“The patient will see you now, doctor”
The NHS is the Conservative Party’s number one priority. We share Britain’s pride in the values that underpin it and we are confident about its future. Putting patients at the centre of the NHS is the best way to improve care, drive up standards and enable dedicated NHS staff to focus on what really matters. However, patients today do not have a strong voice or sufficient influence over the provision of care they receive. A recent survey showed that 32% of primary care patients and 48% of hospital patients felt they had not been sufficiently involved in the decision-making process. Gordon Brown talks about personalised healthcare, but it is Labour’s political interference and targets that are undermining the essence of patient-centred care – public and patient engagement combined with professional freedom. Responding to the needs and expectations of patients is integral to the responsibilities of healthcare professionals. Our proposals will enhance the autonomy of the NHS, and allow healthcare professionals to focus on their patients. We will end the bureaucracy and top-down dictates of politically-inspired targets. Our plans are for autonomy and accountability instead of control. We will build an NHS with patients at its heart.

David Cameron

Andrew Lansley
Summary of Proposals

This policy paper sets out further proposals for enhancing the accountability of the NHS to patients – by putting them at the heart of the NHS. We will:

1. Scrap top-down targets so that decisions about care are made in relation to the individual needs of patients.

2. Enable patients to exercise a choice of GP and primary care commissioner.

3. Renegotiate the GP contract to deliver accessible out-of-hours care and extended access to services.

4. Provide information to support greater patient control over their healthcare and to facilitate choice of hospital and healthcare provider.

5. Establish clear NHS care entitlements through commissioning guidelines.

6. Offer individual budgets for those with stable, predictable long-term conditions.

7. Offer genuine choice in childbirth, including information and access.

8. Provide simpler and clearer telephone access to urgent care.

9. Establish *HealthWatch* – a national and local network to provide a representative voice for patients.

10. Ensure dignity and choice in end of life care.
In his ten years as Chancellor of the Exchequer, Gordon Brown imposed 64 targets on the NHS,\(^3\) with the Department of Health and its regional bodies – Strategic Health Authorities – imposing many more. The burden on the NHS created by this workload is immense: a total of around 250,000 data returns are demanded by the Department of Health from all NHS organisations in any given year.\(^4\)

The greatest challenge created by targets is the way in which they distort clinical priorities. As former Prime Minister Tony Blair’s strategy chief Matthew Taylor has said, targets result in “perverse outcomes” where “people focus on one target at the expense of others and actually that damages the services”.\(^5\) This is clearly demonstrated in breast cancer care:

- A mastectomy is often recommended for women diagnosed with breast cancer, followed by follow-up (or ‘adjuvant’) radiotherapy to kill off stray cancer cells.\(^6\) However, the Government’s target – of women with breast cancer receiving their first treatment within two months\(^7\) – does not apply to follow-up treatment. As a result, follow-up radiotherapy is left untargeted.

Evidence from the Royal College of Radiologists (RCR) shows that, since Labour came to power, waiting times for adjuvant radiotherapy have actually lengthened:\(^8\)

- In 1998, 39 per cent of patients received their adjuvant radiotherapy more than four weeks after their surgery (four weeks is the maximum acceptable waiting time for adjuvant radiotherapy, as defined by the Joint Collegiate Council for Oncology (JCCO) in 1993).
- By 2005, however, 53 per cent of patients were seen outside the maximum acceptable waiting time.\(^9\)

The Government’s own advisory body on radiotherapy – the National Radiotherapy Advisory Group (NRAG) – has endorsed the findings of the Royal College, explaining that, “around 50 per cent of patients are not currently receiving treatment within one month of being ready to treat – the good practice standard set by the JCCO”.\(^10\)
Since the existing breast cancer screening target has distorted one element of the patient pathway, NRAG has called for a target to be set for all radiotherapy treatment in order to offset the distortion covered by the original target, demanding:

“…a specific waiting times target for the start of radiotherapy treatments for all cancer patients, not just those for whom radiotherapy is the first treatment (the current Government target).” 11

The delivery of care which treats patients as individuals is frustrated by such top-down targets. In striving to meet one target, the NHS’s clinical priorities become distorted, and the only way to reverse this distortion is to introduce further targets to offset it.

**We will scrap all centrally-imposed targets relating to clinical processes,**12 and replace them **with a new focus on outcomes.** In the example of breast cancer care above, for example, we would replace all treatments targets with a new outcome measure, focusing on what matters to patients – survival rates. A recent study of 20 European countries found that England’s five-year survival rates for breast cancer are the seventh worst in Europe, and below the European average.

**In order to raise survival rates to the European average first, and then to be amongst the best, the NHS will be tasked with improving five-year survival rates, supported by additional resources liberated from politically-driven targets, and free to tailor treatment around individual needs.**
Choosing a GP is one of the most important health decisions a person 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.\(^\text{13}\) However, for many, access to their local GP remains difficult.

The great majority of people are happy with their GP practice. However, whether they are or not, it is important they are able to change doctor without bureaucratic constraints. It is also important that GPs – as the vital link between patients and other NHS services – know that they are accountable to their patients, who can exercise choice readily. Although changing practice would appear relatively simple, there is often a lack of reliable, accessible information on practices and what they offer. Where 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. Primary Care Trusts (PCTs) control the number of practices and their size. GPs are not free to respond to what the patient wants.

People should also have the right to register with the practice most convenient to them. For some people, this will be the practice closest to their home. However, others may want to register with a practice near their work. At present, many practices do not take on patients who live outside the geographical area agreed with their PCT. This needs to be changed: **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.\(^\text{14}\)**

We do not propose dual registration; we agree with the Government when it said that dual registration was costly and difficult.\(^\text{15}\) It is also inconsistent with GP commissioning responsibilities. There is, however, no reason why GPs cannot have arrangements to enable their patients to access other primary care services where needed.

**To facilitate the choices available to patients, we will ensure that there are no barriers to the opening of new surgeries.** For example, at present, premises funding for GP surgeries is unfairly weighted to those which are already in existence. In addition, the costs of taking on new patients are not fully reflected in the way GP services are remunerated. This particularly affects GP practices where new or expanding settlements are being established in growth areas – a result of the new GP contract. Both need to change: **where demand for a new GP surgery exists, then there should no difficulties in establishing one.**
One of the most difficult issues to tackle is the way in which patients in deprived areas are unable to access to GP services. Some areas of the country, for example, only have around 40 GPs per 100,000 population – others have well over double this number.16

**GPs who choose to deliver services in deprived areas should be rewarded for doing so** – both in terms of being paid more per patient through the weighted capitation formula (which determines how much NHS funding is delivered per patient), and in terms of being better rewarded through a revised Quality and Outcomes Framework (QOF), which takes full account of the baseline data on their patients and the relative circumstances of more deprived areas.

Strengthening primary care services is a vital step in tackling persistent health inequalities. As in other public services, empowering deprived communities through choice and greater control over their lives, and healthcare is essential if we are to transform long-term health outcomes.
The loss of access to GPs now being experienced by patients is the consequence of the structure of the 2004 GP contract. In place of GPs taking personal responsibility to provide 24/7 cover, the new contract transferred the Out-of-Hours (OOH) responsibility to the Primary Care Trust. GPs who gave up OOH care sacrificed £6,000 salary in doing so. Subsequent studies have demonstrated the additional cost of providing OOH care through PCTs is at least three times the amount GPs were formerly paid for this responsibility. Many PCTs have, because of their own deficits, been unable financially to commission enhanced access for GPs, including evening and weekend surgeries, although some GPs have offered these in any case.

Extending primary care access requires the careful balancing of priorities for resources between the OOH service, extended GP surgery opening hours and walk-in centres. In each case this will depend upon patient demand, the relationship between GPs locally and the geography of provision. The existing GP contract could be used to incentivise extended GP access, but only at significant extra cost. What it fails to do, however, is enable these options for access to be integrated efficiently, or to be weighed up on the basis of evidence of utilisation and cost-effectiveness. It is telling that the Government has failed to publish the cost-effectiveness study of the NHS Walk-in Centres promised earlier this year.

The existing GP contract also fails to reflect the opportunity for GPs to hold budgets on behalf of their patients and take the lead in commissioning services for their patients. We will therefore renegotiate the GP contract. We will make the contract consistent with GPs and other primary medical services contractors taking on commissioning responsibilities. They should therefore be responsible for commissioning OOH services for their patients, whether offered through their own practice or via an OOH service provider (which may, of course, be a GP co-operative).

We also propose that GPs should have a simplified Quality and Outcomes Framework, which incorporates patient-reported measures relating to their health outcomes and patients’ satisfaction with the services provided.

As a result of our ongoing engagement with GPs nationally and locally, we are clear that GPs are justifiably angry with a Government which pressured them to agree to the new contract, and yet has subsequently denigrated and disparaged GPs for the consequences of its own policy. GPs want to offer access to the care which patients need and to be able to manage local services more
effectively. GPs are as frustrated as hospital consultants in A&E departments when the OOH services fail to integrate efficiently with primary care, leading to increased A&E attendances.

We do not wish to – and cannot – revert to the previous personal obligation on individual GPs. They must be able to secure their own decisions about work and family or personal commitments. However, GPs, as budget-holders and Primary Care commissioners, will be in a position to respond to the interests and wishes of their patients; to reconcile those with their own commitments and with the services available from GPs, Ambulance Trusts and other OOH providers, enabling their patients to hold them directly to account.
Choice is made real through empowering patients, and patients are empowered if they have the right information. Patients know this; they want to access information but it is often not provided. Almost two thirds of patients are unaware before they visit a GP that they have a choice of hospitals for first appointment. More specifically, patients should be able to obtain information not just about the choice of providers but about their condition, what to expect, what will happen to them, who will treat them, who they can ask about their care, and how they can have a say, or control, over their care. Comparative studies have shown how, with the exception of telephone and online information, Britain falls behind all other developed health economies on this measure.

We will contract with the NHS Information Centre to secure public access to high-quality information relating to the standards of care they may expect from providers. We will do this as part of an Information Strategy for the NHS, including a real market-place in information intermediation, with a range of organisations able to provide interpretation of the validated data on patient services by NHS providers.

This will include information on:

- Standardised mortality rates and morbidity data, adjusted as far as possible for the complexity of the procedures undertaken.
- Location, transport and access.
- Waiting times.
- Patient satisfaction survey data.
- Self-reported outcomes by patients.
- Data on the prevalence of healthcare-acquired infections.

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.
5. Establish, clear NHS care entitlements through commissioning guidelines.

We are setting out in detail how we propose to devolve day-to-day decisions on commissioning services for patients while ensuring that, nationally, clearer guidance is prepared for NHS commissioners, through the NHS Board, based on advice from the National Institute for Health and Clinical Excellence (NICE).  

These commissioning guidelines will play a very important part in future healthcare. They must incorporate both clinical guidance and comparative evidence about the relative cost-effectiveness of treatments and the design of services. They must be designed around the whole patient pathway and enable commissioners to break down institutional barriers to care.

The commissioning guidelines will also, progressively, establish standards of care which the NHS offers to patients. In effect, this will consist of minimum standards – entitlements and enhancements to care – which should be achieved, including certain developmental milestones, where appropriate, in light of the availability of technology, resources or workforce. From the patient’s point of view, this will mean that instead of a bewildering complexity of advice, guidance, appraisals and evidence, they should be able to look to an evidence-based consensus, including clinical, lay and patient participation, setting out what they, as patients, have a right to expect.
6. Offer individual budgets to those with stable, predictable, long-term conditions.

We are committed to extending the control which people have over services provided to them. In social care, Conservative local authorities are piloting ‘In Control’, offering direct payments which care recipients can use to purchase the services they need.23

For many living with long-term illnesses or disability, the divide between health and social care is a constant source of frustration, uncertainty and bureaucracy. For those whom we look after, services which should be seamless are not. Joint commissioning and pooled budgets have not overcome institutional and professional barriers nor, in particular, the divide between means-tested social care budgets on the one hand and free NHS care on the other. Of particular recent concern has been ‘cost-shunting’ between the NHS and local authority social services, putting extra cost and pressure on the means-tested budgets, meaning the care recipients end up paying more.

We want to break down the barriers to better long-term care. While Government ruled this out in their 2006 White Paper, we believe that we can begin to do this best by focusing on the needs and wishes of individuals. 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 individuals 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 care/healthcare divide.

We believe individual budgets and empowerment of this kind have real potential for some patients. It will not be suitable for all. We will make it an option for some, particularly for those with stable, predictable healthcare needs, requiring little medical intervention, but continuing nursing support.

The Conservative Government, will, therefore, alongside local authorities with experience of ‘In Control’ pilot the introduction of individual budgets.
Labour Ministers have admitted that there is no national guidance or criteria which could be used to inform maternity service reconfigurations, for example on distance travelled or optimum location. Meanwhile, the Department of Health is driving ahead with maternity service reconfigurations across the country which, in the absence of evidence, have uncertain outcomes for patient safety and maternal choice.

The last Conservative Government first set out the objective of giving mothers choice in childbirth; the next Conservative Government will make it a reality. Our maternity services consultation, and the responses we have received, show how important it is to mothers to have information and choice about their services, and for them to have continuing access to local services.

We will increase the number of midwives. We will encourage community-based midwifery teams who will provide continuity of care for mothers, 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, or through pressure to centralise services in very large units. Where 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.
The Government has talked about delivering an urgent care strategy and improved OOH care models, but nothing has materialised. Patients urgently need a simpler pathway to access appropriate urgent care and commissioners need a clear framework to deliver it. With three different numbers for three different services (999, NHS Direct and GP out-of-hours), it is unsurprising that too many people do not know who to contact in order to get the right sort of help outside normal GP surgery hours. Coupled with fractured commissioning – too many bodies responsible for purchasing a variety of urgent care services – patients are not accessing appropriate care in an efficient way.

Through locally led commissioning arrangements, we will secure more integrated emergency and urgent care services. These will ensure GP involvement in delivering urgent care which integrates with their primary care responsibilities.

We will also ensure that public telephone access to NHS services will consist of just two choices: ‘999’ for emergency care and a single national number e.g. ‘116 116’ which will access advice and urgent care (83 per cent of adults do not know the 0845 4647 number to call NHS Direct). Integrated initial call-handling, leading to specialised triage and appropriate responses utilising ambulance services, GP out-of-hours care, walk-in-centres, urgent care centres and A&E will help to deliver the right care at the right place at the right time. This is better for patients and more cost-effective for the NHS.

8. Provide simpler and clearer telephone access to urgent care.
Patients need choice. They also must have a voice. Yet in the last five years, patient and public influence over the provision of local NHS services has been undermined by constant political interference.

In December 2003 Labour abolished Community Health Councils (CHCs) and with them the expertise of the volunteers, which was not transferred to their replacement – Patient Forums. No sooner had the latter been established, the Government announced that, from 2008, they would be scrapped and replaced by ‘Local Involvement Networks’ (LINks). LINks will have no power to inspect and monitor services to hold the NHS to account. They will have no power to investigate complaints. They will neither have the independence required nor the networking capability to represent patients on a regional or national level.

We recognise that there are occasions on which patients also need national representation – particularly in respect of national guidelines or when concerns about NHS services occur as a result of policy determined nationally. In December 2005, an independent review of the NHS’s regulatory framework, ordered by the Department of Health, themselves 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 fora to contribute a reasoned collective consumer perspective to the process of reform could well improve both the efficacy and legitimacy of that reform”.28

We share this conclusion. We will establish a national consumer voice for patients: HealthWatch.

HealthWatch will provide support to patients at a national level and leadership to patient representative bodies at a local level. It will also incorporate the functions of the Independent Complaints Advisory Body. HealthWatch will have statutory rights 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.
10. Ensure dignity and choice in end of life care.

We believe that, through the NHS, people should have access to palliative care services appropriate to their need. We believe everyone should be able to exercise choice about their place of care at the end of life.

As a Government, we will support the roll-out of the ‘Gold Standards’ framework for palliative care:

- Communication.
- Coordination.
- Control of symptoms.
- Continuity of care out-of-hours.
- Continued learning.
- Carer support.
- Care in the dying phase.

We will establish, through commissioning guidelines prepared by NICE (building on their existing guidance for adults with cancer), advice to the NHS on end-of-life care which reflects these standards. In the structure for delivering them we will draw on the experience of pilot projects, such as Marie Curie’s Delivering Choice Programme, first piloted in Lincolnshire, and the Preferred Place of Care tool, developed in the Lancashire and South Cumbria Cancer Network.

There are many people who die in hospital but who would have wished to die at home or in a hospice. We cannot hope to meet everyone’s wishes, but with information, support and care, we can achieve the preferred place of care for many more people.

Key to this will be implementing the national tariff with respect to palliative care. This will enable the NHS and the inspirational work of the Hospice movement, together to achieve substantial enhancements to end-of-life care, especially that provided through the voluntary sector. The implementation of the tariff will in effect offer full cost recovery to voluntary sector providers in relation to the services they provide, which would otherwise have been provided in part by the NHS.

In 2005, the Government promised to double its expenditure on palliative care. This has yet to be fulfilled. We will ensure that this promise to those working in palliative care is met. Through our commitments to standards, to service development, and to support for the Hospice movement, with long term clarity over funding, we will work to ensure that the dignity and choice which patients have a right to expect, is met.
Gordon Brown has claimed that the NHS is his “priority”, but it is clear that he cannot deliver the change of direction so desperately needed.

Since 1997, Labour has sought to micromanage the NHS from Whitehall. As Chancellor, Gordon Brown imposed 64 top-down targets on the NHS, and the Department of Health has imposed many more. This has meant that political objectives have come before patient care, and restricted the freedom of NHS professionals to tailor care around individual needs.

Labour’s top-down micromanagement has gone hand in hand with mismanagement. A recent Cabinet Office Capability Review of the Department of Health showed “serious concerns” about lack of leadership, and highlighted its failure to set out, “a clearly articulated vision for the future of health and social care and how to get there”.

The Conservative Party has set out a new vision. We will empower patients and professionals by abolishing top-down targets that compromise patient care. This is the right strategic direction to deliver better standards for NHS patients across Britain.

Labour cannot deliver a more personalised NHS

In his latest Labour Party Conference speech, Gordon Brown repeated his promise to create an NHS that is “accessible to all and personal to all”, and also repeated his pledge to “make GP hours more friendly to families, open up opportunities to see a GP near your place of work as well as your home”.

In spite of this rhetoric, it is clear that Gordon Brown has no new direction for the NHS, merely a retread of tired old announcements and the same flawed approach that has meant that while the NHS budget has doubled, standards have failed to keep up.

They say central control, we say more independence

- Gordon Brown has scaled back the role of independent providers in the NHS. A business board set up to advise the Department of Health on how to improve the purchase of NHS services from the private sector has wound itself up. A board member said the decision was taken because “nothing is moving in the Department of Health and we are wasting our time.”
They say no competition, we say allow all providers to serve the NHS

- Gordon Brown has postponed the system for efficiently procuring independent services in the NHS. Since Gordon Brown moved to Number 10, the Treasury has put on hold the Framework for procuring External Support for Commissioners. This system would have provided an effective purchaser-provider split in the NHS, and may have enabled cost savings through more efficient competition. Gordon Brown has abandoned market reforms in the NHS. As Dave Prentis, general secretary of Unison, the biggest health service union, said after Health Secretary Alan Johnson’s speech to the Labour Party Conference: “We were really pleased that Alan made no mention of markets, competition and choice in improving our health service.”

They say choose and book for a few hospitals, we say give a choice of all hospitals

- Gordon Brown has abandoned the NHS choice agenda. Since becoming Labour leader, Gordon Brown and his closest allies have repeatedly eschewed genuine choice in favour of “voice”. For instance, Gordon Brown has announced: “Local people should have their voice heard, and acted upon in shaping the future of the NHS”. Meanwhile, Labour Minister Liam Byrne last week called for “voice rather than choice” in the public services.

They say yet another review, we say action to improve outcomes now

- Gordon Brown has failed to take action on falling NHS productivity. Instead of taking bold action, Gordon Brown has fallen back on the stalling tactic that he has employed for ten years: commissioning a year-long review and kicking the issue into the long grass. Having commissioned two separate reviews by Derek Wanless on the NHS, Gordon Brown has chosen to announce yet another year-long review, this time headed by Lord Derzi, scheduled to report in June 2008.

They say endless promises on GP performance, we say renegotiate the GP contract

- Gordon Brown has imposed counterproductive top-down targets, many of which have compromised patient care. For instance, the 48-hour target for a GP appointment has not made it easier to see a doctor. In fact, more than one in ten patients now cannot get an appointment within 2 working days, and a quarter cannot book an appointment in advance of 48 hours.

They say top down regulation, we say let doctors focus on patients

- Gordon Brown has swamped NHS professionals with red tape. The administrative workload created by Labour’s targets has been immense. In total, around 250,000 data returns are demanded by the Department of Health from all NHS organisations in any given year. No wonder 40 per cent of people in charge of running hospitals blame top down management and burdensome regulation for having the most damaging effect on clinical engagement.


3. Hansard, 25 January 2007, Col. 2049WA.

4. Conservative Party analysis of: Hansard, 12 June 2007, Col. 999WA; and Hansard, 16 May 2007, Col. 792WA.


9. Ibid.


12. These do not include public health targets, which are the Government’s own targets to measure progress.

13. Department of Health, Our Health, Our Care, Our Say, 30 January 2006

14. At present, less than 70 per cent of payment to practices transfers with patients when they move (Department of Health, Our Health, Our Care, Our Say, 30 January 2006

15. 3.19, p.60 Our Health, our care, our say: a new direction for community services.

16. Hansard, 4 September 2006, Col. 2096WA

17. 2.25, p.11 Investing in General Practice: the New General Medical Services Contract, Department of Health, June 2003.

18. The Government allocated £105 million of funding to PCTs through the new GMS contract for the provision of out-of-hours services in 2005-06. The actual spending on these services was £346 million - more than three times greater (Department of Health, Public Expenditure on Health and Social Services 2006, 21 November 2006.

19. In response to a parliamentary question, the then Health Minister, Andy Burnham promised to publish a funding review of NHS walk-in centres in ‘the early summer’ (Hansard, 25 Apr 2007: Column 1200W). It has not yet been published.


21. P20-22, Engaging patients in their healthcare, How is UK doing relative to other countries, Picker Institute Europe, April 2006.


23. West Sussex County Council, Essex County Council and Norfolk County Council amongst others were selected for the ‘putting people in control of their care’ pilots launched by the Department of Health in 2006.

24. Hansard, 29 November 2006, Col. 793WA-794WA; Hansard, 6 December 2006, Col. 537WA.


30. P.63 – 64 The Labour Party, manifesto 2005

31. Hansard, 25 January 2007, Col. 2049WA.


33. Financial Times, NHS business board disbands as members say it was ‘wasting time’ – 26 September 2007

34. Spectator, ‘Beneath the dynamic surface, Brown is dismantling Blair’s public service reforms’ – 18 July 2007


37. http://politics.guardian.co.uk/backbencher/story/0,2176799,00.html


40. Conservative Party analysis of: Hansard, 12 June 2007, Col. 999WA; and Hansard, 16 May 2007, Col. 792WA.

41. NHS Confederation, Ipsos MORI poll, 30 May 2007.