

Renewal

Plan for a better NHS

Plan
for
change

Foreword

By David Cameron

In its bricks and mortar, people and services, the NHS embodies something which is truly great about Britain. That something is equity: the spirit of fairness for all and the equal right of everyone regardless of age, background or circumstance to get the healthcare they need.

It really is one of the most precious gifts we enjoy as British citizens, providing a lifeline to families up and down the country. That is why the Conservative Party has made the NHS its number one priority. We back it, and want to build it and improve it for everyone.

But everyone knows the NHS faces great challenges today. The rising expectations of patients, advances in medical science, new public health threats and an ageing population are changing the face of health – and healthcare – in our country.

In response to these challenges, Labour is letting down the NHS. Their bureaucratic approach, running our health service through political interference and the imposition of top-down targets, is distorting clinical priorities, failing patients and undermining hard-working professionals. That's why after a decade of Labour's mismanagement, health inequalities are rising, NHS productivity is falling, professionals' morale is at an all time low and our nation's overall health results, such as cancer survival rates, are amongst the lowest in Europe.

It doesn't have to be like this. This document sets out the Conservative Party's plan to renew our bureaucratised NHS. At its heart is an unambiguous commitment to give the NHS the funding it needs.

But unlike Labour, we'll make sure that money delivers the best healthcare it can to patients. For a start, we'll properly establish the NHS as an institution by giving it a constitution. That way we can protect the cardinal, core values of the NHS from the sort of massive, structural – and ultimately pointless - re-organisations that we've seen so much of recently. And by establishing an independent board to run our NHS, we can take politicians out of its day-to-day management.

Next, we will offer steady, purposeful change with a clear direction. In today's post-bureaucratic world, people have more freedom and control over every aspect of their private lives – so Government must accept it no longer has a monopoly on knowledge and power. Incentives must replace targets, and people and professionals, not politicians, should decide how our public services are run.

That's why we will free our NHS professionals and allow them to fulfil the vocation they were trained to do. We will give GPs real control over their budgets so they can re-invest savings and negotiate contracts with service providers to get the best deal for their patients.

And we will scrap all those top-down process targets which make their life a box-ticking misery. Instead, we will publish information about what actually happens in the NHS – such as cancer and stroke survival rates; and the control of diabetes – and let doctors choose how to deliver the best care.

Publishing this kind of information will have one more important effect – it will enable patients to make really informed choices. They'll be able to judge performance and decide which hospital they want to go to, how they are treated and which GP they want to use.

It will replace Labour's bureaucratic, top-down and centralised idea of accountability - between minister and doctor - with a post-bureaucratic, bottom-up and de-centralised one - between patient and doctor.

We should be proud that, in its sixtieth year, people are beginning to look at the Conservative Party as the party of the NHS. But we've got to live up to that honour. And with this plan for change we can deliver a health service which truly is the envy of the world.

Contents

Executive Summary	4
1. An end to top-down control: giving patients a world-class NHS	6
1.1 Our vision for delivering world-class healthcare	6
1.2 The NHS focused on better health outcomes, not government targets	7
1.3 Saving more lives: the improvements we want to deliver	8
2. An NHS people can trust	12
2.1 Care tailored to patients' needs	12
2.2 Trusting GPs	13
2.3 Access to urgent care	14
2.4 Better maternity services for families	15
2.5 Access to an NHS dentist	16
3. The NHS working for patients, not politicians	18
3.1 Ending political interference: an NHS constitution and independent board	18
3.2 Strengthening the patient's voice	19
3.3 Helping patients choose their care and manage their condition	20
3.4 Freedom for healthcare providers and effective regulation	22
4. Safety and standards	24
4.1 Payment by results	24
4.2 Tackling deadly hospital infections	25
4.3 NHS resources for NHS patients	25
4.4 Access to the best medicines: value-based pricing	26
4.5 Protecting the most vulnerable: improving mental health care	26
5. A healthier nation	28
5.1 Making prevention a priority	28
5.2 Promoting healthy lifestyles	29
5.3 A responsibility deal with business	29
6. Our pledge to patients and NHS staff	32
6.1 Proper funding for the services patients need – guaranteed	32
6.2 Stability and security: no more politically-led reorganisations	32
6.3 A responsible deal with the private sector	33
6.4 Valuing staff	33
6.5 Our commitment to quality	34

Executive summary

Conservatives are committed to helping our NHS become world class. We want to reverse the current situation, whereby our nation's overall healthcare outcomes, such as cancer survival rates, continually fall behind those of other comparable countries. We want our NHS to be delivering healthcare that is amongst the best in the world. Achieving this will allow at least 100,000 additional lives to be saved from disease every year. Nothing could be more important.

To achieve our ambitious vision for the NHS, we will rid it of the bureaucratic control of government, and all the Whitehall-imposed targets that are so damaging to patient care. Instead, positive new incentives will be created, driven by empowered patient choices within a more autonomous NHS. A new culture of rising standards will drive major improvements in quality and standards of care.

A Conservative government will:

- Reverse the top-down power relationship governing the NHS, putting patients, not politicians, in the driving seat. Patients will have a real power of choice over their care: which GP or other healthcare provider they want to use, which hospital they go to and even whether they want the privacy of a single room, rather than a ward.
- Empower genuinely informed choices by publishing new forms of information about the results of treatments that healthcare providers achieve. Patients and care commissioners can then see, for example, which hospitals perform well for a particular kind of surgery, or if a local GP has a good record for delivering good outcomes for patients.
- Create positive funding incentives to support patient choice by rewarding successful treatment results for patients. With funding following patients, providers will have clear incentives to achieve higher standards of care; the need for centralised targets and government control simply falls away.
- Give decision-making power back to NHS professionals and shift accountability firmly back to patients by allowing the NHS to be independent from government, with its own constitution, run by an independent board, and made accountable to a new patient body, 'HealthWatch'.
- Put trust in our healthcare professionals: GPs and other primary care commissioners will have real budgets, real freedoms and real responsibility to manage their patients' care. And doctors and clinicians, not government officials, will decide how best to structure care in hospitals.
- Allow independent healthcare providers, as well as NHS Foundation Trusts and other NHS providers, the freedom to supply services to the NHS, if they can do so at the NHS price and NHS standards. Commissioning of NHS services will be separate from healthcare providers and overseen by the independent NHS Board. An independent regulatory structure will ensure high standards of service and care.
- Build new partnerships with local authorities and the business community to help deliver major preventative public health objectives, including reducing the causes of disease, promoting healthy lifestyles and reducing health inequalities.

These reforms will be set in a solid new foundation of funding and support to ensure lasting stability for the NHS. Rising real-terms funding will be combined with greater value and productivity. Effective regulation will ensure high standards of safety and quality in all areas of care activity, from tackling deadly hospital infections to ensuring the safety of vulnerable patients.

We want the next Conservative Government to be judged on how successful we are in making the NHS one of the best health systems in Europe. We want our NHS to deliver better, more personal care and bring an end to Labour's cuts to local services. We want to achieve better access to the best medicines and tackle entrenched health inequalities, and save many more people from premature death.

Our plan to improve the NHS will bring major and lasting improvements to our population's health: an NHS delivering world-class healthcare, providing people with the highest standards of care for generations.

1. An end to top-down control: Giving patients a world-class NHS

The NHS is the Conservative Party's number one priority. We share Britain's pride in the values which built our NHS, and we are committed to providing it with the funding it needs to deliver high standards of healthcare to all, free at the point of use, based on need, not ability to pay. The NHS helps bind us together as a nation, and it is essential to our vision of building a stronger and safer society. Our vision for the NHS is framed by a desire to improve what actually matters to patients: the outcome of their treatment. And our objective is that the NHS should deliver amongst the best health outcomes in Europe.

Eight years ago, the then Prime Minister, Tony Blair, committed the Labour government to matching European levels of health spending. Today, that pledge has been delivered. We now spend an amount equivalent to the European average on healthcare. Unfortunately, however, we have not seen value for money for this extra spending. In fact, productivity within the NHS has fallen year on year, and our overall health outcomes, such as cancer survival rates, are amongst the worst in Europe.

Gordon Brown's own independent reviewer of the NHS finances, Sir Derek Wanless, said last year that the extra cash has not delivered what Labour promised. He said, in spite of the extra funding: 'we are not on course to deliver the sustainable and world class health care system, and ultimately the healthier nation, that we all desire.'¹

The problem is Labour's strategy of trying to manage the NHS through top-down, centralised targets. These targets focus primarily on processes and administration, such as stipulating the time it should take for patients to be processed through their treatment, or for administrative procedures to be completed, rather than the actual results of patient care.

Labour's NHS targets were designed to raise productivity and performance, and ultimately standards of patient care. But in practice they have had the opposite effect. Far too much time and money which should be spent on patient care is instead being directed at administering government targets. As a

result, clinical priorities are being distorted, the autonomy of health professionals is being undermined and staff morale, NHS productivity and care standards, are all in decline.

Conservatives want to support the NHS, and rid it of the bureaucratic targets and endless structural upheavals that are compromising patient care. Instead of focusing on meeting procedural targets, we want to allow NHS professionals to focus on achieving good treatment outcomes for patients. This is the only way to achieve the highest standards of care throughout the NHS.

To achieve this, we will transform the essential power relationship in the NHS, from a top-down relationship where professionals are told what to do by politicians and patients are left to accept the treatment they are given, to one where patients are put first by having the power to choose the service they want, supported by the right information to make that choice meaningful. Improving patient choice, and ensuring competition and contestability amongst healthcare services, are essential to improve patient outcomes.

At the heart of our NHS Improvement Plan is a vision we share with all healthcare professionals: to deliver world-class healthcare. We will ensure from day one of the next Conservative Government, that positive reforms have the right impact. As reform extends, we will guard against poor standards, hold the NHS to account for the quality of services it provides, and ensure that its financial and regulatory framework sustains improving quality. This way, we can deliver the improved health outcomes and efficiency improvements needed to secure rising NHS performance for generations.

1.1 Our vision for delivering world-class healthcare

Our aim is for a world-class NHS achieving the highest standards of care relative to other countries. This is a significant ambition – we now lag behind the comparable international average.

If we were to reach the average standard, an additional 38,000 lives would be saved each year from premature death due to disease. If we realise our ambition for the NHS to achieve health results that are comparable to those of the best performing countries in the world, we can save over 100,000 lives a year.

We will phase out Labour's top-down process targets, so that decisions are made about care in relation to the individual needs of patients. Our outcome measures will drive improvements throughout the NHS. They will do so, not just because the commissioners and providers of NHS care will tailor services around patients, but because patients will be engaged in choosing the provider that best suits them

1.1.1 How Labour's target culture is failing patients

Labour's system of public service provision is based around the use of politically-determined performance targets, which are then passed down to professionals to deliver. Accountability runs upwards to politicians, not outwards to service users, who have very little say over how services are delivered.

Care priorities in the NHS are driven by top-down targets which focus on processes and administration rather than clinical need. In theory, some targets can look sensible – no-one wants to wait a long time to be seen in Accident and Emergency, or to be unable to get a GP appointment at short notice. But in practice, focusing front-line staff on meeting targets, and all the reporting and administration that goes with them, means that professionals are too often concentrating on satisfying the requirements of bureaucrats rather than actual patient care.

For example, if a patient is seen within the correct timeframe, but as a result their health suffers because they have not been observed for long enough or by the right person, clearly something is wrong. Yet this is exactly the sort of distortion of clinical priorities that Labour's system can encourage. This frustrates professionals, harms patients and erodes trust in the ability of the NHS to deliver the outcomes we all want.

A target that is often cited for creating major distortions of clinical priority is the four-hour A&E waiting time limit. This target has led to reduced measured waiting times in A&E, but has encouraged some very perverse practices as hospitals strive to achieve the target. These include:

- increasing short stay hospital admissions;
- making inappropriate admissions to other hospital units; and,
- moving critically ill patients from high dependency areas, where this may not have been in the patient interest.

As Chancellor, Gordon Brown imposed 64 targets on the NHS.

His Government imposed a further 37 in its 2007 Comprehensive Spending Review. As a result, the Government demands 250,000 data returns from all NHS organisations every year.² Apart from the excessive bureaucracy caused by targets and their distorting effect on clinical priorities, these targets are expensive: over the last five years, £2 billion has been spent solely on pursuing the four-hour limit at A&E.³

There is now a wealth of evidence that shows targets are having a direct and negative impact on the NHS. For all Labour's reorganisations, for all its targets, audits and reviews, the Office of National Statistics has shown declining productivity in the NHS, with a 2.5 per cent a year decline at times of the greatest increases in budgets and most intensive targeting.⁴ The fact that so much money is being spent on distorted activities aimed at meeting targets which have nothing to do with delivery of care is a key factor explaining declining productivity and performance, despite the dedicated work of NHS staff.

The problem of process-driven targets also extends to primary care. We support the system which links GPs pay to performance but do not support the large number of points awarded for administrative processes in comparison to clinical ones. For example, GPs have been awarded more points for updating records and information systems, essentially a contractual requirement, than for looking after patients with chronic lung disease and stroke. Any system which prioritises box-ticking above the provision of life-enhancing care is unacceptable.

1.2 The NHS focused on better health outcomes, not targets

Instead of measuring NHS performance against a plethora of procedural targets, we will focus on improving the overall results of people's treatment in the NHS, known as 'NHS outcomes' – not the processes that produced them. Measuring outcomes does not simply replace one set of government diktats with another. Outcomes are fundamentally different from targets because healthcare professionals focused on outcomes are not being commanded by bureaucrats to adopt specified procedures or processes to achieve results. What matters is the result itself, not how it is achieved.

By collecting and making public the results of treatments and patients' healthcare experiences, we will enable patients, NHS

1 The King's Fund, 'Our Future Health Secured?', September 2007

2 Conservative Party Analysis, June 2008

3 The Times, 24 December 2007

4 Office for National Statistics, Public Service Productivity: Healthcare, January 2008

professionals and the general public to see, for example, which hospitals perform well for a particular kind of surgery, or if a local GP has a good record for delivering good outcomes for patients.

Patients and healthcare commissioners will then be able to judge providers by their results and make their choices over where to go for care accordingly. With funding following patients, patient choice will drive powerful incentives for providers to raise standards of care.

1.2.1 Trusting expert opinion

Independent experts now agree that NHS performance management that is focused on securing better patient outcomes instead of monitoring process targets will lead to improved patient care. For example:

- “We need to radically overhaul the way that we measure success in the NHS, by putting patient satisfaction and outcomes at the heart of a new approach.” (Dr. Gill Morgan, former Chief Executive, NHS Confederation, BBC News, 22 January 2007)
- “Routine collection and use of outcomes measures in the NHS is both practical and essential. We expect it to lead to improved outcomes, performance and productivity, thereby providing significant benefits to patients.” (Office of Health Economics Commission, NHS Outcomes, Performance and Productivity, March 2008, p.9)
- “Patient reported outcome measures have been used extensively in clinical trials....they are urgently needed now as they were in Nightingale’s time.” (Professor Alan Maynard, The Guardian, 4 September 2007)
- “If we are going to have healthcare services that invest for health, we must find new ways of assessing their value and their productivity, or achievements in improving health.” (Healthcare Commission, State of Healthcare Report Summary 2004, 2004, p.9)
- “The next step for healthcare is not about more reorganisation. It is about ensuring there is genuine support for healthcare professionals to measure and report clinical and patient-reported outcomes so that long-term improvements in the quality of patient care can truly be achieved.” (Stephen Thornton, Chief Executive, The Health Foundation, BBC News, 20 June 2007)

1.2.2 How focusing on outcomes raises standards

A focus on outcomes, not targets, will drive improvements throughout the NHS, not just because the commissioners and providers of NHS care can tailor services around patients, but because patients can be genuinely empowered to choose the provider that best suits them.

Publishing information about patient outcomes can help dramatically improve results throughout the NHS by:

- giving professionals better information about the procedures and treatments that work;
- giving patients and healthcare commissioners accurate information on which to base their choices; and,
- aligning financial incentives for healthcare providers around best practice and successful treatment outcomes.

Unlike with Labour’s process-driven targets, under our system professionals within an autonomous NHS will be free to make the right clinical decisions they feel will help achieve the outcomes we want to see. Patients and healthcare commissioners will be able to judge providers against their success in meeting these targets and make their choices accordingly, while the funding regime will reward success and encourage under-performing providers to improve.

1.3 Saving more lives: the improvements we want to deliver

Focusing the NHS on achieving better health outcomes will allow us to monitor its results compared with other country’s health systems. We want our NHS to deliver world-class health outcomes, so we have committed a Conservative government to be judged against how it improves our nations’ overall health in terms of some key outcomes for preventing premature death from disease and making quality improvements in patient care, as identified below.

Achieving performance against these commitments comparable to average European standards across the NHS could save nearly **38,000** lives a year. Performing at the same level as the best health systems could save at least **100,000** lives a year.⁵

1.3.1 Five-year survival rates for cancer in excess of EU averages by 2015

A recent study of 20 European countries found that England has one of the worst five year cancer survival rates in Europe, with outcomes on a par with some Eastern European countries that spend less than one third of the UK’s per capita healthcare budget.⁶

In order to raise survival rates in excess of EU averages, the NHS will be tasked with improving five-year survival rates, supported by additional resources liberated from politically-driven targets. The data required for measuring five year outcomes is already collected by the Information Centre and National Cancer Registries. Instead of focusing on only part of a cancer patient’s treatment, clinicians will be free to tailor all treatment around an individual’s needs in order to achieve what matters most to patients – improved survival rates.

• Five-year cancer survival rates in excess of EU averages by 2015 would mean that between 4,600 and 34,500 lives could be saved:

Every year around 230,000 people in England are diagnosed with cancer. Only 45 per cent of cancer patients in England survive for five years after diagnosis. The European average is 47 per cent and the European best (in Sweden) is 60 per cent.⁷ Therefore, on the basis of current survival rates, 103,500 people would still be alive after five years; on European average rates 108,100 people would be alive after five years; and on European best rates, 138,000 people would be alive after five years. That means between 4,600 and 34,500 lives could be saved every year.

1.3.2 Premature mortality from stroke and heart disease below EU averages by 2015

National targets exist to ensure patients do not wait for longer than three months for intervention, yet no clinician would signal this as an appropriate quality measure. The role of government policy is not to determine the targets involved with the process of delivering care, but to measure the results in terms of survival rates and health improvements. The Government’s process targets do not reflect best practice across the world and should be subject to clinical interpretation.

• Premature mortality from stroke reaching below comparable country averages by 2015 would mean that between 13,199 and 24,874 years of life could be saved:

Every year approximately 110,000 people in England have a stroke. In the UK, 117 years of life below age 70 are lost to cerebrovascular disease per 100,000 of the population. This compares to just 91 in Germany, 83 in France and 68 in Australia.⁸ The population of England is 50,762,900, so England’s population would lose 59,393 years of life to cerebrovascular disease, compared to just 46,194 in Germany and 34,519 in Australia. That means that between 13,199 and 24,874 years of life could be saved every year.

• Premature mortality from heart disease reaching below comparable country averages by 2015 would mean that between 4,400 and 17,600 lives could be saved:

275,000 people in England have a heart attack each year. 11.8 per cent of people in the UK die within 30 days, compared to just 10.2 per cent on average in the OECD and just 5.4 per cent in New Zealand, the best performing country.⁹ Therefore, 32,450 people currently die within 30 days in the UK. If OECD average rates were achieved then just 28,050 people would die; and if the best OECD rates were achieved then just 14,850 people would die. That means between 4,400 and 17,600 lives could be saved every year.

1.3.3 Premature mortality from lung disease below EU averages by 2020

Declining lung function causes a lower quality of life and premature death. Rates of chronic lung disease mainly reflect the legacy from smoking and certain occupational health exposures. Government targets do little for lung disease because they focus on process measures used solely in General Practice.

The NHS currently has no way of knowing whether treatments and services are helping patients, let alone which treatments or pathways help the most. Under our system patient outcome measures would be recorded at regular intervals to judge patient perception of care and the quality of a pathway across primary and secondary care as a whole. Healthcare commissioners would be free to design care packages around the needs of patients, rather than simply ensuring that certain processes were followed in order to hit government targets.

5 These numbers of lives saved are calculated by adding together the lives that would be saved in each of the five areas identified in section 1.3 if the NHS were to perform to (a) average European standards or (b) the highest European standard. For prudence, we have not included the lives saved from raising standards of quality more generally, to avoid any risk of double-counting.

6 Lancet Oncology, ‘Cancer survival rates continue to improve, but UK still lagging behind’, 21 August 2007.

7 Eurocare 4 study, reported in The Lancet, 21 August 2007

8 Leatherman & Sutherland, The Quest for Quality: Refining the NHS Reforms, 20 May 2008

9 OECD Health Data, 2007

- **Mortality from lung disease below EU averages by 2020 would mean between 15,737 and 23,860 lives could be saved:**

In the UK there are 78 deaths per 100,000 per annum from respiratory diseases, compared to just 47 on average in the EU15 and 31 in Austria, the best performing EU15 country.¹⁰ The population of England is 50,762,900. Therefore, 39,595 people currently die each year in England from lung disease, compared to just 23,859 if we achieved European average rates and just 15,736 if we achieved European best rates. That means between 15,736 and 23,859 lives a year could be saved every year.

1.3.4 Mortality amenable to healthcare brought down to the level of comparable countries

Measures of avoidable mortality are used internationally to measure the extent to which healthcare services save lives and contribute to population health. Avoidable mortality refers to the number of deaths (under age 75) that should not occur in the presence of effective and timely healthcare. Causes of death are included in this indicator if there is evidence that they are amenable to healthcare interventions. Healthcare interventions include those aimed at preventing disease onset as well as treating disease.

- **Mortality amenable to healthcare brought down to the level in comparable countries would mean between 6,599 and 19,290 lives could be saved every year:**
In the UK there are 103 premature deaths per annum per 100,000 population from causes that are potentially preventable with timely and effective healthcare, whereas there are just 90 in Germany and 65 in France.¹¹ The population of England is 50,762,900. Therefore in England there are 52,286 deaths per annum from causes that are potentially preventable with timely and effective healthcare, compared to just 45,687 if we achieved German levels of care and 32,996 if we achieved French levels. That means between 6,599 and 19,290 lives could be saved every year.

1.3.5 Year on year improvements

We will also aim to achieve the following specific quality improvements:

- **Year-on-year improvement in patients' satisfaction with their access to, and experiences of, healthcare**

The past decade has seen targets directed to controlling specific services, with a narrow focus on casualty waiting times or access to see a GP. Evidence suggests these targets have been met by diverting attention or resources from other areas and in places by flexing the rules; they have had little effect on the reform of services. We will ensure Primary Care Trusts (PCTs) commission independent samples to gauge patient satisfaction with a range of healthcare services. This will allow PCTs to make more informed decisions about the providers they contract with, and enable patients to see which providers deliver the best services.

- **Year-on-year improvement in patient-reported outcomes for patients living with long-term conditions**

There are no current statistics or data for the great majority of those seventeen million patients living with a long term condition. But as we move towards a system where the individual patient is given a budget with which to design their own care package, we will require detailed outcome information to assess progress. Care for these conditions is often fragmented between different care providers, leaving patients and their families confused whom to call. Targets exist to deal with these problems, but they tend to measure the delivery of processes at one point in the health system – typically the administration of a test or treatment to a given demographic group over a given timeframe. We propose to replace these by collecting, collating and publishing patient-reported outcome measures for chronic diseases. We will consult on outcome tools for other common disease areas.

- **Year-on-year reduction in the number of adverse events**

Over 6,000 patient deaths are reported every year as a result of health-related events. Our view is that it is very rarely the case that one individual causes such an error; rather it is the system of care that contributes to these tragedies. We are therefore committed to an open and transparent approach to learning from failure. It is vital that patients understand the risks they face when submitting to health procedures delivered by a provider. We will consult on key outcome charts used in Australia, Germany and the USA where quality standards are often devised by experts and collected voluntarily. A safety improvement environment can only be created by strong local clinical leadership informed by good information about care trends. We will bring forward measures to reward learning cultures, reinforce the importance of staff training, provide event simulation and debriefing. We will consider penalties for the most serious adverse outcomes.

We are consulting on other outcomes about which patients and professionals should be able to access up-to-date information. These will include: NHS dentistry, maternity services and palliative care. In addition to our focus on outcomes, we are also developing complementary policies in each of the areas above.

¹⁰ British Thoracic Society, The Burden of Lung Disease, 28 June 2006

¹¹ Leatherman & Sutherland, The Quest for Quality: Refining the NHS Reforms, 20 May 2008, p.109

2. AN NHS PEOPLE CAN TRUST

2.1 Care tailored to patients' needs

From giving patients greater choice over the care they receive, to giving GPs greater autonomy over their budgets, we will create a more personal NHS with more power for patients to determine the shape of services, hence improved access to better local services. We will end Labour's top-down approach to managing the NHS from Whitehall, which is undermining the work of doctors and nurses, and forcing cuts to the local services on which patients rely.

We believe the NHS should be more patient-focused. That means creating a service that is more accountable to patients, both for the kind of care they receive, and for the results of care. The best way to achieve this is to enhance the power of patients to choose the care they want.

2.1.1 Choice of a primary care commissioner

Choosing a primary care commissioner, such as a GP or nurse is one of the most important health decisions we can make. On average, each one of us sees a GP four times year, and 15 per cent of the population sees a GP in any two-week period. However, for many people, access to a local GP of their choice remains too difficult.

When people want to register with a new GP practice, they are sometimes unable to do so because that practice is not open to new patients. The problem is that Primary Care Trusts (PCTs) control the number of practices and their size, and GPs are not actually free to respond to what the patient wants. Many practices do not take on patients who live outside an area agreed with their PCT. There is also often a lack of reliable, accessible information on practices and what services they offer.

We will change this and give people the power to choose the practice most convenient for them. For some people, this will be the practice closest to their home. Others may want to register with a practice near their work. Appropriate mechanisms need to be put in place to ensure that patients can choose to register with the practice most convenient to them – and practices need to be adequately rewarded, not penalised, if they take a patient who wishes to transfer to them from another practice.

While Conservatives are openly committed to giving people the right to choose their primary care commissioner, Gordon Brown is still dithering over the issue. In July 2008, the Government published a strategy for Primary Care, the main focus of which was supposed to be giving patients more choice of GP. But Labour appear to favour only partial solutions, such as extending practice catchment areas. Unless patients are free to choose any GP they want to be registered with, and change at any time, they do not have genuine choice.

Our pledge to give people the right to choose their primary care provider is an important step towards empowering patients. The majority of people are happy with their GP practice. But if they become unhappy with the service they receive, it is important they can change without bureaucratic constraints. This will also ensure that, based on local needs and circumstances, GP practices respond to patients' access needs, whether for extended opening hours or, as surveys show is a more widely held concern, to be able to make appointments more than 48 hours in advance. It is also important that GPs – as the vital link between patients and other NHS services – know that they are fully accountable to their patients choices.

2.1.2 Choice of a hospital

We will empower patients with real choice, in consultation with their GP, over where they get their secondary care. Hospitals not only differ in terms of locality, ease of access and the services on offer, they differ in terms of results. Some are more specialised at dealing with particular conditions, for example, so it is crucial that this information, and the power to use it, is placed firmly in the hands of patients.

Gordon Brown's outdated approach to the NHS sees patients as passive recipients of healthcare. It keeps health information in the hands of government officials, not the public. Because of this, there is a lack of good publicly available information on post-treatment success hospitals achieve. People are not able to make genuinely informed choices about the care available.¹² The Government's own patient surveys show that almost two thirds of patients are unaware before they visit a GP that they have a choice of hospitals for first appointment.

We believe patients should be able to obtain information, not just about the choice of providers, but also about what to expect and what will happen to them, and how much control they can have over their care. Later sections of this report show how we will unleash an information revolution in the NHS where hospitals, trusts and other providers collect and publish key information about the health outcomes they achieve to allow genuine choice over hospitals to become the norm, not the exception.

2.1.3 Choice of care – a single room in NHS hospitals

As well as choosing their hospital, we want patients to have a greater say in how they are treated while in hospital. A major issue for patients that have to undergo a stay in hospital is whether it is appropriate that they stay on a ward with other patients. Some people prefer to share a ward with others, but a significant proportion, of around 35 per cent according to recent surveys by MORI,¹³ want to be accommodated in a single room.

This is not simply a fickle preference. Many people object to having to stay in a mixed-sex ward in particular, for obvious reasons of privacy. But people also find their particular condition makes it uncomfortable to be in a ward with others, such as those in a state of discomfort or distress.

Labour have been making promises to abolish mixed sex wards for over a decade, but nearly a third of hospitals still treat patients in these wards.¹⁴ And in 2001, Labour issued guidance that all new hospitals should have at least 50 per cent single room capacity,¹⁵ but four out of every five new hospitals opened since then do not meet this standard.¹⁶

A Conservative government will allow patients to choose a single room in NHS hospitals when they are booking their treatment. In line with our wider plans for empowering patient choice, the NHS will publish information about whether patients' choices for single rooms were met, which patients can use as they choose which hospital to receive their care from. With funding following the patient, this will provide very strong incentives for hospitals to build the capacity patients require.

Capital funding will also be in place for hospitals to make the upgrades necessary to meet demand. These funds already exist for upgrading hospitals with refurbishments and extra capacity, and this is allocated on a needs basis, so under a Conservative government, the Department of Health would make single room capacity one of the priorities for allocation.

2.1.4 Individual budgets for patients with long-term conditions

We will enable those with a stable, predictable, long-term condition to have access to an individual budget. If someone with a long-term condition, who is living at home, is able to be assessed through a single assessment process, which incorporates both health needs and social care needs, then a 'pooled budget' could be determined for them. The calculation of the budget would consist of two parts: one, social care and means-tested, the other healthcare-related and free. Based on this, an individual and their carer(s), would be given the flexibility and empowerment to choose their providers. They should be able to exercise that flexibility across the social/healthcare divide.

2.2 Trusting GPs

When it comes to listening to the wishes of patients, one thing Labour have completely failed to understand is how much we value our local health services in this country. So Conservatives will make sure patients have access to the local services they need. We value, too, the "relationship medicine" which is one of the best features of our GP care, and we will make sure family doctor services are protected. We have never supported Labour's plans to replace family doctor surgeries with big, impersonal 'polyclinics'. Under our proposals, GPs would be central to improving patient care. Under Labour, they have lost responsibility for commissioning and out-of-hours care, they have been in conflict with the Government, and are now being pushed into big impersonal polyclinics.

We need to put GPs back at the heart of our health services by giving them direct control of budgets for their patients' care. We have also pledged to give responsibility for commissioning out-of-hours care back to GPs, allowing GPs to provide it through a GP cooperative should they wish, or commission the service in a way which genuinely meshes with GP services.

2.2.1 Giving power back to GPs – budget holding and

13 Public Perceptions of Privacy and Dignity in Hospitals, study for the Department of Health, Ipsos MORI, March 2007

14 Conservative Party Freedom of Information Act request, December 2007

15 Hansard, 26 February 2008, Col.1462WA

16 Conservative Party Freedom of Information Act request, February 2008

commissioning

We want to allow GPs to manage the entire relationship that a patient has with the NHS. In order to do this GPs should control the budgets that NHS patients are entitled to, and there is a good economic rationale for this. Budget-holding is a natural guarantee of efficiency, ensuring money follows the patient and it is spent on frontline care rather than on bureaucracy. GPs – rather than remote managers – should be responsible for reconciling the available resources with clinical priorities and patient choice.

And there is a good health rationale for GP budget-holding too, in terms of continuity of care. The family doctor service is the simplest and most direct way to ensure that, even if patients see many specialists, there is always one doctor in charge: the doctor closest to the patient. This is especially important when it comes to preventative action or the management of chronic conditions, which require significant patient involvement.

With the GP having the ability to advise the patient and to commission care on their behalf from any willing provider at NHS costs and at NHS standards, we put patients back at the centre of decisions made by healthcare professionals. GP-led commissioning in primary care combines the decision-taking responsibility for where and how patients are treated with the finances which are necessary to support it.

In aligning these two tasks the clinician's voice, on behalf of their patient, is strengthened because the GP is responsible for the resources needed to support his or her judgement. And if a GP is engaged in inappropriate or inefficient referral practices, they will be able to identify and address them easily. This will help drive efficiency improvements in the NHS.

In addition, commissioning requires an understanding of the current and future epidemiology of an area – i.e. the burden of disease which exists there. GPs in primary care are among those best placed to assess and anticipate an area's burden of disease.

GP-led commissioning in primary care is the best tool, therefore, to develop the effective use of procurement and contract processes so that they secure delivery of services that best meet the needs of an area's population.

Labour has partially recognised the value of commissioning at practice level in introducing Practice-Based Commissioning (PBC). But PBC still means Primary Care Trusts hold the purse strings, and GPs neither hold real budgets nor have the ability to reinvest savings on behalf of their patients. We will ensure GPs hold real, not hypothetical budgets, that they can hold and vary contracts with healthcare providers, and that they can reinvest any savings they make.

2.3 Access to urgent care

Patients should have just two choices in respect of urgent care: is it an emergency or not? This should be reflected in two national numbers: the existing "999" number for medical emergencies and a new simpler, "116 116", number for all other urgent calls.

"116 116" would be the single telephone gateway to access NHS Direct, GP out-of-hours services or other urgent care services. This would help to mitigate existing confusion about who to call for urgent care services, and by virtue of being a simpler number, would be easier to remember - a poll conducted by Which? revealed 83 per cent of adults did not know the 0845 4647 number to call for NHS Direct. The EU is currently looking at mandating 200 numbers beginning with 116 1 * * and 116 2 * * for non-emergency public services, including healthcare, throughout the EU. After appropriate consultation by Ofcom and the EU, we would look to replace 0845 4647 and the multitude of local GP out-of-hours numbers with a single '116 116'.

Urgent care services should identify emergencies immediately, and be able to offer advice, treatment, a home visit, referral or access to an appropriate clinician, through a single pathway, combining providers as necessary. This could be realised through:

- Franchising out NHS Direct initial call-handling to Ambulance Service Trusts;
- Ambulance Service Trusts would also be able to take initial call handling on behalf of Out-of-Hours Services;
- NHS Direct would retain responsibility for national marketing of the telephone system and online/web-based advice;
- Primary Care Trusts (PCT) should ensure that the contract specifications for A&E services, Ambulance Services, Walk-in-Centres and Out-of-Hours Services, provide for integrated call-handling, consistent triage protocols, and networked or co-located services, in order to ensure access to urgent care is timely, appropriate and minimises unnecessary attendances for emergency care;
- PCTs and GP commissioners should be jointly responsible for commissioning GP Out-of-Hours Services, ensuring GP engagement in design of linkages to GP services. PCTs should be responsible for commissioning A&E, Ambulance Services and Walk-in-Centres;
- NICE should provide commissioning guidelines for urgent care, providing evidence-based criteria for patient access and a basis for local contracts.

2.3.1 Accident and Emergency (A&E)

Government guidance on A&E departments says they should serve a population of at least 450,000 people,¹⁷ but on average, each A&E Department in England serves a population of just 247,214.¹⁸ If this guidance was rolled out nationally, scores of A&E departments would be closed down. Evidence is clear that, while some patients should be "blue-lighted" to a specialist service, e.g. for trauma, heart attack, stroke or an aneurism, other patients need local access to be safe, and the great majority of A&E attendances can continue to be cared for at an accessible local emergency department. We will stop A&E closures which undermine such locally accessible services

2.4 Better maternity services for families

2.4.1 Maternity services

The Government was recently forced to admit, under Freedom of Information Act requests, that 40 maternity units in England have been or are likely to be closed or lose services.¹⁹ Instead of supporting these local services, the Government wants to supersize them. Its guidance to the NHS calls for maternity units to cover at least 3,000 births per year,²⁰ but one in three maternity units caters for fewer than 3,000 births and the evidence is that smaller maternity units tend to perform better.²¹ It will not be possible to offer choice to mothers if obstetric services become more distant. We will ensure that safe and accessible maternity services are available for mothers.

We will also increase the number of midwives. We will encourage community-based midwifery teams who will provide continuity of care for mothers, and will support home birth options, or help mothers determine the best circumstances for them, based on their relative risk and wishes.

We will ensure that the choice of access to local maternity services is not taken away as a result of the impact of the European Working Time Directive, as is currently the threat, or through pressure to centralise services in very large units.

If the necessary risk assessments and services are in place, we will support the retention of smaller obstetric units, continuing to offer access to services locally.

2.4.2 Health visitors

We have pledged to provide thousands more health visitors across the country so families have the support and advice needed to give every child a good start in life. We know that the first steps in a child's development are crucial. Children's experiences in their earliest years go on to affect how well they do at school and their physical and emotional health right into adulthood.

¹⁷ Clinical options workshops, West Surrey NHS, March 2007

¹⁸ Hansard, 21 March 2007, Col. 996WA; 19 March 2007, Col. 720WA

¹⁹ Conservative Party Freedom of Information Act request, April 2008

²⁰ Looking to the Future, East of England Strategic Health Authority, December 2006

²¹ Analysis by the House of Commons Library, June 2008

This is why health visitors are so important. As highly qualified nurses or midwives, they are specially trained to work with mothers and their babies to help new parents with the huge challenge of bringing up children. International evidence shows that when parents receive more visits from health visitors, children are more likely to be healthy, do well at school, find better jobs and stay out of crime.

For example, the Nurse Family Partnership programme in the US, which gives home visits for vulnerable families, has produced dramatic results, including improvements in women's prenatal health, reductions in children's injuries, fewer subsequent pregnancies, greater intervals between births, increases in fathers' involvement, increases in employment, reductions in welfare and food stamps, improvement in school readiness, reductions in child maltreatment among poor married teens, and a major reduction in emergency room visits for children between one and two years old. This intensive home visiting programme had 50% better outcomes when nurses, rather than para-professionals, were used to deliver the programme.²²

It is unacceptable that Labour have actually cut health visitors by 2,000 over the past four years. Now the average time parents spend with a trained health visitor in the first year after their child is born is just four hours and six minutes.

With the extra health visitors we will provide, which will amount to 4,200 across the country, every family will be guaranteed comprehensive services including:

- At least two visits from a health visitor before you give birth to advise you on your diet and health during pregnancy and to help you prepare for bringing up your child;
- Visits totalling at least six hours during the first two weeks after your child is born;
- A visit from a health visitor every two weeks during the next six months of your child's life;

- A visit from a health visitor at least once a month when your child is aged between six months and one year. This is to support you in helping your child start eating solid food and develop good sleep patterns. The health visitor will also give you advice about how your family can best cope with looking after a growing child; and,
- At least two visits from a health visitor every year when your child is aged between one and five. This is to give you advice on injections for your child, as well as to provide your child with regular check-ups for his or her hearing, sight, development and growth.

2.5 Access to an NHS dentist

The Department of Health has admitted that the number of NHS dentists declined by 500 last year alone,²³ and a recent study for the Citizens Advice Bureau found that 7.4 million people have not been to an NHS dentist since April 2006 because of difficulties in finding one.²⁴

The new dental contract cost the NHS in excess of £120 million because the income Primary Care Trusts should have received from patient charges has been much lower than the Department of Health anticipated.

We want to improve patient access to NHS dentistry and work with the priorities of the dental profession.

²² See the research at www.nursefamilypartnership.org, and reports in 'Facing the Future: A review of the role of health visitors', Department of Health, June 2007

²³ Department of Health, Evidence to the 2008 Pay Review body for Doctors' and Dentists' Remuneration, 5 November 2007

²⁴ CAB Press Release, 16 January 2008

3. THE NHS WORKING FOR PATIENTS, NOT POLITICIANS

The NHS is far too important to be allowed to be exploited by politicians for partisan gain. It needs long-term stability and its professionals need the freedom to set priorities that are solely in the best interest of patients. Far too often, Labour have made decisions affecting the NHS that were taken not in the best interest of patients, but for blatantly political reasons.

Ministers have directly gerrymandered in the reconfiguration of NHS services for political ends. For example, before Peter Mandelson resigned as MP in Hartlepool, the local hospital had been facing planned cuts to its maternity services. But when he resigned and a by-election was called, the Department of Health quickly reversed the decision to avoid any political fall-out for Labour. When the election was over, the hospital was cynically stripped of its maternity services as originally planned.

3.1 Ending political interference: an NHS constitution and independent board

In November 2007 we published our draft NHS Autonomy and Accountability Bill, which outlined a strong statutory framework to set the NHS free from constant political meddling.

3.1.1 The NHS board

To ensure that political interference does not result in the distortion of clinical priorities and the denial of autonomy to front-line NHS clinicians, we will establish an independent NHS Board, which will be responsible for setting the commissioning guidelines of NHS care and replace the NHS Executive which currently lies within the Department of Health under the control of Ministers.

NHS Board members will be appointed by The Secretary of State for Health on the basis of recommendations made by the Appointments Commission. The Board will report to a Chief Executive and a non-executive Chairman. The NHS Board will reflect the highest standards of corporate governance and transparency. Its Chairman and Chief Executive will be fully accountable for their statutory responsibilities, and the NHS Board itself will be required to report to Parliament.

The NHS Board's statutory duties will be to:

- Secure comprehensive health services;
- Deliver improvements in the physical and mental health of the population; and
- Deliver improvements in the diagnosis and treatment of illness.

These are duties consistent with those of the Secretary of State, but legislation will require that the Secretary of State relinquish them and that powers in relation to providing NHS services are undertaken through the NHS Board.

The Secretary of State will agree with the NHS Board a set of objectives to deliver health outcomes that are comparable to the best in the world, as set out in Chapter 1, which is consistent with the level of resources for the NHS determined by Ministers and approved by Parliament. The NHS Board will also be responsible for publishing guidelines for NHS commissioners, based on advice from NICE which will set evidence-based standards of care, enabling patients to see what their entitlements are and what they can expect from services.

We will also end political meddling over money, removing the scope for distributing resources for reasons of political expediency rather than clinical need. An example of this is how the Secretary of State, in November 1998, demanded that a key objective of the NHS funding formula should be, 'to contribute to the reduction in avoidable health inequalities'.²⁵ Although the objective sounds admirable, it had the effect of creating a mismatch between the supply of NHS resources and the demands on the service – a situation which has led to what the Department of Health admits is a 'moderate correlation' between NHS deficits and the funding formula.²⁶

NHS resources for services should be allocated to areas in

order to ensure, so far as possible, equal access to healthcare. Resources should be matched to the relative burden of disease. Resources for public health services, geared to improving health outcomes through health promotion and prevention of disease, and to the reduction of health inequalities, should be separately allocated. To avoid creating political opportunities to manipulate the funding formula, NHS resource allocation should be set by the NHS Board, independently of Ministers.

3.1.2 An NHS constitution

Alongside establishing the NHS Board, we will establish the NHS as an institution. At the moment the NHS has no charter, no articles of incorporation, no governing document at all. And now, in the 21st century, as the pace of social and medical change is accelerating so fast and when so much needs to improve about the way we organise healthcare, now more than ever we need to protect the core values of the NHS against the sort of pointless upheavals we have seen so much of under Labour.

We believe there is a crucial need for proper legislation to ensure that all bodies and organisations providing NHS care would have to have regard to core principles of the NHS in caring for patients, and for the duties and responsibilities of NHS bodies, and rights for patients, to be clearly set out in statute.

We will enshrine ten core NHS principles in legislation, for the first time establishing a guaranteed, statutory basis for the principles applied by NHS bodies. These are:

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide a comprehensive range of services.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.
4. The NHS will respond to different needs of different populations.
5. The NHS will work continuously to improve quality services and to minimise errors.
6. The NHS will support and value its staff.

7. Public funds for healthcare will be devoted solely to NHS patients.
8. The NHS will work together with others to ensure a seamless service for patients.
9. The NHS will help keep people healthy and work to reduce health inequalities.
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

3.2 Strengthening the patient's voice

For Ministers and the NHS Board to be truly accountable, patients need to have a strong voice at both local and national level. All patients need to have easy access to an NHS watchdog with a powerful, national brand and a strong local presence.

3.2.1 Labour failure

Labour have failed to provide a voice for patients:

- Community Health Councils (CHCs) – which had originally been established in 1974 – were abolished on 1 December 2003, after almost 30 years' existence. The expertise they built up in helping patients was simply lost.
- The longevity of CHCs contrasts with the brevity of their successor bodies: Patients' Forums. Patients' Forums were established in December 2003 and are set to be abolished by the end of this year.²⁷
- Labour are currently establishing Local Involvement Networks (LINKs) in the place of Patients' Forums.

These changes have delivered three different mechanisms for patients and members of the public to engage and involve themselves in the development of NHS services in less than four years. We believe that mechanisms for engaging patients in their health services need to be enduring, so that awareness and engagement increases over time and the experience of those who operate these mechanisms is retained.

²⁵ Department of Health, Resource Allocation: Weighted Capitation Formula, 27 May 2005

²⁶ Department of Health, Explaining NHS deficits, 20 February 2007

²⁷ Department of Health, A stronger local voice, 13 July 2006

In keeping with our commitment to avoid organisational upheaval, we will not abolish LINKs. We will use LINKs, when established, as the foundation of our policies for patient and public involvement in health at a local level. However, we are of the view that LINKs – as currently planned – are too weak and will have too few powers to command the confidence of patients and members of the public. Therefore, we believe that:

- LINKs should be made independent of local authorities. Our plans to enhance the accountability of NHS services to local authorities are outlined below.
- LINKs should be given additional powers of inspection, and the ability to act as advocates for patients who complain about NHS services.

In December 2005, an independent review of the NHS's regulatory framework – ordered by the Department of Health concluded that: "...the importance of consumers/patients in the values of Health Service reform is frequently expressed but not always so effectively mobilised. Establishing representative national and regional to contribute a reasoned collective consumer perspective to the process of reform could well improve both the efficacy and legitimacy of that reform." We share this conclusion.

3.2.2 HealthWatch

We will establish a national consumer voice for patients: HealthWatch. HealthWatch will provide support to patients at a national level and leadership to LINKs at a local level. It will also incorporate the functions of the Independent Complaints Advisory Body.

HealthWatch will have a clear statutory right to be consulted:

- Over guidelines issued nationally concerning the care NHS patients should receive ('commissioning guidelines').
- Over decisions which affect how NHS care is provided in an area. It will also be able to make representations to the NHS Board in relation to the planning of NHS services, such as where an Accident and Emergency Department closure is proposed.

3.3 Helping patients exercise choice and manage their care

In today's post-bureaucratic world, where people are increasingly empowered with greater information and choice in practically every field of their lives, government must accept it no longer has a monopoly on knowledge and power, and allow more decentralised, open systems where people and professionals, not politicians, take the lead on how our public services are run.

But giving real choice to patients, and allowing professionals to decide on the best strategies for providing healthcare, will not be possible unless they can access sophisticated data about the performance of treatments, hospitals and doctors.

We want to see an information revolution in the NHS, which will allow us to replace the top-down central control Labour have imposed with a system where the collection, collation and publication of data on health experiences and outcomes makes the NHS truly accountable to patients, and leaves professionals free to decide how to provide the best healthcare to patients.

3.3.1 Providing quality data

We will make the Care Quality Commission and the NHS Information Centre work to ensure high-quality information is made available about the standards of care people can expect from providers. We will facilitate this by allowing a real market-place in information intermediation, with a range of organisations able to interpret validated data for patients about the services offered by NHS providers.

This information will include:

- Comparable mortality and morbidity data, adjusted as far as possible for the complexity of the procedures undertaken;
- Location, transport and access factors;
- Referral-to-treatment times;
- Patient experience and satisfaction survey data;

- Self-reported data from patients about the results of their treatments;
- Data on the prevalence of healthcare-acquired infections;
- Data on service standards, including how patient preferences on single rooms were met and the availability of infection control facilities;
- Information about GPs and other primary care commissioners' services, such as ease of access, outcomes of treatment and patient satisfaction.

We are confident that the provision of high-quality information available in the public domain and presented to patients by GPs will help make providers of NHS care truly accountable to patients, and drive large gains in the standards of care provided by them. We are even more confident that, as choice drives better information, so patients' experience of their healthcare will improve.

We use the term 'revolution' to describe these plans because they will require a systemic shift from Labour's system of public service provision based around the use of Whitehall-determined performance targets. This system is predicated on the collection of small, specific and often unrepresentative amounts of information that are only made available to politicians and bureaucrats.

Professionals and citizens lack the knowledge to make accurate judgements about the effectiveness of a service because genuinely useful information – about results, not processes – is either not collected or not published in an accessibly comparable format. This results in a system where the bureaucrat is king, and in a public sector in which professionals are undermined and unable to deliver the services that users demand.

3.3.2 Using data to monitor our performance nationally

Public availability of accurate and sophisticated information about the results and quality of NHS services not only has the power to put users in control of services and to dramatically drive up quality. This data can allow for comparison between hospitals, PCTs and regions, and allow the development of new evidence bases for future research.

There is an emerging body of evidence to suggest that, in addition to improved professional accountability and patient choice, the process of publication acts as a stimulus to improved health outcomes overall. For example, a recent study showed the death rate for coronary artery bypass graft patients after public data disclosure was significantly lower than it had been before, falling from 2.4 per cent to 1.8 per cent.²⁸

We believe that a culture of public accountability based around robust information would reduce the likelihood of repetition of scandals such as that affecting the Bristol Royal Infirmary's paediatric cardiac surgery. In Bristol, a mortality rate double the national average was noted before the crisis, but public ignorance of the data allowed the original decline in service to be compounded by a lengthy period of inaction. Effective structures for professional accountability, focused on published outcome measures, should facilitate more effective and more timely intervention.

Looking at care results across the NHS will allow us to see where we are making progress nationally, where we need to improve, and ultimately give us a clearer idea of how our healthcare results compare to those of other countries.

3.3.3 IT projects in the NHS

We must also recognise the need to improve IT in the NHS. Who can imagine a 21st century health service in which digital imaging cannot be transferred, where appointments cannot be made on-line, or where patient records are not available electronically? The key is for technology to serve clinicians, not the other way around; and for patients to have confidence in and more control over their data.

Our review of NHS IT will set out the way forward to realise better the gains from new technology in the NHS. In place of Labour's centrally determined and unresponsive national IT system, we will extend competition between suppliers, relate standards to user need, and ensure that healthcare providers take real ownership of their IT.

28 Bridgewater et al, 'Has the publication of cardiac surgery outcome data been associated with changes in practice in Northwest England?' Heart, Jan 2007

3.4 Freedom for healthcare providers and effective regulation

We want to give NHS Trusts far more freedom to innovate and to adjust the way they provide services in response to their patients' wishes locally. We will encourage every NHS Trust to become a self-governing NHS Foundation Trust. This should include provider 'arms' of PCTs. Alongside NHS Foundation Trusts, which are public benefit corporations, we will enable any willing provider, who is able to meet NHS standards within NHS tariffs, to offer services to NHS commissioners.

We are conducting an internal review to establish how the Secretary of State can in future support sufficient levels of capital investment without distorting competition, and how the legitimate interests of creditors can be recognised whilst at the same time ensuring NHS services can be maintained for patients. This review will encompass how capital costs should be reflected in the tariff, as well as the extent to which NHS-sector providers should be able to access public dividend capital, capital grants and Treasury guarantees for their borrowing. While management and lenders will lose out as a result of failure, we will ensure that patients do not.

3.4.1 Effective regulation: the Care Quality Commission

Healthcare needs to be regulated more effectively. We will strengthen the role of the proposed Care Quality Commission so it becomes an effective quality inspectorate. The Care Quality Commission will have a statutory duty to undertake inspections of healthcare commissioners and suppliers. Complementary to the statutory duties of other bodies, the Care Quality Commission will provide a multi-purpose inspectorate, with the functions of:
Licensing healthcare providers subject to a de minimis criteria which will include considerations of professional regulation. For example, each GP providing healthcare will not need to be licensed by Monitor, because they will already be bound by the professional regulation of the General Medical Council.

- Licensing and inspection of social care institutions and operations relating to the Mental Health Act.
- Providing external audit and ensuring the propriety of public expenditure, as well as offering value-for-money audit and advice.
- Conducting safety inspections of providers, with powers of intervention in the event of service failure. This will be risk-

based, so that those providers with a proven record of safety will be subjected to a lower level of inspection.

- Conducting quality inspection of providers, with powers to refer them to Monitor and to NHS commissioners if it finds breaches of licence or breaches of commissioning guidance. This will again be risk-based, so that those providers with a proven record of offering high quality services will be subjected to a lower level of inspection.
- Determining the common standards of information which may be made available to patients for the purposes of informing patient choice.
- Validating the information which providers submit to commissioners for the purposes of monitoring contract compliance, and which providers submit to Monitor for monitoring potential breaches of licence.
- Notifying Monitor, which currently regulates Foundation Trusts, in the event of a risk of service failure.

3.4.2 A stronger role for Monitor

We will also legislate to develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS. Monitor will be given the statutory duty to be the economic regulator for the healthcare sector, and will have the following duties:

- Securing the provision of universal access to healthcare services
- Promoting competition in healthcare services, wherever practicable
- Promoting safety and quality in healthcare services
- Promoting efficiency and economy in the provision of health services
- Promoting research and development in health
- Promoting the sufficient supply of skilled healthcare professionals

Monitor will exercise the following key functions:

- Authorising NHS Foundation Trusts
- Intervening in the event of market failure; ensuring that services for patients are maintained and that assets needed for this are protected.
- Controlling market entry, including authorising the constitutions of NHS Foundation Trusts
- Applying price controls and, in particular, determining the NHS tariff
- Specifying the 'universal service obligations' and protected services which providers will have to deliver; stipulating licence conditions requiring that providers guarantee services to the NHS; and determining the levels of subsidy needed to maintain a 'provider of last resort' in the case of market failure
- Exercising concurrent competition powers, such as how competition laws are applied to the healthcare sector
- Promoting NHS Foundation Trust freedoms
- Adhering to best regulatory practices

4. Safety and standards

We will incentivise high standards as positively as possible by ensuring that hospitals, clinics and other care providers are rewarded for achieving good results. But proper regulation, and exacting standards over issues like hospital infection control will also be needed to ensure that high standards of safety are met throughout the NHS. And we will consider contract penalties for serious but preventable adverse outcomes from healthcare.

4.1 Payment by results

Patient choice needs to be supported by a powerful system which offers rewards to the best providers. We believe that the best way this can be achieved is by allowing money to follow the patient to the provider of their choice. Allowing money to follow the patient in this way rewards successful and efficient providers and offers incentives to poor providers to improve productivity and raise the standards of patient care they deliver.

This principle underpinned the last Conservative Government's 'internal market' reforms of the NHS which drove the unprecedented rate of service improvement in the early 1990s. It was abandoned by the incoming Labour Government in December 1997, but returned as policy in 2002 and was progressively introduced from 2003-04 under the name of 'payment by results'.²⁹

The absence of such an incentive between 1997 and 2003, and the loss in efficiency which resulted, is an important factor in explaining the NHS's declining productivity in recent years:

- 1.2 million more people would be getting hospital treatment if Labour after coming to power had kept up the rate of increase in hospital treatments as that achieved by the NHS under the internal market.²⁹
- If Labour had reduced the length of time patients had to stay in hospital since 1997 at the same rate as the Conservatives did before 1997, the NHS would have the equivalent of over 10,000 extra beds.³⁰

Since 2003, the value of NHS activity covered by payment by results has increased markedly: it now stands at some £22 billion.³¹ We support payment by results, but believe there are some key ways in which it can be improved.

4.1.1 Primary care commissioning

As it currently operates, payment by results creates powerful incentives for providers to increase activity, but it has not been introduced alongside similarly powerful mechanisms for commissioners to manage the activity levels which they have to pay for. The result is an unbalanced market, in which hospitals can drive activity and cost beyond the level needed by commissioners, who may wish to structure service referrals differently.

This imbalance can be solved by creating mechanisms to manage demand more effectively, which is why we support the return of powerful, clinician-led commissioning in primary care.

4.1.2 Information on services

The information which is needed to support payment by results is so poor in many NHS providers that – even with the transparency engendered by payment by results – NHS hospitals have little idea which of their activities are profitable under the NHS tariff. They and their commissioners are therefore often negotiating value-based pricing in ignorance of the overall system consequences.

Without adequate service-level information, each price listed in the tariff necessarily groups many different 'casemixes' and clinical interventions together under a single price. This means there is considerable potential for astute providers to 'cherry-pick' routine, high-volume procedures, leading to a situation where low-volume, high-cost cases will eventually not be undertaken because they are not profitable.

Imperfect information results in market failure, so a much greater emphasis on service-level economics is required. We propose a regulatory framework that will ensure that providers of NHS care manage their services in a way which encourages the collection and use of information.

4.2 Tackling deadly hospital infections

Tackling deadly infections is now an absolutely essential priority for NHS hospitals. Labour have been making promises to tackle hospital infections for over a decade, but are failing to deliver the standards of safety patients need.

The number of people killed by MRSA and Clostridium difficile is six times greater than when Labour came to power.³² In the last year alone, there were 6,000 cases of these infections in England.³³ Hospital-acquired infections now kill three times as many people as are killed on the roads.

The Government's own health watchdog says that three-quarters of hospitals do not have the capacity to isolate patients with hospital infections.³⁴

A Conservative government will give patients a guarantee that hospitals will be able to provide sufficient isolation facilities for essential clinical and infection control. As part of our strategy to offer more single rooms in NHS hospitals, we will be able to provide a basic guarantee of enough single rooms to combat deadly hospital infections. Hospitals will be free to meet this guarantee according to their particular needs, using NHS capital funds

While making sure every hospital has the facilities to isolate patients who have infections like MRSA, so that other patients are protected, we also believe it should be a basic rule of social policy that payment for NHS services should reward success, not failure. So, hospitals should not be paid – or paid in full – for a treatment which leaves the patient with an infection like MRSA if this was preventable by proper cleaning or isolation, for example.

4.3 NHS resources for NHS patients

Among the core principles is that NHS resources should be used for NHS patients and that patients should have access to care through the NHS based on their need, not their ability to pay. In view of this, the NHS requires that you cannot both be an NHS patient and a private patient in relation to the same episode of care. Patients, therefore, who have been refused life-extending treatments on cost-effectiveness grounds have had their NHS care withdrawn if they purchase the drugs privately.

At the heart of this problem are two questions: Why is the

NHS treatment not comprehensive, and why is it therefore not possible to distinguish between NHS treatment and private treatment? Through our consultation, we will address positively how we can secure value-for-money access to clinically effective medicines. We will also seek to clarify the NHS' responsibilities for providing comprehensive treatment, making clear where the boundary of NHS care lies.

This should enable the issue of the relationship of NHS and private care to be clear: NHS patients should not be charged for their treatment and receive care based on their need. Outwith NHS entitlements, private patients should not see their entitlement to NHS care affected by their private care, either positively or negatively.

A key reform in this context is to achieve improved access to new and effective medicines within a value-for-money drug pricing regime, based on the therapeutic and innovative value of new medicines provided to the NHS.

4.4 Access to the best medicines: value-based pricing

There is a new approach to offering new drugs to patients which allows drug companies to launch new drugs through the NHS, but allows the NHS to only pay according to the benefits the drug brings to patients. This is known as value-based pricing and has already been used to a limited extent.

For example, the drug company Novartis recently agreed to provide Lucentis, a sight-saving drug which did not yet have proven long-term cost effectiveness, on the NHS by having the NHS pay for the first 14 injections of the drug, and if the patient needed any more after that, Novartis would pay. This enabled NICE to approve the drug and will hopefully lead to thousands more people not losing their sight.

It is absurd that this approach cannot be applied more widely in the NHS. We should encourage the NHS to use whichever medicines are clinically effective, and agree to pay the drugs companies according to the therapeutic benefit and innovative value. NICE should be involved in this process, working with drug companies to set fair prices for new medicines – rather than refusing new treatments which it deems too risky in terms of cost.

We will therefore negotiate the NHS' drug pricing mechanism to reflect this new value based pricing mechanism. It is an

29 Figures drawn from analysis of figures in Hansard, 21 June 2004, Col. 1281WA; Hansard, 25 February 2005, Col. 904WA; and Department of Health, Hospital Episodes Statistics, 13 December 2006

30 Figures drawn from analysis of figures in Hansard, 18 October 2006, Col. 1325WA; and Department of Health, Hospital Episodes Statistics, 13 December 2006

31 Department of Health, Departmental Report 2007, 18 May 2007

32 Office of National Statistics, 28 February 2008

33 Health Protection Agency, 24 April 2008

34 Health Protection Agency, National Confidential Study of Deaths Following MRSA Infection, November 2007

innovative solution to a critical problem.

Moving to a new system will mean payment by results for drug companies. Some existing treatments will get a lower price from the NHS, but innovative drugs with good clinical benefits will do better. Overall, as the Office of Fair Trading has recognised, this system “offers the prospect of delivering greater benefits to patients for the same level of expenditure, thereby improving value for money and giving better rewards to companies to invest in the most valuable drugs.”³⁵

4.5 Protecting the most vulnerable: improving mental health care

Mental health wards accommodate some of the most vulnerable patients the NHS provides care for. Wards must be safe, and patients must at least be safe from attacks, or prevented from attacking other patients and staff.

4.5.1 Safety a priority

Using the Freedom of Information Act, the Conservatives uncovered the shocking fact that 14,000 assaults took place against patients in mental health wards in the last year. The attacks included more than 180 assaults on children in mental health care, and 435 sexual assaults on mental health patients, of which 15 were rapes.³⁶

The Healthcare Commission recently published the findings of a review of inpatient mental health services. They concluded that:

“One in nine trusts scored “weak” on the criteria relating to safety, showing that in these trusts there was considerable room for improvement in ensuring the safety of service users, visitors and staff... [The Commission] pointed to high levels of violence, with 45% of nurses and 15% of patients reporting that they were physically assaulted in 2007. The report said there was insufficient attention to the sexual safety of patients and overcrowding in some trusts.”³⁷

The latest National Audit of Violence also found that in adult wards, 92 per cent had single-sex toilets, 93 per cent had single-sex bathrooms and 51 per cent had single-sex day areas. Additionally, when asked, 19 per cent of inpatients said that they had to share space with members of the opposite sex when they did not want to.³⁸

As part of our plans to guarantee enough isolation capacity in

NHS hospitals to ensure patient safety and dignity, we will ensure mental health patients are all accommodated in single rooms.

4.5.2 Improved services

Around one in four of us will have a mental illness at some time. The scale and complexity of mental health issues is not reflected in service provision and services are often the first to suffer when resources are cut.

We will ensure that GPs and school nurses are able to refer patients to appropriate professionals speedily and at an early stage.

We will make patient choice a reality within mental health through our ‘any willing provider’ policy, and seek to reduce dependency on powerful and expensive drugs with a focus on alternative therapies.

While health policy focuses principally on the NHS, the actual determinants of ill health lie outside it – poverty, housing, environment and heredity are all potentially more significant determinants of health than the local capacity of the NHS.

Preventing disease through attending to public health issues such as obesity, alcohol abuse and sexually transmitted infections, is becoming increasingly important as a strategy for tackling the rising costs of preventable health problems. We aim to make public health central to our plan to help Britain become a healthier nation.

5.1 Making prevention a priority

To ensure public health is made an enduring government priority, we will build a stronger public health infrastructure. A cross-Government focus on public health will be reflected in the responsibilities of the Department of Public Health and with separate public health funding to give focus and delivery, including:

- **A strengthened Chief Medical Officer’s department**, made more independent of ministers. The Department would advise the Secretary of State for Health, who would be responsible (rather than a junior minister, as now) for public health, on the steps he or she would need to take to tackle today’s epidemics of obesity, alcohol abuse and sexually-transmitted disease.
- **A robust public health infrastructure**, which would see local Directors of Public Health – jointly appointed by PCTs and local authorities – determine how funding for public health services would be spent. These Directors of Public Health would be better placed to make effective interventions across the health, local government, education and social housing sectors.

- **Separate public health budgets.** At present, budgets for public health interventions are largely channelled through PCTs. With PCTs either in deficit or being asked to support hospitals in deficit, most of these budgets have been raided. Over time, these budgets should be taken from PCTs and spent through our new public health structure, rather than through traditional NHS bodies whose focus is on acute and community services.

This initial work on infrastructure is essential to tackle the downgrading of public health as a priority by the Department of Health under Labour.

5.1.1 Labour failure

Labour have failed to make public health a priority. Gordon Brown’s independent reviewer of the NHS, Sir Derek Wanless, said recently that it is ‘indicative of the relatively low priority given to public health that, while non-public health medical staff numbers have increased by nearly 60 per cent since 1997, the number of public health consultants and registrars has gone down overall.’³⁹

As a result, we are not doing enough as a nation to tackle even the most obvious public health problems. Take obesity as an example:

- **Obesity Rising.** Between 1995 and 2005, the proportion of men classified as obese rose by half to 23 per cent of the male population, and the proportion of women by 42 per cent to around 25 per cent of the female population. Nearly one in five children is now classified as obese.⁴⁰
- **British adults the most obese in Europe.** The UK now has more obesity than anywhere in the OECD except Mexico and the US.⁴¹ England has a higher rate of obesity than anywhere else in the EU. In the UK 22.6 per cent of adults are obese, compared to just 12.9 per cent in Germany, 9.4 per cent in France and 8.5 per cent in Italy.⁴²
- **Obesity could cost £60 billion by 2050.** A government report, published last year projected: ‘The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050. The wider costs to society and business are estimated to reach £49.9 billion per year (at today’s prices).’⁴³

35 The Pharmaceutical Price Regulation Scheme, an OFT Market Study, February 2007, p53

36 Freedom of Information requests made in September 2008

37 Healthcare Commission press release, 23 July 2008

38 The pathway to recovery: A review of NHS acute inpatient mental health services, 23 July 2008

5. A healthier nation

- **Government dithering on food labelling.** The Government have still failed to make a clear commitment on food labelling. Since 2004, Conservatives have provided a clear direction on food labelling: labels on the front of all packaged food showing what percentage of our guideline daily amount of calories, fats, sugar and salt a product contains, with a voluntary adoption of 'traffic lights'. The European Commission is now also calling for a European-wide front of pack GDA approach. The focus on food labelling has distracted the Government and food industry from addressing other important areas such as portion size, reformulation and advertising.
- **Failure on school sport.** Labour are failing to deliver even their current commitments on school sport. A forthcoming report by the Central Council of Physical Recreation will reveal that 14 per cent of 5-16 year-olds (about 900,000 pupils) are missing the two-hour target for sport in schools; some five- to 11-year-olds are being offered only half an hour of physical education a week, the equal lowest tally in the EU; and 70 per cent of British teenagers stop doing any organised sport at 16 compared to just 20 per cent in France.⁴⁴ Lottery funding going to grassroots sport has fallen by nearly 50 per cent, from £397m in 1998 to £209m last year.⁴⁵

But possibly the biggest failing of Labour on public health is that health inequalities are becoming entrenched. Labour's Secretary of State for Health, Alan Johnson, claims, "I have always said that tackling health inequalities is one of my top priorities."⁴⁶ But since Labour took office in 1997, there has actually been a widening of the gap between infant mortality of the poorest and richest households.⁴⁷ And probably most shockingly of all, life expectancy inequalities across the UK are at their widest since the Victorian era.⁴⁸

Overall, people from lower socio-economic groups suffer shorter life expectancy, higher infant mortality, and a greater likelihood to experience ill health than those from higher socio-economic groups.⁴⁹ We must do more to tackle the social and environmental causes of ill health in our most deprived areas.

Secondly, we have to ensure that we put life in our years, not just years on our life. Extended life expectancy, if it also means increased morbidity in old age, spells economic and social catastrophe. Yet that is exactly the risk.

5.2 Promoting healthy lifestyles

There are many people in Britain whose weight, lack of physical activity, or lifestyle choices present a serious threat to their health, and a potentially preventable burden on the NHS. Of course it is right for government to respond to these public health challenges, but we do not believe nannyism is the right approach to take to promote behaviour change.

Leadership, information, incentives and empowerment will be characteristic of our approach. We will empower people and local communities, and work in partnership with business, Local Government, communities and families to deliver on a healthy living agenda – in schools, workplaces, local clubs and through NHS services. Legislation will be a last resort.

As well as no nannyism, we will seek to ensure that no-one has excuses for an unhealthy lifestyle because they lack the healthcare or governmental and community support they need. We will take action to ensure people have the opportunities, information and incentives to promote healthy living. But it is ultimately down to the personal responsibility of the individual to use this information and make decisions over improving their health for themselves.

5.3 A responsibility deal with business

As part of the national strategy for public health, we need to ensure that the corporate responsibility of business, and the ability of businesses to contribute to the promotion of healthier living, is fully and successfully engaged.

To achieve this, we have set out the concept of a 'Responsibility Deal': how, instead of the constant and escalating resort to legislation and regulation and public sector intervention, we should instead enter into a non-bureaucratic partnership with the business community, together to tackle key challenges in society.

There are ten aspects of the responsibility deal:

- We will support EU proposals for a mandatory GDA-based front of pack food labelling. We will not add UK regulation to this. Additional traffic-light or colour-coded information will be voluntary.

- Industry-led reformulation initiatives and reduction of portion sizes.
- Proportionate regulation on advertising and positive campaigns from the industry and government to promote better diets.
- A combined business and Government social responsibility campaign to promote healthy living, including the use of role models, community engagement and positive peer pressure.
- A new focus on public health through Local Area Agreements, incorporating direct local business involvement in campaigns to promote exercise, community sport and healthy lifestyles.
- A responsible drinking campaign matched by community action projects to address drug abuse, STIs and alcohol abuse, using a proportion of drinks industry advertising budgets and supported by the Government.

- Community Alcohol Partnerships, based on the successful example from St. Neots in Cambridgeshire.
- Clear labelling on alcoholic drinks and a push for the standardisation of labelling where necessary at a European level.
- Incentives and a local structure, through business organisations, for SMEs to improve the health of their employees, working with business organisations, "NHS Plus" and the Fitness Industry Association.
- An 'Investor in Health' accreditation scheme alongside 'Investors in People'.

39 The King's Fund, Our Future Health Secured?, September 2007

40 Our Future Health Secured: A Review of NHS Funding and Performance, 11 September 2007

41 OECD Health Data 2007

42 Department of Health, Health Profile of England 2007, 22 October 2007

43 Foresight, Tackling Obesity: Future Choices, 17 October 2007

44 Reported in The Telegraph, 7 January 2008

45 Hansard, 25 June 2007, Col.49 WA

46 Speech by Alan Johnson MP to the Institute for Public Policy Research, June 2008

47 DWP, Opportunity for All, October 2007

48 BMJ, Health inequalities and New Labour: how the promises compare with real progress, Mary Shaw, George Davey Smith, Danny Dorling, April 2005

49 DWP, Opportunity for All, October 2007, p49

The Conservative Party understands the vital role the NHS plays in this country. We believe it helps bind our nation together, and we want to support and improve it. We want it to be central to our vision for building a stronger, safer society.

Our commitment to the NHS and preserving its core values of fairness and equity will be unshakeable. And we will give the NHS the funding, the stability and the support it needs to provide the best healthcare possible to patients.

As well as our commitment to the positive reforms set out in this improvement plan, we make some key pledges to patients:

6.1 Proper funding for the services patients need – guaranteed

We will always make sure the NHS is supported with the funding it needs. We are committed to increasing the resources available to the NHS in real terms. Specifically, we have promised to match Labour's planned spending on health until 2010-11. In 2010-11, the Department of Health's budget is set to exceed £127 billion per annum.

6.2 Stability and security: no more politically-led reorganisations

We promise to end the damage caused by pointless and disruptive reorganisations of the NHS. We will ensure this stops, and we will not allow any meddling with existing local or regional structures.

Labour have undertaken nine major reorganisations of the NHS since they came to power:

1. The abolition of GP fundholding and the creation of Primary Care Groups (1997).
2. The abolition of the central NHS Executive and the incorporation of its functions into the Department of Health (2000).
3. The abolition of the eight regional offices of the NHS Executive and their replacement by 28 new Strategic Health Authorities (2002).
4. The abolition of Primary Care Groups and the creation of 303 Primary Care Trusts (2002).
5. The abolition of Health Authorities (2002).
6. The creation of NHS Foundation Trusts (2003).
7. The regionalisation of Strategic Health Authorities (2006).
8. The merger of Primary Care Trusts (2006).
9. The regionalisation of NHS Ambulance Trusts (2006).

6. Our pledge to patients and the profession

A study of Labour's NHS reforms, estimates that just the 'one-off' costs of these unnecessary changes was £3 billion since 1997.⁵⁰

We know that this massive organisational upheaval has got in the way of long-term planning and been a huge distraction for NHS staff from what they do best. We will allow the NHS the stability to focus on providing high quality care to patients.

6.3 A responsible deal with the private sector

The future of the NHS depends on resources being used ever more effectively to deliver improving health outcomes. Over the past eleven years Labour have missed a golden opportunity to work in partnership with the private sector to provide better care, not privately, but free at the point of need on the NHS. Despite believing that market mechanisms work, they have failed to open up the market for the provision of NHS care so as to drive up standards.

We need a level playing field. All NHS patients should be free to choose any provider of care for their treatment – so long as that provider can provide treatment at the NHS price. So that could be an independent hospital or an NHS Foundation Trust, depending on the patient's preference. Moving to this system, driven by patient choice, means people will get treatment more quickly and there will be a far stronger incentive for standards of care to improve.

Labour have too often rigged the system in favour of the private sector. Their failed first wave of Independent Sector Treatment Centres (ISTCs) cost 11 per cent more than it would have cost the NHS to provide the same treatment. Then a mismatch between supply and demand led to some ISTCs working at under 60 per cent of their capacity but still being paid in full.

Now, Labour are rigging their polyclinics scheme in favour of the private sector too. The Department of Health's Primary Care Strategy, published on 3 July 2008, announced plans to end the system by which GPs are guaranteed a minimum income, regardless of patient volumes. However, procurement documents buried on the Department of Health's website reveal Labour's hypocrisy, as new providers of polyclinics will be guaranteed a minimum income to help them get off the ground, giving them an unfair advantage over existing GPs and making it easier for them to draw patients from other

practices.⁵¹

We need to end this flawed approach. Conservatives will always look to work with the private sector in a way that is fair. We will not let NHS providers to be put at a disadvantage. And at the same time, we will not neglect opportunities to work with the private sector to improve standards of care, and opportunity and choice, for NHS patients.

6.4 Valuing Staff

Essential to the delivery of improved outcomes is a well-skilled and motivated NHS workforce. Labour have demoralised NHS staff and in the last three financial years have sanctioned the raiding of education and training budgets to deal with deficits arising in the acute sector. Our Improving Public Services Policy Group has already announced proposals to re-engage with those involved in the delivery of our public services, and to build a new partnership with the professions. Further to this, we will:

- consult with health professionals and their employers, NHS Employers, the NHS Confederation and other stakeholders on our policies for building an NHS workforce that is fit for the future;
- ensure that the painful lessons learned in the Modernising Medical Careers fiasco are reflected in the Government's approach to Modernising Nursing Careers (MNC). MNC must command the support of nurses. It must also include professional responsibility for continuing professional development within the nursing profession;
- develop a much more structured form of nursing training, along the lines of the structured passage from medical training to speciality status;
- make the process of workforce training more autonomous of the Department of Health. We believe that the professions should take on greater responsibility for determining training, and that the role of the Department of Health in this process be minimised. We will therefore seek to establish "Medical Education England", as recommended by Sir John Tooke's Review, and a parallel body, 'Nurse Education England' to develop nursing careers for the future;

- we believe that those who employ health professionals – both NHS and independent sector – should themselves take on responsibility in relation to workforce planning, and accept the risk should they get it wrong. The transfer of risk is a key element in this proposal: in taking on risk, providers are provided with incentives to avoid either a major over- or under- supply of health professionals, given the deadweight cost of educating and training beyond requirements if there is an oversupply, and the extra costs of meeting staff shortages if there is an undersupply; and,
- we will develop "Skills for Health" to become a fully-fledged sector skills organisation, with a responsibility to deliver healthcare training either in-house or through commissioned places. All large employers of health professionals will be required to provide training places, or contribute a levy which will train and develop healthcare staff.

Only when NHS staff feel valued and are enabled to focus on patient care instead of targets, can the quality care that patients deserve be delivered.

6.5 Our commitment to Quality

In the long run, the effects of strong commissioning, patient choice, an information revolution, professional empowerment and contestability among healthcare providers will drive productivity and quality. Throughout the NHS, patients will receive care that is free at the point of delivery, but will also have greater control over their healthcare and enabled to seek out quality services.

Overall, our programme for raising quality includes:

- Evidence-based commissioning guidelines which give patients and commissioners clear guidance on the standards of care patients have a right to expect.
- The abolition of process targets, and a structure of outcomes which will drive commissioning and contracting.
- Service standards which are required to be met by healthcare providers as part of the Care Quality Commission.

- Data on service standards made public to empower patient choice.
- A consistent system of evaluation of healthcare treatments and interventions, encouraging new drug treatments, medical devices, vaccines, screening and better public health.
- Reforming the way in which the NHS pays for drugs so that the prices pharmaceutical companies receive bear a direct relation to the additional value a treatment brings to patients above and beyond the next-best treatment.
- A zero-tolerance approach to hospital infections – as currently happens at the very best hospital trusts in the country – to minimise avoidable healthcare associated infections.
- Progressively securing best practice through the tariff structure and through payment-for-performance mechanisms, to ensure contracts incentivise quality.
- Support for innovation through the NHS Research and Development programme, to include Clinical Research Networks to ensure access to best practice, and the development of Academic Health Science Centres.
- A strengthened structure, in cooperation with the Royal Colleges and Specialist Associations, to provide evidence-based criteria for patient safety in relation to service configuration. We will stop reconfigurations which do not improve patient safety, maintain necessary access, or respond to demand from GPs and commissioners.

50 The Sunday Telegraph, 25 February 2007

51 Department of Health, Payment model guidance, 2008



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