with professional and technical expertise.



## 2.2 Health and public policy

2.2.1 Public policy has a wide-ranging influence on many factors affecting health. In 1983, the World Health Organisation (WHO) set out making public policy more health - orientated as a major priority in health improvement. We would therefore ensure that Health Impact Assessments are done on new legislation and the budget wherever possible. These should in particular focus on the impact of policies on health inequality and groups with special health needs.

## 2.3 Health and the environment

2.3.1 Liberal Democrats recognise that there are a wide range of environmental factors which can impact on health. These principally fall into three categories: housing, air quality, and chemical pollution.

2.3.2 Cold, damp housing results in around 25,000 excess winter deaths, and contributes to poor health generally. Liberal Democrat policies on home energy efficiency are set out in detail in policy paper 58 *Conserving the Future* (2003). Key Liberal Democrat policies to tackle this include improving targetting and increasing the budget for the Warm Front programme which pays for home insulation (funded by cutting nuclear power subsidies), increasing the Energy Efficiency Commitment which obliges utility companies to invest in energy saving, cutting VAT on energy saving materials, and allowing pensioners' Winter Fuel Bonus to be taken in form of an energy saving materials package at a slightly higher retail value than the cash payment.

2.3.3 There is considerable concern that air pollution arising from traffic, factories, homes and offices, and agricultural practices may still be injuring the health of a significant percentage of the population. It has been estimated that 24,000 people die every year prematurely as a result of air pollution. Many of the principal air pollutants come from traffic. These include nitrogen dioxide, particulates (PM10), and carbon monoxide - all of which can be detrimental to health. Sulphur dioxide is added both by diesel vehicles and power stations. There are also volatile organic carbons (VOCs), which arise from traffic and the use of products containing organic solvents. Liberal Democrat policies to reduce traffic congestion and pollution are set out

in policy paper 41 *A Strategy for Sustainability* (2000) and policy paper 46 *Transport for People* (2001). Our key proposals include incentives for cleaner fuels, promotion of public transport options as well as walking and cycling, allowing congestion charging to be introduced at local discretion, and increased local monitoring of air quality.

2.3.4 Recent research highlighted in the WWF report *Compromising our Children* (2004) has shown the extent of health problems caused by exposure to a range of man made chemicals: for example, brominated flame retardant chemicals that may be found in videos, TVs, computers, soft furnishings, car seats, and furniture; PCBs which can arise from old industrial transformers, and some building materials; and dioxins, emitted by power stations and some factories, and open burning of some plastic wastes. Particularly worrying is the effect some of these chemicals can have on the neurological development of children. The EU is currently negotiating a new directive on Registration, Evaluation, and Authorisation of Chemicals (REACH); Liberal Democrats will argue for strong action to end the use of toxic chemicals where alternatives already exist, and strictly limit the use of dangerous chemicals where there is no viable alternative and the application is necessary.

## 2.4 Empowering local communities

2.4.1 It is central to Liberal Democrat thinking that people should be able to exercise the maximum possible control over the decisions that affect their lives. This philosophy finds expression in our commitment to a 'bottom-up' approach to decision-making and the delivery of neighbourhood-level services and the involvement of voluntary groups. We have already set out how this approach informs our thinking in social care in policy paper 60 *Promoting Independence, Protecting Individuals* (2003). Recent research has also demonstrated that a supportive local community plays a critical role in detecting problems early, in promoting good mental health, and in helping people to recover from illness. Neighbours can often provide the kind of friendly support that professionals are unable to. The formal voluntary sector, and the more informal links between local people, can provide advice, telephone support, can check up on people after they have come out of hospital, or carry out small repairs at home that

can make an enormous difference to people's recovery, or the ability of older people to stay active in their own homes. Lack of a social network of contacts has been shown to be a risk factor for heart disease, and therefore almost certainly for a plethora of other diseases. Neighbourhoods with a strong community ethic are also likely to suffer less from crime, with knock-on benefits for health through reducing social stress and substance abuse which are contributory factors to many forms of illness, and in particular mental health problems.

2.4.2 Research also shows that finding there is a useful role you can play to support local people can often be vital to staying healthy or recovering from depression. Volunteer programmes, self-help groups for arthritis, diabetes or asthma, or mutual support for neighbours through time banks, have all been tested with great success in doctors' surgeries and other health institutions. For example, the Rushey Green Group Practice in South London is able to give prescriptions to patients for friendly visits, small repairs or other forms of social support by running a time bank on the premises. Patients who are time bank participants visit the surgery less and, especially in the case of long-term depression, rely less on drugs. Such initiatives need to be better supported and rolled out through the NHS. We will therefore broaden these partnerships between health professionals, patients and their neighbours, so that they play a key role in the promotion of public health.

2.4.3 Liberal Democrat policies to help foster and support strong communities include strengthening and reforming local government generally, including a power of general competence, reinforcing the ability of Local Authorities to facilitate community action. In particular, we seek to encourage volunteering and community action through the development of initiatives like 'time banks'. More details of our policies for strengthening communities can be found in policy paper 37 *Engaging Communities*, and policy paper 45, *Local Economies, Local Choice*. In particular we will:

- Remove Whitehall targets that undermine new methods of working alongside patients.
- Provide training for health professionals to use their patients as assets in their own and other people's recovery.

- Require all health institutions to put in place strategies to involve patients as partners in the delivery of healthcare.

## 2.5 Poverty and unemployment

2.5.1 Poverty and unemployment have been linked to poor health due to factors such as poor diet, worse environments in poorer areas, inadequate housing, and stress. Mental ill health can be triggered by such life stresses. The 1998 Acheson Report on Health Inequality found that even after taking account of the higher prevalence of health risks such as smoking among poorer groups, poor people still have worse overall health than the population at large. This could be attributed to people's sense of powerlessness to control their own lives. Liberal Democrat policies to tackle these problems include reforming the New Deal with more targeted action for those with greatest difficulties finding a job, extra support for Early Years Centres which will have major health promotion role, and will close educational attainment gaps between social groups, promoting Credit Unions/Community Banking to reduce dependence on loan sharks, enhancing the state pension, and replacing Council Tax with Local Income Tax which would reduce the burden of tax on low income groups. More details on our policies for addressing poverty can be found in policy paper 43 *An Inclusive Society* (2000), policy paper 45, *Local Economies, Local Choice* (2001) and policy paper 62 *Fair Foundations* (March 2004).

## 2.6 Obesity: lack of exercise, poor diet

2.6.1 Obesity is linked to a wide range of serious illnesses, including heart disease, type 2 diabetes, and breast and colon cancer. Rates of obesity are rising, with nearly a quarter of the adult population now clinically obese. Increases in obesity among children are particularly alarming. The Health Select Committee has reported that obesity may soon overtake smoking as the number one preventable cause of disease and death in this country. Currently some 30,000 people die each year from obesity related diseases.

2.6.2 Obesity results from a combination of lack of exercise and inappropriate diet. Falling exercise levels arise from an increase in sedentary occupations, the expansion of car ownership and

use of cars for relatively short journeys, long working hours, and lack of facilities for exercise. Safety fears about traffic and crime mean parents are less willing to allow children to walk or play unsupervised. Policies to encourage walking and cycling are set out in the last Liberal Democrat Transport policy paper *Transport for People* (2001). More details on Sport policy can be found in policy paper 66, *Personal Best*, to be debated at the September 2004 party conference. Key Liberal Democrat policies to tackle these problems include a National Programme of Home Zones for residential areas, and Quiet Lanes in rural areas, which will make it easier to walk or cycle, allocation of road space to cycle lanes, two mandatory hours per week of exercise/sport within the Minimum Curriculum Entitlement, and focusing government sport funding primarily on participative activities which improve health. Crucially, we need a long term strategy to ensure that in planning the development of our communities opportunities for walking, cycling and use of public transport are built in at the design stage.

2.6.3 Poor diet is a key determinant of bad health and one of the main factors underlying the rise in obesity. Consumption of processed foods which have a high energy density, that is a high number of calories to weight, which are high in fat, sugar or salt, and low intake of fresh fruit and vegetables, is frequently linked to the difficulty for many people in accessing good food. This in turn is linked to a food retailing industry which relies on standardised product, national marketing, and high number of out of town stores inaccessible by public transport. Liberal Democrat policies to tackle these problems include a range of measures particularly focusing on communities, schools and food standards.

2.6.4 In communities, we would:

- Ensure that community plans in general, and regeneration projects in particular, have a food policy that takes account of the needs of all sections of the population.
- Support community healthy eating projects, such as the Gorbals Time Bank in Glasgow which runs a fresh food delivery service.
- Encourage local authorities to be proactive in ensuring that where allotments and community gardens exist, resident growers'

opinions form an active part of the community plan, and where there are none provision can be made for them.

- Support schemes to promote the local growing and marketing of food, such as local accreditation schemes to give people the choice of purchasing products produced in their local area, farmers' markets and other local marketing initiatives, and local farmers' co-operatives for marketing, distribution and other economic efficiencies.

2.6.5 In schools, we would:

- Develop 'health literacy' programmes in schools including the teaching of diet/food preparation in the Minimum Curriculum Entitlement to ensure that at 16 a young person has a thorough knowledge of basic cooking skills and a knowledge of what makes for a healthy diet.
- Require schools to develop nutrition policies governing the use of vending machines in schools, with the involvement of students in the process.
- Set and monitor compliance with national nutritional standards for all school meals including restrictions on energy dense products such as crisps and fizzy drinks.
- Investigate the viability of a 'positive pricing' policy, where healthier school meals are cheaper, subsidised by a premium on less healthy meals.
- Ensure that all free school meal vouchers have sufficient value to enable children to eat a balanced and healthy lunchtime meal, consisting of two courses and a drink.

- Encourage provision of cooled water rather than sugary drinks in schools.
- Facilitate school breakfast clubs run by local community groups.

2.6.6 To improve food standards we would:

- Require the Food Standards Agency (FSA) to develop, in consultation with the food industry, standards for the responsible marketing of food and drink to children with

nutritional criteria that such products should meet.

- Require the FSA and Ofcom to develop a policy on restricting advertising of unhealthy foods during children's television programmes.
- Establish a Healthy Eating Fund to be supported by voluntary contributions from the food processing industry. Companies would be asked to contribute to the fund a percentage of their spending on advertising of food high in sugar, salt and fat, on a basis to be agreed with the FSA. The Fund could be used to support public information initiatives on healthy eating and projects to improve the availability of healthy foods.
- Require the FSA to draw up targets for the reformulation of processed foods to reduce energy density and the levels of fat and sugar. Adopting a voluntary approach modelled on the salt reduction plans but signalling a willingness to use regulation if progress is not sufficient.

## **2.7 Drug abuse (including alcohol and tobacco)**

2.7.1 Smoking, excessive alcohol consumption and use of illegal drugs cause a great deal of ill health. Smoking alone is responsible for 120,000 preventable deaths a year. The costs to the NHS of treating alcohol dependence are up to £1.7 billion per year, and according to a MORI poll only 7% of men and 22% of women know what the government recommended maximum levels of alcohol consumption are. Liberal Democrat Policies on illegal drugs are set out in detail in policy paper 47 *Honesty, Realism, Responsibility* (2002). Liberal Democrat policies to reduce ill health caused by alcohol and tobacco use include strengthening controls on smuggling of drink and tobacco and trafficking of narcotics by creating a new Border Control Force; introducing Nicotine and Tobacco Product Regulation (to parallel regulation of medicines by Medicines and Healthcare Products Regulatory Agency), as happens in the USA; banning smoking in enclosed public places and workplaces; promoting strong health messages on the health risks and addictiveness of tobacco, especially aimed at children; reducing the drink driving limit from 80 to 50 millilitres of alcohol; clearer

labelling of alcohol products based on units of alcohol, linked to a major public information initiative to publicise the recommended intake limits; reviewing existing guidance on alcohol advertising and promotion; and improving training of health care workers, particular in the primary sector, in identifying and tackling alcohol dependence problems.

## **2.8 Mental health**

2.8.1 While the causes of mental illness remain controversial, there is increasing evidence for a variety of social and environmental factors which contribute to its onset or cause deterioration of existing problems. Policies which would help prevent mental health problems include:

- Promoting social support networks through community initiatives like time banks.
- Increasing opportunities for physical exercise, which promotes good mental health.
- Tackling the housing problems which contribute to stress and affect mental health.
- A more constructive approach to drugs policy with the emphasis on education, treatment for addiction and harm reduction strategies rather than criminal sanctions.
- Positive mental health promotion, especially in schools.

## **2.9 Sexual health**

2.9.1 Sexual health is a major area of concern. Britain has a higher rate of teenage pregnancy than any other developed nation except the USA. Rates of syphilis and gonorrhoea have increased sharply in the last five years, while one in ten sexually active young women is estimated to be infected with chlamydia (a leading cause of infertility). Liberal Democrat policies to address these problems include:

- Developing a National Service Framework for Sexual Health Promotion, Screening and Treatment Services.
- Improving access to sexual health and GUM clinics, the services they provide and the premises in which they are provided.

- Improving services for people with HIV/AIDS including the development of self care programmes (see 3.8).
- Targeting of sexual health messages in media for key groups: i) teenagers and ii) the 'newly single' in their 30s and 40s.
- Delivering appropriate sex education to all children from Key Stage 2 with the aim of promoting personal sexual responsibility, substantially reducing teenage pregnancies and problems with Sexually Transmitted Infections (STIs).
- Accelerating roll out of the national chlamydia screening programme, and piloting screening for groups outside the existing range (women under 25).
- Higher priority for contraceptive services, including advice on the full range of contraceptive options to be available in all GP surgeries; free condoms in GP surgeries and other sexual health service providers; and improved access to emergency contraception, including in a pharmacy setting.

## **2.10 Health and the workplace**

2.10.1 Business has an interest in preventing ill health. In 2002, 33 million days were lost through ill health. Sickness absence cost the UK economy £11.8 billion in 2002. Employers have the responsibility to provide a safe, secure and health-promoting environment, and the opportunity to promote and encourage their employees to live healthy lives. In order to encourage employers to develop good health promotion and occupational health practice within their organisations we will develop an Investors in Health (IIH) standard modelled on the Investors in People accreditation scheme. An organisation that achieved Investors in Health would provide a healthy environment in which to work, provide information about healthy habits of diet, exercise, and sleep and support and advice. IIH would be self-funding just as IIP is. Like IIP this would not require extra form filling or bureaucracy.

# ***Enabling People to Have Real Control Over Their Health***

Liberal Democrats will give people greater control over their own health and a greater say over how they are treated when they need the support of the NHS. Our key proposals are:

- We will give individuals feedback on their current health status and advice on healthier choices through a targeted health MOT, which would guarantee every person access to appropriate health-screening tests.
- We will restore free eye and dental checks.
- We will provide clear information to support healthier choices, for example by ensuring there is simple traffic light food labelling warning.
- We will provide more information on treatment options by developing systems for collecting and publishing information on treatment outcomes.
- We will expand the choice of treatment options to include complementary and alternative medical therapies where clinically appropriate.
- We will improve the management of chronic diseases like diabetes, for example by supporting people to take control over their own treatment.
- We will increase the availability of healthy choices for example by encouraging schools to open their leisure facilities to the wider community.

## **3.1 Introduction**

3.1.1 Even if public health policy delivers a population more engaged with its own health, and even if everyone lived healthy lifestyles, people will still fall ill, and healthcare and other support will be required. Liberal Democrats place a high value on the right to self-determination and the dignity of the individual, and therefore do not believe that as soon as someone becomes unwell they should simply be regarded as the passive recipient of treatment administered by professionals. We advocate a model of health and care where people are seen as partners in decision-making processes. The patient's own view of what gives them the best quality of life should be at the heart of the healthcare system, and their right to control their own lives must be paramount. The people who use the health service should have a direct input into how it is planned and managed, and clear avenues of redress when things go wrong.

## **3.2 Preventive medicine and early intervention**

3.2.1 While it should be a clear goal of public policy to maintain good health for as long as possible, if a person begins to fall ill it is important that they are diagnosed quickly. For example, there are as many as one million undiagnosed sufferers of type 2 diabetes, who in many cases could manage their condition by some simple changes to diet and exercise, but may suffer long term disability if nothing is done. We therefore support an increased emphasis on screening services.

3.2.2 In particular, the National Institute for Clinical Excellence (NICE) would be asked to devise clinical guidelines for a 'Targetted Personal Health MOT'. This would mean that every individual would be guaranteed access to relevant screening tests according to their own personal risk factors, such as age, sex, ethnicity and medical history. People would be invited to take whatever tests were appropriate for them at different ages. The results would allow people to

receive treatment or lifestyle advice and tackle any emerging problems sooner rather than later. The testing would of course be voluntary and there is no question of anyone 'failing' their MOT. The purpose of the programme is simply to aid early intervention. The roll out of the Health MOT would be linked to the implementation of electronic patient records which would enable call-up based on personal risk factors.

3.2.3 As part of this work NICE would review the clinical effectiveness of currently available screening tests and make recommendations for further research. We would also increase funding for research, development, piloting and evaluation of new screening programmes. The expertise of the National Screening Committee would be incorporated within NICE as part of this programme. Also as part of this programme of work, the Health and Care Commission (HCC see 4.4.1) would be asked to conduct an audit of the range and availability of screening tests in primary care settings. We also support evidence based practice guidance such as the regularly updated *Health for All Children* produced by the Royal College of Paediatrics and Child Health, which advises health visitors on which child health screening programmes are most effective.

### **3.3 Free Eye and Dental Checks**

3.3.1 Liberal Democrats have always opposed charging for eye and dental checks. Such charges discourage people seeking regular checks which can allow problems to be identified and dealt with quickly. We would therefore abolish charges for eye and dental check-ups. Because there is evidence that for most adults without a history of dental problems checks as frequently as every six months may be unnecessary, we would implement NICE's guidance on the period between dental checks (expected later this year).

### **3.4 Expanding the opportunities to take healthy choices**

3.4.1 The concept of Healthy Living Centres, originally developed since 1999 with national lottery funding, could be taken on board by local authorities as part of a joined-up approach to tackling the causes of ill health. These centres help to reduce health inequalities by tackling the social and economic factors affecting health. Examples include smoking cessation, screening programmes, training and skills schemes and

dietary advice. Under our proposals they could include joined up social services and healthcare, leisure services and benefits and housing advice. However, we do not want to set out a top-down, one size fits all approach, so we would ensure that local health commissioners have the freedom to develop services to fit local needs. Improving access to health advice through NHS Direct, walk-in centres, and expanding the role of community pharmacies can all make an important contribution to helping people understand healthier choices. These routes of access to the NHS are particularly important to encourage men to take a more active interest in their health.

### **3.5 Information to support healthier choices**

3.5.1 It is our goal to increase people's ability and opportunity to self-advocate and self-manage in matters of health and care where ever possible. We all have personal responsibility for our own health, but we are not all well equipped by our life experience and formal education to take this responsibility. In the long run we will aim to increase the health literacy of the population through changes to the school curriculum to increase teaching in schools on topics relevant to health, such as exercise, nutrition and sexual health. Physical education in schools should give children an understanding of how their bodies work, as well as an opportunity to play sports and take part in participative activities. Citizenship education should cover how to make the best of the health service and how to seek further support and advice.

3.5.2 We also want to enhance the health literacy of adults. Information should be more widely available online and on telephone helplines, through initiatives like the telephone and internet services of NHS Direct, both on general health issues and on how the health service works, for example on the procedures for changing one's GP (many do not know they can do this) and how to make a formal complaint. We would examine the potential for developing the role of Community Practitioners and Health Visitors so that they could support and advise adults as well as young children.

3.5.3 Improving the nutritional information available about the foods people buy is a key aspect of health literacy. We would therefore require the Food Standards Agency (FSA) to

consult with the food industry on the details of a mandatory front of packet nutritional labelling scheme, based on a traffic light system for high, medium and low quantities of fat, salt and sugar or energy density. This would mean every processed food product would come with a label giving improved, easy to understand information about its health and dietary impact. We would also establish a national weight loss register to build an evidence based for national guidance on diet to lose weight and diet to maintain a normal weight, and use this as basis for public information campaign on good diet/healthy living. In schools, we would require caterers to give better information about the nutritional benefits of different foods, based on the traffic light system.

### **3.6 Better Information on outcomes**

3.6.1 At the heart of healthcare decision-making is the right of the individual to give or withhold their consent to treatment. Assisting a person to form a judgement about the right course of treatment for them is a key task of the clinician. Choice in healthcare is at its most real for people when they discuss with their clinician the treatment options and how their condition is to be managed. For many conditions, there will be a wide range of options, including lifestyle changes, physio - and occupational therapy, drug therapy, surgery, complementary or alternative therapies, or indeed a combination of these. GPs and other clinicians should be encouraged to advise patients about the risk of side-effects and physiological or psychological dependency, before starting intensive courses of drug therapy.

3.6.2 At present there is a serious lack of systematic data on treatment outcomes at whole population level. We would commission NICE and the HCC to develop systems for evaluating and coding outcomes of treatments on patient's Electronic Patient Records. This would be used to produce anonymised information on procedure and treatment outcomes.

3.6.3 People can only make meaningful decisions about the treatment options open to them if they and their GP have access to reliable information. We would ensure that all providers of NHS services supply information on the range, ease of access, length of wait and quality of health services available. Although choice over type of treatment is the most important choice, patients should also be able to choose between consultants

and hospitals within the NHS. We therefore proposed (see policy paper 53 *Quality, Innovation, Choice*) that having received the advice of their GP or other health professional on hospitals and consultants, the patient should be allowed to be referred to the consultant and hospital of their choosing, conditional on the treatment being considered sufficiently clinically effective and cost-effective, and to the overall budgetary constraints of the health commissioner. We would ask the Health and Care Commission (HCC) to establish a national database of clinically-based actual and average hospital waiting times. The database would record the length of waits from first GP referral to commencement of treatment. It would also include referral times for diagnostic procedures. The database would be available online and should be made accessible through internet services. This would not include any information on individuals, confidential or otherwise. We would also expect the HCC to collect and publish case-adjusted information on the outcomes achieved by individual clinicians. Information on patient satisfaction should also be available, although both patient satisfaction and clinician competence data has to be treated with caution, and we would ask the HCC to evaluate best practice in these areas. We would make publicly available the data already collected on cancer incidence, cancer types and cancer mortality by local area.

### **3.7 Complementary and alternative medical therapies**

3.7.1 To increase the choice of treatment options people have on the NHS we would ask NICE to undertake a systematic review of the clinical effectiveness of Complementary and Alternative Medical (CAMs) therapies. We would allow the inclusion of CAMs in the treatments available on the NHS where NICE recommends them, or where in advance of formal NICE evaluation the cost of that therapy is no more than the lowest conventional treatment offered and the patient's GP supports its use. As part of this programme we would audit the range and type of problems for which patients currently consult CAMs practitioners. This would give a baseline as to which problems and patients are most likely to benefit, for example, osteopathy and chiropractic for back problems, acupuncture for neurological and joint problems, herbal medicines and homeopathic medicines for mental/emotional,



systemic and allergic conditions. Services should be introduced after careful evaluation. The work of the Foundation for Integrated Health on evaluating best practice of existing integrated healthcare services in the NHS offers a useful guide to complement the work we plan to commission NICE to undertake in this area. Measured introduction of treatment with CAMs therapies at primary care level has the potential to reduce expensive secondary referrals and/or long term expensive drug therapy in a range of conditions.

3.7.2 People should continue to have the right to exercise choice over the food supplements they purchase. Depending on how the Traditional Herbal Medicinal Products Directive, the Medicinal Products for Human Use Directive and the Food Supplements Directive are translated into domestic legislation and regulation they could place unnecessary restrictions upon the choice exercised by consumers of vitamins and minerals. We would review any legislation introduced by the current Government to give effect to these Directives with a view to maximising consumer choice over the use of food supplements.

### **3.8 Supporting self management**

3.8.1 In our social care policy paper *Promoting Independence, Protecting Individuals* (2003) we argue that those commissioning care must do so in ways that protect and promote self-determination, independence and personal management of care. We also set out plans to improve Personal Care Plans and formal advocacy support. Self-management of medical conditions, particularly long term conditions, is a continuation of that approach. At any one time there are as many as 17.5 million adults living with a chronic disease. Living with long-term conditions for the individuals affected and their families can often mean physical and psychological difficulties, socio-economic problems, reduced quality of life and social exclusion.

3.8.2 People living with long-term medical conditions can become expert in their condition and how they personally respond to treatments and therapies. Both they and family carers can be better placed than clinicians and care staff to manage the condition. The application of this knowledge and experience can make an enormous

difference to the quality of care a person receives. This is beginning to be recognised through the work of patients groups in developing practical self-management protocols and support groups - a good example is the set of excellent programmes developed by Diabetes UK. Evaluations of self-management programmes have found that they contribute to reduced severity of symptoms, significant decreases in pain, improved life control, increased activity, improved resourcefulness and life satisfaction.

3.8.3 To make the option of self-management real for more people, we would place a clear duty on local health commissioners to commission self-management packages involving patient groups in their design, delivery and evaluation. The evidence from the Expert Patient Programme pilots leads us to conclude that self-management is best tailored around the needs of individuals and should usually be disease-specific. Robust evaluation of clinical and quality of life improvements flowing from self-management should be undertaken and the results distributed to health commissioners, professionals, expert voluntary groups and patient groups to support the development of and participation in such schemes locally. In addition, clinical staff should also be encouraged to support individual patients in increasing their own self-management. We would fund research and pilot projects that involve patients and local people in specialist areas like tackling diabetes, asthma, arthritis, bereavement, and depression.

3.8.4 As part of our review of Payment by Results (see 4.6.7) we would explore the potential for extending the idea of Direct Payments which are currently an option for people needing social care. Once tariffs have been devised for long-term medical conditions it should be possible to make a Direct Payment (a cash payment in lieu of directly provided care). Our proposals for Personal Care Plans would allow both the social care and health aspects of a person's care to be brought together and where a person wishes to arrange their own services for a Direct Payment to be made. This might for example allow a person to put together a package of physio - and other therapists and NICE approved CAMs inputs. Such an approach would further underpin the development of self-management schemes. The transfer of commissioning responsibilities to local authorities should allow the integration necessary

to make a reality of Personal Care Plans and Direct Payments for people with long-term medical conditions. Support from the local authority or user groups may be necessary to assist with administrative aspects, for example payroll.

### **3.9 Developing advocacy in health and care**

3.9.1 The kind of advocacy we wish to see develop needs to be closely tailored to the needs of individuals, especially those who may have learning difficulties or other disadvantages. It also needs to be wholly independent of the 'system' if vulnerable people with a well-founded suspicion of authority are to have confidence in it. This is why voluntary groups are particularly well placed to provide advocacy services.

3.9.2 We would place a duty on local authority health and social care commissioners to ensure that people have access to the necessary support to make informed decisions about their own health and care, not merely to pursue complaints. We would expect this normally to be done by commissioning advocacy services from local voluntary sector advocacy services.

3.9.3 Of course the first advocate for the patient should be the GP or other primary health professional. Professional attitudes towards patients have changed significantly over recent years, but there is still scope for more training on increasing rapport building with patients and training on improving understanding of the patients' viewpoint. The training once developed should be compulsory over a five-year period as part of Continuous Professional Development.

### **3.10 Involving the public in healthcare decision-making**

3.10.1 Liberal Democrats opposed the abolition of Community Health Councils, and are concerned that in the Government's rush to abolish them the patient's voice has been lost. We are not persuaded that the new structures are likely to be more effective than the old CHCs. As some changes to the new arrangements would inevitably follow from our commitment to give Local Authorities the health commissioning role, we would take the opportunity to review and simplify the structures for patient and public involvement.

3.10.2 The functions of Patient Forums and Independent Complaints Advocacy Services (ICAS) could be combined into a single arms-length body, which could also take on the old campaigning role of the CHCs. This would amount to the reintroduction of Community Health Councils, although the new CHCs would not be in all respects identical and issues of geographical coverage, representativeness, and the balance between community representation and handling individual complaints would of course need to be addressed. Each Trust would retain its own Patient Advice and Liaison Services (PALS). The Government have already announced the abolition of the Commission for Patient and Public Involvement in Health (CPPIH). Performance monitoring of the CHCs and PALS should be taken on by the Health and Care Commission (HCC).

### **3.11 Involving user groups in healthcare**

3.11.1 As well as having the opportunity to self-advocate and manage we want to see patients and carers being actively involved in the design and assessment of services and the journeys or 'clinical pathways' that they take through the system. When commissioning health and social care services, local authorities should ensure that user groups are involved at an early stage and the necessary resources are devoted to seeking the views of hard to reach and vulnerable service users. We envisage the new CHCs promoting and supporting user groups.

3.11.2 We also support the establishment of GP practice user groups to make recommendations for change on a regular basis. The implementation of the recommendations would be monitored by the new CHC and local authority commissioner.

### **3.12 Evaluating healthcare interventions from the patients perspective**

3.12.1 Regular, rapid feedback from individual patients on treatment episodes, alongside formal reviews and inspection, is absolutely essential to management and clinicians in improving service and clinical performance. Sustained and systematic assessment and feedback of patient satisfaction with the care received and final clinical outcomes should therefore become an intrinsic function of NHS delivery throughout the system.

3.12.2 For brief interventions such as Accident and Emergency and GP consultations there should always be opportunity and encouragement for patients to record comments giving patient satisfaction. This might be done through short standardised questionnaires and the results analysed by computer. For all inpatient episodes a standardised feedback form should be given to the patient or their family on discharge.

3.12.3 User groups as described in 3.11 should be encouraged to highlight areas of concern, suggest improvements and help to design changes.

### **3.13 People with mental health problems**

3.13.1 Liberal Democrats believe that people with mental health problems have the same rights as any other patients to exercise self-determination and be treated with dignity. Therefore we would wish to see the same approach taken to promoting independence and maximising autonomy described earlier in this paper. Specialised advocacy and support involving voluntary groups is particularly important to ensure that the needs and wishes of people with mental health problems are met.

3.13.2. This is why Liberal Democrats were deeply critical of the proposals in the Government's draft Mental Health Bill published in June 2002. In response to widespread criticism, the Government did not proceed with the original draft Bill, but a new draft Bill is expected. Liberal Democrats would insist on the following key points in any new legislation:

- The principle of reciprocity should be upheld so that where there is compulsion there must be an entitlement both to appropriate care and adequate access to such care, and independent appeal and advocacy.
- A need to match any new administrative arrangements with the necessary resources.
- Allowing patients to nominate a person to act on their behalf, and to have advance statements.
- A guarantee of access to trained advocacy.

3.13.3 Coercive approaches to mental health are driven by the stigma associated with mental ill health, fuelled by sensationalist media coverage of incidents involving mentally ill people. However, a more effective approach would be to invest in earlier community-based, non-compulsory treatment. This will require an increase in capacity, particularly specialist mental health nurses and occupational therapists. In government, we would act to counter damaging stereotypes of the mentally ill, through general anti-discrimination policies and by positive public education efforts. We would review the NSF on Mental Health services to see if new standards were needed to ensure that issues of access, stigma and medication were properly addressed.

### **3.14 Clinical negligence and patient safety**

3.14.1 While the total number of clinical negligence claims is not increasing, their cost of settlement is going up. The damages awards in cerebral palsy and brain damage cases run into many millions of pounds per case. There is a stark contrast between the provision for children born with congenital cerebral palsy compared with those who suffer the same very disabling condition from negligently managed childbirth.

3.14.2 Apparent injustices such as this, together with the prospect that it would lead to speedier resolution of claims, potentially lower legal costs, and greater willingness on the part of clinicians to admit to errors, have led to considerable support for the introduction of a no-fault compensation scheme. Liberal Democrats have supported this approach. No fault, however, does not mean no accountability. Where government, companies, the NHS or individuals have caused serious medical harm through negligence or deliberate failure to investigate and make public failings, then an independent inquiry, and where necessary criminal or civil proceedings should ensue.

3.14.3 If the NHS Redress Scheme (as set out in the Chief Medical Officer's report *Making Amends*) were to be implemented, a Liberal Democrat government would review its operation with a view to moving towards a fuller no-fault system.

3.14.4 According to government figures, one in ten patients admitted to hospital becomes even more ill because of medical errors and negligent

care. A study has estimated that mistakes cost the NHS £2 billion for the extra time patients need to stay in hospital, on top of clinical negligence costs running at more than £500 million per year. Added to this are the cost of misdiagnosis and mis-prescription. A range of policy responses are required to address this wide spectrum of problems, but a common theme is the need for NHS management to focus on the actual needs of the patient rather than meeting political targets. To streamline the bodies with responsibilities for patient safety, we would establish an NHS Safety Agency, to be formed from a merger of the National Patient Safety Agency, the National Clinical Assessment Authority and the Medicine and Healthcare Products Regulatory Agency.

### **3.15 Palliative care, bereavement and death**

3.15.1 Palliative care aims to provide total care for patients whose disease is not responsive to curative treatment, and focuses on pain and symptom control, psychosocial and spiritual wellbeing, quality care and support for the patient's family and carers. Liberal Democrats believe all people should be able to access the care they need both in the management of long-term medical conditions and at the end of life. Access to this care should not be limited by a person's age, diagnosis, social or ethnic background or any other factor. We believe that palliative care should receive greater resources as total NHS spending rises.

3.15.2 There is a clear need for improvements to palliative care. Hospice patients are being given a lower priority as a result of the system of fines for delayed transfers of care. Hospices are reporting that social services and community hospitals are prioritising acute hospital patients over hospice patients as a result of the fines. Carers of people with terminal illnesses have extremely high levels of unmet need and distress. One study of patients and families in the last weeks before death found that the needs of the family exceeded those of the patient.

3.15.3 It is important for the government to recognise the wealth of experience and expertise in the voluntary hospice movement as well as in the NHS. Liberal Democrats believe palliative care is best developed through a strong partnership between the NHS, local authorities and the voluntary sector supported by a National

Service Framework and sustainable funding for existing services, before seeking to develop of new services. Guidance on palliative care services for children and for non-malignant disease should form the next steps forward.

3.15.4 In addition to joining up policy on palliative care and improving bereavement services, we believe there is a need to look more broadly at how we approach death as a society. Death is often still seen as a taboo subject. But this reluctance to acknowledge death can make people more isolated and afraid. There are many benefits to be gained by supporting citizens to cope with death and loss. These include psychological and psychosocial benefits to the individual, with a corresponding reduction in demand for health services, and more stable workforce benefiting employers and the economy. Palliative care services are an important way of helping people to cope with death and loss, but there are other ways that this process could be supported. Canada has led the way in this field by developing a cross departmental End of Life strategy.

3.15.5 Liberal Democrats therefore call for the drawing up of a cross-departmental strategy, involving stakeholder organisations from outside Government, looking at how we can support people in the UK to cope with death and loss. Elements of this strategy could include:

- Public education.
- Bereavement support.
- Support for dying at home.
- Respite care.
- Benefits and other support for carers.
- Education for non-health care staff who interact with the public - e.g. social services staff, benefits advisers.
- Links between palliative care services and prisons and secure mental health hospital wards.
- Improvements to the burial system and funeral industry.

3.15.6 As part of the development of this strategy, the scope for leave and benefit entitlements for people caring for a terminally ill relative should be examined.

# ***Supporting Healthy Choices and Delivering Quality Services***

Liberal Democrats will allow the NHS to deliver more real benefits for patients by reducing waste, making more efficient use of staff, and prioritising resources where they can do most good. Our key proposals are:

- We will remove central targets which interfere with clinicians' ability to do their best for individuals.
- We will drive up standards by giving a voice back to local people through making commissioning of health and social care a function of the Local Authority, and through making strategic development of health and social care a responsibility of elected Regional Governments.
- We will make the NHS more of a health service, not a sickness service, enabling better decision-making through stronger advice on public health issues.
- We will cut out waste in the NHS by, for example, reducing Hospital Acquired Infections like MRSA through a package of measures including strengthening the powers of infection control teams and stricter protocols on hospital hygiene.
- We will focus the Department of Health on making strategic decisions to improve the health of the nation.
- We will guarantee honest, long-term funding of the NHS by earmarking National Insurance as the NHS Contribution.

## **4.1 Introduction**

4.1.1 Liberal Democrats are committed to a radical devolution of power to local people and local health services. Our vision is to shift power out from Westminster and closer to patients and to the people who care for them. There will be less pressure on Ministers to interfere, less central control and target setting and patients and the public will be able to influence their own local services. We believe that this is the key to improving the health service. Local decision-makers can spend more wisely as they can understand local problems and priorities. Money and valuable staff time will not be wasted on top-down initiatives or reporting structures that have more to do with national political imperatives than real benefits to patients.

4.1.2 To make this vision of a more accountable and responsive service work, there has to be a clearly understood funding stream for the NHS. Flexibility of response requires the freedom of local health purchasers to access services from a

diverse range of providers, combined with tough audit and inspection arrangements to ensure quality of care and value for money. A framework for national standards of access and care on which local and regional tiers can build will be retained, with a strong national capacity for evidence-based assessment of clinical effectiveness and cost-effectiveness.

## **4.2 A Department for Health**

4.2.1 We would refocus the Department as a Department for Health concentrating on public health issues, medical/professional training, workforce planning and regulation and standard setting, and medicines control. The Department's current role in defining national targets for the NHS would be ended. Responsibility for determining national performance measures and collecting and publishing such data would be the responsibility of the Health and Care Commission. However, we believe that while giving maximum scope for local and regional discretion in design and delivery of services and

priority setting, even in a highly devolved system there must be a continuing national responsibility for:

- i) Ensuring standards of professional training and competence.
- ii) Measuring performance based on clinical outcomes and disseminating that information.
- iii) Inspection and audit to implement ii).
- iv) Minimum standards for quality of care and patient experience.
- v) Assessing cost-effectiveness and clinical effectiveness of treatments and technologies.

4.2.2 The NHS is asked to supply a huge amount of data to the Department of Health and other agencies. An analysis by the NHS Confederation found that over half the data returns to the Department of Health would not have been collected if they had not been requested. Collecting valuable feedback for planning, effective management and data for research is essential. Too much information collected about the performance of NHS is contested and unreliable.

4.2.3 In order to streamline data collection we would give the HCC responsibility for the collection, validation and publication of health and social care data with the same status as the Office for National Statistics. Our aim would be to increase the independence and reliability of the information published. As a first step the HCC would undertake an audit of Department of Health data collection to weed out duplications and remove redundant requests. The HCC would also have the task of determining in consultation with the Local Government Association and NHS Confederation clear principles for performance management and reporting and a minimum set of common performance measures. We would also expect the HCC to build in a 'justification for request' as part of its data request protocols.

4.2.4 For the foreseeable future funding for the NHS will come from nationally determined levels of the NHS contribution (see 4.6), and so the Department for Health would retain a legitimate interest in the setting of national standards of

service. There should be two categories of national standard:

- i) Minimum standards of access to primary (including dental treatment), secondary and tertiary care services.
- ii) Condition-specific and generic standards based on existing National Service Frameworks. We would aim to introduce new frameworks working with clinicians and patient groups, starting with conditions in which there are currently wide variations in the standard of care based on local pockets of bad practice (e.g. sexual health, palliative care). We would evaluate the overall population health effects before they are agreed. We would also undertake a review of existing NSFs and would publish estimates of the cost of their implementation. We would have these standards mutually agreed between national, regional and local levels of government, rather than dictated by central government as at present.

4.2.5 Regional and local government could set standards that are above and beyond national minima, both for general access to services and for particular National Service Frameworks, using the performance measures developed by the HCC. The reformed standards 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, at the same time as knowing how much they are required to pay through the NHS contribution and any additional local taxation. Informed choices can then be made, through the democratic process, about the costs and benefits of additional funding to address local health priorities.

### **4.3 Devolution and democratisation**

4.3.1 Liberal Democrats believe that local people should have a stronger voice in their local health service. The key to this is democratising the planning and purchasing of health services.

We would therefore transfer the existing commissioning role of unelected Primary Care Trusts to local government at the same tier as social services. We would place a duty on local authorities to commission services to meet the identified health needs of their population. This duty would include protection for minorities and requirements to actively consult and seek to engage hard-to-reach groups. Commissioning should be based on quality of service, not just lowest cost. Pooled budgets at this level will end the artificial division between people identified to have 'Health' rather than 'Social' care needs, facilitating a 'seamless service'. Transferring commissioning to elected local government should include management of waiting lists for all activity.

4.3.2 The opportunity of this change should be taken to give new impetus to innovative health commissioning as a main driver of improved care, through better co-ordination with social care commissioning, better engagement of the local population, taking account of the impacts between health commissioning and other local service provision, and providing national benchmarks on activity sensitive to variations in age and deprivation. There should also be greater input from a strengthened Public Health function. While we welcome the establishment of Childrens' Trusts as a way of providing more integrated services, we would go further by also including the commissioning of these services in local government.

4.3.3 Devolution within some geographically dispersed and diverse authorities (such as County Councils) may mean there are several area committees controlling the Health and Social Care budget. This would be a matter for local decision.

4.3.4 Giving political accountability over health commissioning to local authorities does not of course mean that councillors will directly take decisions on the medical care of individuals, any more than the existing political accountability of Social Services Departments means that councillors directly take decisions over individual child protection issues. Professional decisions will remain for professionals. We believe that the existing culture of local government is in general more sensitive to dealing with voluntary and user groups, and this will be a positive influence on the culture of the health service in a more integrated

system. It is also likely that greater integration of commissioning may lead to more rational resources allocation, for example as between primary and secondary care.

4.3.5 Involvement of patients, carers and voluntary organisations on the one hand and expert medical and public health advice on the other within the new commissioning arrangements is vital. Following the review of patient involvement structures recommended in Chapter 3, we would look to the reformed Community Health Councils to take a strong role. We would review and strengthen statutory rights of consultation on existing services as well as detailed involvement with regard to any new developments.

4.3.6 At the regional level responsibility for strategic development of health and social care services, including regional aspects of workforce planning, would go to elected Regional Assemblies, abolishing the existing unelected Strategic Health Authorities and drawing down powers for the Department of Health and Government Regional Offices. Regional Assemblies would directly commission health and social care for more highly specialised services. The regions could also facilitate consortia of local authorities to commission treatment for conditions which are too specialised for purely local commissioning where appropriate. In our social care policy paper *Promoting Independence, Protecting Individuals* we set out our plans for Regional Health and Social Services Authorities (RHSSAs) under the democratic control of elected Regional Governments where the populations of those regions so chose in a referendum. Until elected Regional Government comes into being we would establish RHSSAs as joint boards comprised of councillors appointed by each local authority in the region. RHSSAs would also provide an excellent forum for cross-district information exchange and joint planning.

4.3.7 There are some highly specialised treatments which need to be commissioned and provided at a level above that even of an English region - cranio-facial surgery for congenital deformity would be one example. Specialised services provided to very small number or patients, often involving complex and lifelong treatments, are a real challenge to commissioners. Therefore we propose the retention of both regional Specialised Commissioning Groups

(SCGs) and the National Specialist Commissioning Advisory Group (NSCAG) to advise Regional Assemblies and on the provision of specialised services. It has proved politically very challenging to make optimum decisions in the configuration of such services. We propose that the Secretary of State should retain final responsibility for such reconfiguration decisions in England and continue to be advised by the Independent Reconfiguration Panel.

#### **4.4 Cutting Quangos in the NHS**

4.4.1 The Department of Health is currently undertaking a major review of arms-length bodies. We will look closely at the conclusions of this review. In our social care policy paper *Promoting Independence, Protecting Individuals* paper we outlined our proposals to merge the Commission for Healthcare Audit and Inspection (CHAI) with the Commission for Social Care Inspection (CSCI), and throughout this paper we have indicated the tasks we would expect the new Health and Care Commission (HCC) thus created to undertake. We also set out in 4.5 proposals for creating a powerful arms-length body responsible for devising, delivering and evaluating programmes to prevent and control disease. In Chapter 3 we set out proposals for an NHS Safety Agency from a merger of the National Patient Safety Agency, the National Clinical Assessment Authority and the Medicine and Healthcare Products Regulatory Agency who currently have overlapping remits. In line with our proposals for streamlining the system of patient and public involvement, we support the abolition of the Commission for Patient and Public Involvement in Health reducing the waste and bureaucracy created by maintaining national and regional offices. The funds released should be re-allocated to the front-line to allow our new Community Health Councils to be fully effective in representing the interests of their local communities. Performance monitoring and quality control of CHCs and PALS should be taken on by the HCC.

4.4.2 We support the work of NICE in evaluating clinical effectiveness and cost-effectiveness of treatments. In Chapter 3 we propose that the work of the National Screening Committee be included within the remit of NICE and would also see the work of the Immunisation and Vaccination Committee discharged in this way. We would carefully examine the need to

increase the resources available to NICE to enable it to consider more treatments more quickly, and give it greater autonomy in choosing which treatments to prioritise. In general NICE guidance should be advisory rather than mandatory, however we would expect the HCC to monitor implementation as part of its routine programme of inspections. In coming to decisions about the implementation of NICE guidance and guidelines commissioners would need to be able to demonstrate how their decision meets their statutory duty to assess and meet the health needs of the local population. There are treatments routinely available on the NHS which are of questionable medical value - for example tonsillectomies of which about 40,000 are performed in England each year. While NICE's programme of evaluations addresses this problem with regard to new treatments, we would give NICE greater freedom to evaluate existing treatments in order to reduce waste on ineffective practice.

#### **4.5 A new focus on public health**

4.5.1 A key part of our new vision for the health service is to make promotion of good health the first priority of health policy. Currently the policy and resources are focused on the treatment end of the health and sickness spectrum. The NHS is a sickness service in all but name. The Secretary of State for Health has in practice acted as Secretary of State for the NHS. We want to see the NHS as part of a wider health system, that system brings together a wide range of public and private agencies. Through both the range of services and its community leadership role local authorities are well placed to develop and deliver programmes designed to promote good health. In order to create the framework for such an approach, our policies would include:

- Making the Secretary of State for Health clearly responsible for public health, and giving the Department of Health responsibility for sports and nutrition policy. The Secretary of State as Chair of a Cabinet Committee on Public Health, backed up by the explicit authority of the Prime Minister's office, should also ensure that there is a coherent health information and promotion effort across all government departments.
- Establishing a new Centre for Disease Prevention and Control (CDPC) headed by



the Chief Medical Officer. The new agency would combine the Health Protection Agency, Health Observatories and Health Development Agency. CDPC would also take on the health promotion function and advice on the implementation of Health Impact Assessments (see 2.2). Within CDPC, the health promotion functions lost when the HEA was disbanded and the HDA formed will be restored and protected from political interference. These restored functions will range from national level activities such as campaigns to professional and technical support for local level programmes.

- Requiring the Department of Health working with NICE and the CDPC to improve the data collection and research capability required for evidence based public health policy. This should include local piloting of health development records in schools.
- Transferring the role of Director of Public Health to local government to assist with the new commissioning role and ensure that health promotion and prevention are included in their community plans.
- Placing a duty on NICE to examine cost effectiveness in the context of potential savings to the public purse as a whole, not just savings in NHS Budgets.

4.5.2 There is wide recognition of the lack of adequate public health specialist advice and services. For example, in 2003, 13 out of 28 Strategic Health Authority areas in England were found to be below the safe minimum staffing levels for health protection and communicable disease control. The Faculty of Public Health in March 2004 published a report advocating an overall 40% public health staff expansion to deliver an effective service on the current NHS structure. We will work towards this goal by increasing the funding of training posts for non-medical and medical trainees, ensuring that all those entering from NHS posts had their pay protected.

4.5.3 We would establish a strategic workforce plan for public health as advised in the Wanless Public Health report. As part of this exercise, the balance between medical and non-medical public health staff will need to be reviewed.

## 4.6 Funding

4.6.1 To increase accountability and ensure a secure funding stream for the NHS we will establish an earmarked NHS Contribution. The contribution will be based on National Insurance. This change of funding does not require any increase in NICs to meet current plans to fund the NHS. Items currently financed from the NI fund (such as retirement pensions) would be funded out of general taxation.

4.6.2 As with present arrangements for funding the NHS the new system would not cover existing social care spending. However, where appropriate we would expect local authorities to take the opportunity to integrate health and social care spending (i.e. commissioning of services). The earmarked NHS Contribution and the money for social care could flow into the same total 'pot' locally, removing the perverse incentives in the system to 'cost shunt', and allowing the abolition of the system of penalties for delayed transfers of care.

4.6.3 In the short term, NHS contribution funding would be simply be allocated to health commissioners in England on the basis of the current formula. However, in the longer term as the English Regions move towards democratic regional government they would have the freedom to vary the rate of the NHS Contribution (on employees, but not on employers) if people elect a regional assembly which wants to make that change. The money that increases raise in their region could be used for the NHS in their region.

4.6.4 Similarly, once local income tax was established as the basis for funding local services and our other reforms of local government had been enacted local authorities would be able to use locally raised revenue to top up national and regional funding for the health service in their area.

4.6.5 With respect to the financing of investment in the NHS, Liberal Democrats set out in policy paper 53 *Quality, Innovation, Choice* our general approach to the benefits and drawbacks of PPP/PFI schemes and traditional public sector financing. We do not rule out NHS Trusts or other public procurers using PFI schemes, but this should be on the basis of a clear assessment of their merits. We have set out various accounting reforms which Liberal

Democrats would introduce to remove the existing financial biases towards a PFI/PPP approach. Liberal Democrats believe that if a PFI/PPP procurement approach is to make sense for improving public service provision, it should do so in its own terms, not because the system has been rigged. In addition to accounting reforms, we would review PFI/PPP generally. In particular, we would examine the impact of early exclusion of bidders, transaction costs, greater transparency in contract details, improvement of Public Sector Comparators, clearer mapping of risk, more robust sensitivity analysis, refinancing arrangements, and the use of break clauses to prevent 'locking in'.

4.6.6 As part of our reform of the governance and accountability arrangements for health commissioning we would review the implementation of Payment by Results. The way in which the Government's patients choice programme and tariffs system interact with the commissioning function could have the unintended effect of reducing the ability of the commissioner to redesign care pathways. The system creates a strong disincentive to reducing episodes of hospital treatment. It is vital that patients are treated in the community when this is clinically the best option. However, as currently proposed, acute service providers will be reluctant to facilitate this shift, as each case they 'lose' will contribute to their own financial instability. Also we note that the Audit Commission has warned that if PCTs do not put in place systems to manage demand, the new system could cause 'considerable' financial difficulties. Effective demand management will require close links with primary care and managed referral pathways.

4.6.7 Whilst not rejecting the introduction of a tariff system and recognising its potential advantages, we would want to ensure that the tariff system does not get in the way of collaborative working across primary, secondary and tertiary care boundaries. The Government's current proposals need to be substantially reviewed to address the following concerns:

- The tariff must fund appropriate treatment of expected patient problems. It should not reward inefficient and clinically unnecessary behaviour and it must fairly fund exceptional patient care.
- Financial risk should be shared fairly

between commissioners and providers - ensuring that providers are paid equitably and appropriately for costs incurred in patient care, but especially for the very complex patients whose care costs are exceptional in comparison to average costs; and equally that payers are not paying over the odds for exceptionally low cost services.

- The system should avoid unnecessary complexity or overly simplistic one size fits all approaches.
- The construction and level of tariffs must be clear, clinically plausible and fair. Tariffs must be comprehensible to health staff beyond those directly involved with doing the calculations if they are to help inform reasonable patient management choices and support clinical care improvements.

## 4.7 Healthcare charges

4.7.1 Liberal Democrats are committed to ending charges for personal care for those requiring long term care in any setting, as recommended by the Royal Commission chaired by Lord Sutherland. We believe that it will help to deliver a more efficient service as it will break down artificial barriers between the funding of 'health' and 'social' care. It is also right in principle to end the scandal of people having to sell their homes to pay for basic care.

4.7.2 We would also ensure that eligibility for NHS funded continuing care is based on uniform rules throughout England. The current Government has been content to allow the 28 Strategic Health Authorities to devise and apply their own criteria and for PCTs to use their own assessment tools for determining eligibility. The result has been to allow common levels of health need not consistently triggering entitlement to NHS support in different parts of the country. This is a wholly unsatisfactory situation made worse by confusion over the rules governing entitlement to registered nurse contributions in nursing homes. We would issue clear statutory guidance requiring uniform eligibility for free NHS care regardless of setting and ask HCC to monitor compliance.

4.7.3 The current level and incidence of charges for prescriptions is also a deterrent to some people from seeking medical attention, or to

follow courses of medication prescribed. The charges can also represent a significant burden on people who need a large number of prescriptions but do not qualify for the existing exemptions - a report by Citizens Advice in 2001 showed that 37 per cent of respondents with long-term health problems were unable to get all or part of their prescription dispensed free. As a first step to addressing this problem, we would freeze the level of prescription charges and initiate the first review of the medical conditions exempted from charges since 1968. The aim of the review would be to consider the case for ending charges, examining the impact of charges on access, equity and health outcomes. We would also want the review to make recommendations on the removal of anomalies and determine which medical conditions should qualify for exemptions with a view to widening the exemptions.

#### **4.8 Cutting waste and containing costs**

4.8.1 Valuable NHS resources are frequently wasted. A specific example of this is the cost of dealing with Healthcare Acquired Infections (HAIs), which in addition to causing more than 5,000 deaths per year, have been estimated by the National Audit Office (NAO) to cost the NHS £1 billion annually. There should be an independent, scientific inspection of hospital cleanliness and infection control by the HCC giving a national picture of the hygiene levels of England's hospitals. Infection control teams must be given the resources and the authority to undertake their jobs effectively. Strict protocols should be introduced to enforce the use of hospital changing facilities and laundries so that staff do not have to wear uniforms out of the hospital. Current arrangements for monitoring HAI would be changed to ensure that speciality level information was available to clinicians. Redesigning clinical pathways so that there are fewer steps and fewer patients needing to go to hospital at all will obviously reduce the risk of infection spreading. To tackle the growth of antibiotic resistance, there should be a visible and sustained campaign to educate clinicians and the public against the overuse or inappropriate use of antibiotics, and strict regulations against the overuse of antibiotics in agriculture.

4.8.2 Due to the high number of vacancies and difficulty retaining staff within the NHS, more reliance than ever is being placed on agency staff.

Last year, £1.4 billion was spent in the NHS on temporary staff. Of course it is sensible to spend on agency staff as part of a strategy that makes the best use of permanent staff, but as the Audit Commission has revealed too many NHS trusts have lost control of their agency budgets, have no idea how much they are spending, and have no sense of direction and strategic purpose behind that expenditure. A major problem with staff retention and the growth in part time working stems from a lack of workforce planning and insufficiently flexible career structures and work patterns. It is possible that retention could be improved and the need to rely on agency staff reduced if NHS employers paid more attention to the needs of staff in terms, for example, of flexible hours, career breaks and sabbaticals. In the absence of such flexibility, some home trained staff work overseas, leave the health sector or choose to work through agencies which guarantee them flexibility. It should become routine practice that all staff leaving permanent NHS employment or choosing to work part-time should be asked whether changes to their work arrangements would allow them to stay or work longer hours, and a body of data built up to understand better the needs of staff.

4.8.3 An area of NHS expenditure which has increased at a particularly rapid rate is the overall drugs bill. In cash terms, the total spend in England increased from £3.69 billion in 1993 to £8.23 billion in 2003. While new drug treatments certainly deliver major health improvements, and can lead to reduced health costs (eg. statins reducing the risk of stroke/heart attack), in the long run it is clearly unsustainable for the drugs bill consistently to increase more rapidly than the overall NHS budget. Some of the approaches to treatment options and self-management advocated elsewhere in the paper will tend to reduce dependence on drug therapies. However, we believe there is scope for improving the efficiency of prescribing and purchasing drugs in the NHS, increasing generic prescribing in the community sector and learning from experience overseas, in particular New Zealand. This is a very complex policy area and we intend to publish more detailed proposals before the next General Election.

#### **4.9 Increasing efficiency through redesigning care pathways and role expansion**

4.9.1 Staff, medical and non-medical, are the NHS's greatest resource and it is essential that best use is made of them and that their talents are developed. There is tremendous scope for using the staffing resources within the NHS more efficiently. There are many tasks traditionally undertaken in acute hospitals which can be done by GPs or other health professionals in the community with shorter waiting times and at lower cost. There are also many roles traditionally carried out by GPs which can be taken on by practice nurses, therapists and other practitioners allied to medicine. Such a shift in the job mix also reflects the changing pattern of disease, with more long term medical conditions which are best managed in the community rather in secondary care.

4.9.2 Redesigning 'care pathways' means that GPs, nurses or therapists develop a specialist area of expertise as Physicians with a Special Interest (PwSIs) and patients within their local area are then referred to the local PwSI rather than to a hospital - based consultant. Redesigned services like this can result in waiting lists being substantially reduced. More advice and support to local authority health commissioners in rolling out PwSIs in key specialties would therefore be a high priority.

4.9.3 Similarly, in some areas nurse practitioners run clinics on influenza, diabetes, travel health issues, smoking cessation, and Wellwoman/Wellman clinics. They can perform procedures such as cervical smears and ear syringing. We would support the development of staff accreditation, training and career development programmes to facilitate new ways of working, such as prescribing by nurses, therapists and pharmacists. We would also support the development of care pathways with allied health professionals taking on the role of PwSI.

4.9.4 Redesign can also be used to improve the interface between health and social care, for example to reduce admission and discharge planning before elective admission and on day of emergency admission. It is important that clinicians and local clinical leaders are fully involved by commissioners at an early stage in redesigning care pathways locally.

4.9.5 Community pharmacy is already making an important contribution to delivering primary care but the potential is far from fully realised. The new pharmacy contract offers the opportunity to unlock that potential to move beyond traditional dispensing. Community pharmacists also have an important part to play in providing health promotion and preventative services. They are well placed to engage with people who rarely if ever come into contact with their GP or other NHS staff.

4.9.6 The barriers to role expansion and more flexible use of staff need to be tackled. Partly this is a cultural problem, with the strong traditional divide between medical staff and other health professionals. As the new more flexible ways of working prove their worth, we would expect this to be eroded in the long term. However, there is more which could be done in terms of training and continuous professional development to encourage flexibility. Many of the interpersonal aspects of patient care are common to medical and non-medical health professionals, and common training courses in these generic skills would help encourage role flexibility.

4.9.7 If nurses, therapist and other healthcare professionals are being asked to take on more highly skilled roles, there is a legitimate expectation that they will be rewarded accordingly. Liberal Democrats have always favoured local flexibility over pay. Since our last major policy paper to address this issue, policy paper 53 *Quality, Innovation, Choice* (2002), the Government have negotiated the *Agenda for Change* settlement for non-medical staff in the NHS due to come into force in December 2004. This both sets out procedures for evaluating job content, and for allowing local pay top-ups of up to 30% to address local recruitment difficulties. If successfully implemented *Agenda for Change* promises to deliver much of the necessary flexibility both for role expansion and local recruitment and retention. We would therefore review its progress in meeting these objectives after a reasonable period for evaluation.

#### **4.10 Increasing efficiency through better use of IT**

4.10.1 Better IT was identified in the Wanless report as one of the areas in which the NHS seriously lagged behind best practice in the economy as a whole. The scope for improving

efficiency through better IT is huge. For example, electronic prescribing massively reduces prescribing errors, which frequently arise from misreading of handwritten prescriptions. The provision of Electronic Patient Records would, among other advantages, make screening programmes much easier to target and make it easier to keep track of records when people move house, or are transient. In the 21st century an organisation like the NHS should not be reliant on paper records. The National Programme for Information Technology shows that the Government has finally recognised the importance of the development of joined-up ICT systems for the whole of the NHS. However, there are significant risks for a project this size and progress so far has been dogged by problems, including resignations and accusations of secrecy. It is essential that the programme's leaders work hard to include frontline clinicians and administrative staff in the development of the new IT systems, or we could end up with a massively expensive and unworkable failure. In the past there has been too much emphasis on technology and not enough on systems.

#### **4.11 Rebuilding NHS dentistry**

4.11.1 Lack of access to NHS dentistry remains a subject of serious concern. NHS dentistry has suffered since the early 1990s from a lack of confidence from the dental profession caused by the Conservatives mishandling of the 1992 dental services contract and a lack of priority from Government since. Over half the population are not registered with an NHS dentist, and calls to NHS direct concerning dentistry increased by 70% between November 2001 and February 2004.

4.11.2 The crisis in dentistry has arisen from two main causes: a failure of workforce planning in the past with fewer dentists being trained than was necessary, and a method of paying dentists which unlike the NHS GP contract is on a crude piecework basis.

4.11.3 The Government's dental workforce review, which Ministers took over two years to publish, has found that there is currently a shortfall of nearly 2000 dentists (whole time equivalent). This is set to rise to up to 5,000 dentists in 2011. The Government have reacted to this review by announcement several new measures to improve recruitment:

- Measures to improve recruitment and retention of dentists, with the equivalent of 1,000 extra NHS dentists being recruited by October 2005.
- Expanding the number of training places for dentists by 170 from 2005 onwards, an increase of 25% on the existing total.
- Dental hygienists and therapists will increasingly do the less complex work. The Government will expand the total number of dental therapist training places from 50 to 200.

4.11.4 We support these initiatives but have concerns that in the light of the dental workforce review, they may be too little, too late. We approve of the Government's proposals in *Options for Change* to reform the way that dentists are paid, and to give responsibility to Primary Care Trusts to commission services for their patients. We believe these plans could attract dentists into NHS work. However this may not be sufficient to reverse the long-term decline in NHS dentistry if underlying issues are not addressed. The British Dental Association has found that six out of ten dentists are threatening to reduce their NHS commitment or leave the service altogether. It is essential that the Government take these concerns seriously and make sure that dentists are supporting the new proposals. Dentists need to be kept informed of the details of the plans, and the timetable for their implementation.

4.11.5 The Government have allocated some funding increases to rebuild NHS dental services in areas of worst access; we would see this as a priority area for any additional resources that became available.

#### **4.12 Building healthcare capacity closer to home**

4.12.1 In the context of general pressure on NHS resources, there are some specific categories of staff which we would see as top priorities for additional funding. These are typically professionals whose work has a particular public health, preventive or community character, where a relatively small investment can lead to major long term benefits in terms both of patients' quality of life and reducing the need for expensive hospital treatment.

4.12.2 As mentioned in Chapter 2, we place a high value on the work of Health Visitors, who perform a vital health promotion function with young families, and would like to see their role expanded, particularly in leading initiatives benefiting whole communities rather than just individual families. Instead of a top-down, one size fits all solution of community matrons stationed in GP surgeries as proposed by the Government, we would prioritise a bottom-up approach where local health commissioners were able to develop innovative roles to fit with the needs of the local community. The role of central government would be to underpin this work with sensible workforce planning capacity.

4.12.3 The work of District Nurses play an important part in helping people to live independently in their own homes, and thereby contributes to their dignity and self determination while reducing hospital admissions and re-admissions. They frequently take a leadership role in integrated care teams, and are able to deliver preventive programmes, for example in helping frail and elderly people to avoid injury from falls. They also are well placed to facilitate user involvement in planning local services. We would like to see the role of District Nurses develop further, with more District Nurses becoming nurse prescribers and more scope for specialisation, for example in palliative care.

4.12.4 A recent CHI report on Primary Care Trusts reported long waiting lists to see physiotherapists and many people being driven to go private. Physiotherapy can be vital to maintaining personal independence and is a vital alternative to drug therapy. Few PCTs appear to be taking initiatives to tackle shortages of therapists. We would give priority to expanding the number of physio- and occupational therapists available in community settings.

4.12.5 Timely diagnosis can be hampered by shortages of professionals involved in diagnostics, such as radiographers, and by the availability and age of diagnostic equipment. For example, nearly a third of MRI scanners are still in service in the NHS past their recommended replacement date. We would increase investment in scanners and other diagnostic equipment to ensure that the NHS was not forced to rely on out of date equipment. There is a clear shortage of radiologists, which is an important obstacle to rapid diagnosis. Every GP practice should have

direct access to diagnostic services where appropriate.

### **4.13 Diversity of healthcare providers**

4.13.1 We believe that health commissioners must have the freedom to procure health services from a wide range of providers. There must be a level playing field between different types of providers in terms of contractual arrangements and similar matters. Commissioning means not only the process of buying but also choosing which services are needed and monitoring the quality of services received. Planning should represent a significant part of the commissioning process. However the Commission for Health Improvement found that few PCTs were doing so because they were not making the fullest possible use of the information available to them.

4.13.2 Following the transfer of PCT commissioning functions outlined in 4.2.1, the community health functions of existing Primary Care Trusts would continue to be delivered. As part of the new contractual arrangements for GPs services PCTs will be able to take on roles traditionally covered by GPs where appropriate, eg. emergency cover, out of hours services, contraceptive services, or new services which GP practices might not wish to provide, eg drug rehabilitation. PCTs should hold contracts of Personal Medical Services and General Medical Services GPs. As part of their work in commissioning health local authorities may wish to look at opportunities to co-locate some existing staff such as social services or occupational therapists within PCT premises or by agreement within GP premises. They could also make arrangements to provide Complementary and Alternative Medical Therapies (CAMs) where these were cost-effective and the local health commissioners wished to fund them.

4.13.3 It should also be open to NHS Trusts to migrate to Public Benefit Organisation status, as described in policy paper 53 *Quality, Innovation, Choice*. PBOs are a form of mutual organisation, which would represent in their internal decision-making structure the full range of stakeholders, including the workforce, users and the local community more generally, and would also enjoy greater financial freedoms than existing NHS trusts including Foundation Trusts, in particular freedoms to raise money on the capital markets.

4.13.4 The removal of excessive central direction from Whitehall will allow local providers, whether as public sector Trusts or Public Benefit Organisations (PBOs), to be more innovative and responsive to local needs and priorities.

4.13.5 We have consistently argued that the Government's Foundation Trusts are a deeply flawed attempt to allow democracy and diversity of provision in the NHS. They are still subject to Whitehall diktat, have very limited financial freedoms, and have governance arrangements likely to create self-perpetuating oligarchies. We would give Foundation Trusts the choice of moving to PBO status or returning to Trust status. Within our proposed new system the absence of national targets will give all Trusts far greater autonomy than they currently enjoy. Once all Foundation Trusts had become PBOs or NHS Trusts, we would wind-up the Independent Regulator of NHS Foundation Trusts.

4.13.6 The voluntary sector has a long history of innovation in the provision of health care. Voluntary organisations are often good at identifying new areas of need and developing innovative services to meet them, even before those needs have been recognised by the NHS - palliative care is an example of this. They have played an effective role as an advocate for service users, particularly in the fields of mental health and learning disability. Small-scale local voluntary groups have promoted self-help, built friendly networks of local support, and provided a broader range of support than professional institutions can. They can also help to change the relationship with professionals so that patients are equal partners in the delivery of care.

4.13.7 The voluntary sector faces a number of problems in operating in partnership with the NHS. At present, voluntary organisations are often left to continue funding innovative services indefinitely, because there is little incentive for the NHS to take over funding them once it becomes accepted that they are meeting identified needs. There is also a constant risk that the State may simply treat the voluntary sector as a disempowered delivery mechanism in order to get services provided on the cheap. Such an approach will in the long run undermine community self-help, increase dependence on professionals and probably end up increasing costs.

4.13.8 To make the partnership between local authorities, the NHS and the voluntary sector as providers work to maximum benefit, we believe that health commissioners at all levels need to take account of the special features of the voluntary sector, with appropriate training where needed. In particular, where voluntary organisations are providing unique and valuable services it may be necessary to give long-term funding directly for their core operations in addition to short-term project based grants.

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 and 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. If approved by Conference, this paper will form the policy of the Federal Party, except in appropriate areas where any national party policy would take precedence.

Many Liberal Democrat policy papers contain proposals which would change the way public money is spent. Many also involve passing new primary legislation. Clearly, in a single parliament, it might not be possible to implement all of our policies. Therefore, at the time of a General Election, the Liberal Democrats produce a manifesto which details specific spending and legislative priorities should the party be elected to government. This means that no proposal in this paper should be taken as a guarantee or as a spending commitment for a first parliamentary term until it has been published in a fully costed manifesto containing our priorities and guarantees.

### **Working Group on Health Policy**

Dr Richard Brighton (Chair)  
Paul Burstow MP  
Patsy Calton MP  
Dr Merilyn Canet  
Lord Clement Jones  
Rachael Collins  
Lynda Goldenberg  
Cllr Stephen Gordon  
John Gray  
Clare Hamblen  
David Hart  
Barbara Hewett-Silk

Sandra J Lawman  
Dr Ian Mack  
Cllr Mark Morris  
Brian Niblett  
Margaret Rowley  
Sarah Teather MP  
Dr Miranda Whitehead  
Revd Simon Wilson

*Staff:*

Christian Moon  
Emily Frith

*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.*

Comments on the paper are welcome and should be addressed to: Policy Unit, Liberal Democrats, 4 Cowley Street, London SW1P 3NB

ISBN: 1 85187 724 X

© August 2004

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Printed by Contract Printing, 1 St James Road, St James Industrial Estate, Corby, NN18 8AL.  
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