

Healthcare for the Future.

Policy Paper on Health and Social Care Policy in
Wales

Spring Conference 2015
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Purpose of Policy Document/Background

This paper has been approved for publication by the Welsh Liberal Democrat's Policy Committee as a Policy Paper, for debate at Welsh Liberal Democrat Spring Conference in Cardiff, February 2015.

Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom. The Party in England, the Scottish Liberal Democrats, the Welsh Liberal Democrats and the Northern Ireland Local Party determine the policy of the Party on all other issues, except that any or all of them may confer this power upon the Federal Party in any specified area or areas. If approved by Conference, this paper will therefore form the policy of the Welsh party.

Many of the policy papers published by the Welsh Liberal Democrats imply modifications to the existing government public expenditure priorities. We recognise that it may not be possible to implement all these proposals immediately. We intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next National Assembly for Wales election.

Comments on the paper are welcome and should be addressed to:
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Foreword

It was a Liberal, William Beveridge, who first proposed the NHS. It was a Welshman, Nye Bevan, who established the NHS. The NHS and an understanding of the importance of health are part of the very DNA of the Welsh Liberal Democrats. Our party will always be guided by the founding principles of the NHS - providing free care, when you need it, regardless of your ability to pay. Building on those principles, we will tackle the inefficiencies of the present organisation to achieve higher standards of care.



The NHS is our most treasured public service and it must be protected and improved. Welsh Labour has let the NHS down. Although we spend more per head on the NHS than England, we suffer worse outcomes - longer waiting times, slower ambulance response times, lower standards of treatment. This cannot continue. However, these challenges must be seen in the context of the NHS across the UK, struggling to respond to demographic changes, poor lifestyle choices, and rapid developments in medicines and scientific advances.

We want an NHS which works for the changing needs of our society. In coming years, we should expect a higher demand for all public services in Wales – including health. We need to understand the future of healthcare in Wales, in terms of an aging population, a rural population and rising levels of chronic conditions and mental health issues. We will also need to forecast the future impact of technology and new developments on our NHS and ensure we can keep up with the speed of progress. We must grapple with the question of how we sustain our NHS with finite resources, whether money or personnel, against an ageing population and advances in medical care.

This paper sets out some of the policies we would introduce in Government to secure the future of the NHS.

A handwritten signature in black ink that reads "Kirsty Williams".

Kirsty Williams AM

Leader of the Welsh Liberal Democrats and
Shadow Minister for Health and Social Services

Introduction

Welsh Labour has let the NHS down. Although we spend more per head on the NHS than England, we suffer worse results - longer waiting times, slower ambulance response times, poorer and poorer access to new treatments.

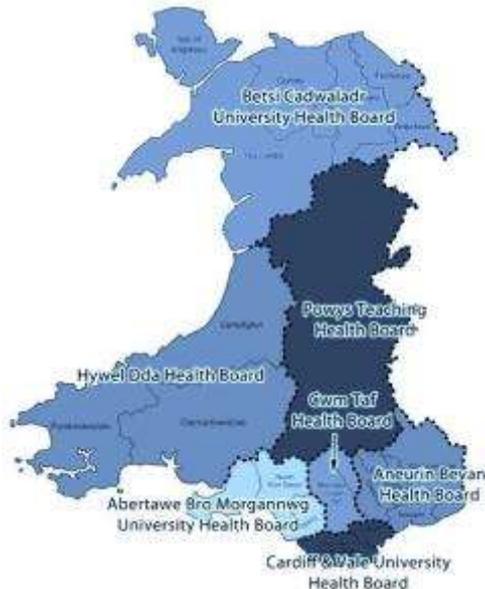


Figure 1:
<http://www.wales.nhs.uk/gallery/HealthBoards2.jpg>

The NHS is the largest single area of devolved spending in Wales' public services. The Wales Audit Office (WAO) reports that the budget for Wales' Department of Health and Social Services in 2012-13 was around £6.1 billion.¹ In 2010, health represented 42% of the Welsh Government's revenue budget – Wales Public Services 2025 has estimated that by 2024-25, between 57% and 67% of the Welsh Government's revenue budget could be taken up by health, if spending rose to match the cost pressures. This obviously has huge ramifications for all other budgets.²

The NHS "faces significant cost pressures just to stand still. But the public does not want a health service that simply stands still. We expect it to get better – to cure more diseases and to offer new and better treatments – in order that we can have longer and healthier lives". The issue of providing the NHS with sufficient funding for it to do the job we expect is possibly the greatest challenge facing the Welsh NHS.

It has been documented that the Welsh NHS faces a funding gap of £2.5 billion a year by 2025. At the same time, indications suggest that local government will need to make up a shortfall of up to £900 million by 2018, stretching social care and areas which benefit public health. Marcus Longley of the University of South Wales estimated that the NHS needs around £200-250m extra a year just to "stand-still" and avoid a potentially "catastrophic failure of service".³

Recently, the Welsh Government has chosen to cut the health budget by 8.6% in real terms in recent years.⁴ If we were to protect health spending, that would require cuts to funding for other service areas – including things such as transport, and education. Research by the IFS has shown that were we to protect the health budget from cuts, other services would face an average cut of between 5% and 8-9%.

It is clear that money alone will not be enough. Extra funding may support the status quo, but this alone will only delay the problems facing our health and social care services. We must be creative and find long-term solutions.

¹ Wales Public Services 2025 – Mark Jeffs (2013) *Future Pressures on Welsh Public Services*, <http://www.walespublicservices2025.org.uk/wp-content/uploads/2013/09/Mark-Jeffs-WPS2025-Full-Report1.pdf>, p.9

² Ibid., p.9 & 16

³ <http://www.bbc.co.uk/news/uk-wales-politics-29431502>

⁴ IFS (2013) *Scenarios for the Welsh Government Budget to 2025-26*, available at <http://www.ifs.org.uk/comms/r83.pdf> P.5

The Welsh Liberal Democrats will always be guided by the founding principles of the NHS - providing free care, when you need it, regardless of your ability to pay. Building on those principles, we will tackle the inefficiencies of the present organisation to achieve higher standards of care.

We will look at developing new ways of utilising private and not-for profit finance to enhance opportunities for capital investment, to improve the state of our hospitals and the equipment within them. While we rule out Labour's costly PFI, we will find new and alternative models such as growth bonds or Local Asset Backed Vehicles (LABVs) which could be developed.⁵

We will cut waiting times by cutting waste and using resources more efficiently. We will improve healthcare by switching ineffective spending in the NHS to the frontline. Moving NHS resources into prevention and greater local service provision has two benefits: people live longer and healthier lives and the NHS saves money in the longer term.

We would establish an Office for Health spending to act as ongoing, independent and expert assessor of the effectiveness of NHS expenditure. It will be required to monitor rigorously how each Local Health Board (LHB) and Trust spends its budget, holding them accountable to an agreed set of outcomes. With its assistance, Ministers must ensure that NHS funds are used to optimal effect. It will monitor provision by external bodies, relations with the third sector and any private finance.

We must also “promote realistic messages about what can be delivered within NHS resources”.⁶

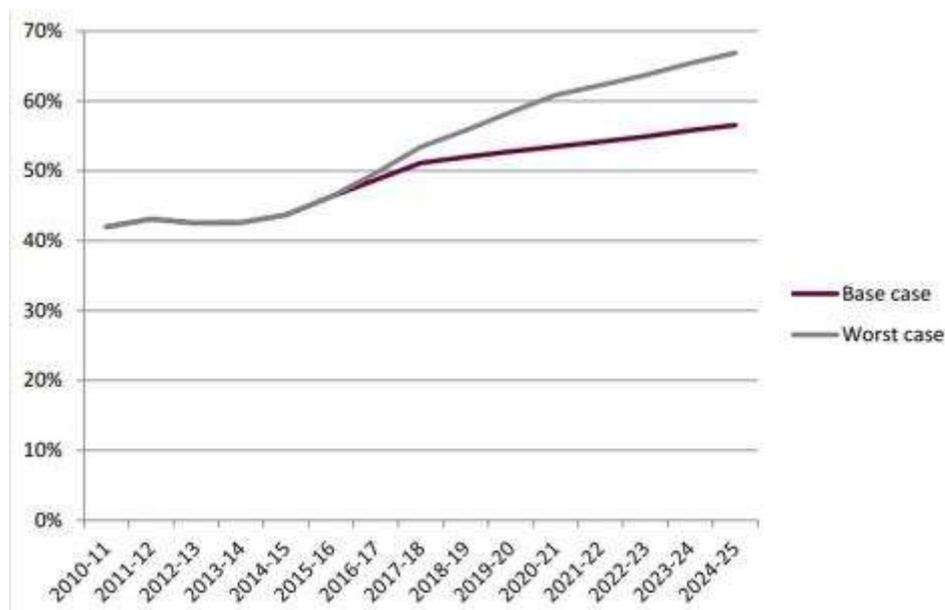
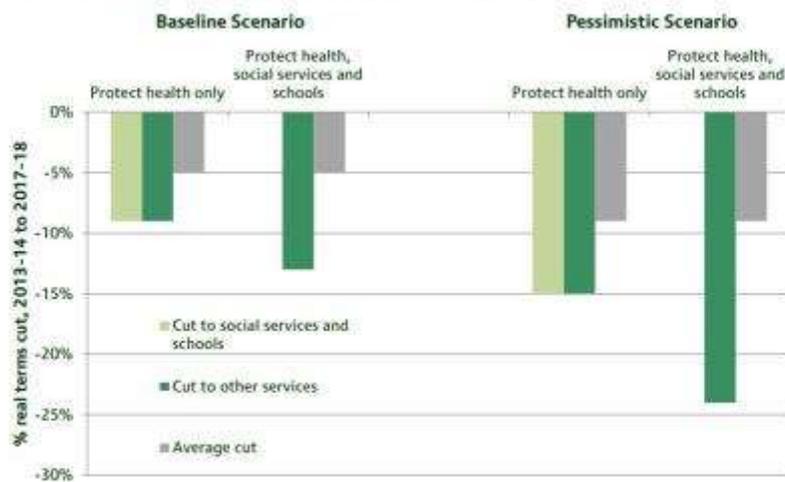


Figure 2: Projected health spending as a proportion of Welsh Government revenue budget - <http://www.walespublicservices2025.org.uk/wp-content/uploads/2013/09/Mark-Jeffs-WPS2025-Full-Report1.pdf>

⁵ <http://www.civitas.org.uk/nhs/PFIDec2012.pdf>
<http://www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/1146.pdf>

⁶ BMA (2014) *General practice – a prescription for a healthy future*, p.4.

The trade-offs between now and 2017-18



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Figure 3: <http://www.walespublicservices2025.org.uk/wp-content/uploads/2013/11/The-shape-of-pain-to-come-Welsh-budget-scenarios-to-2025.pdf>

Core Principles

We believe that the Welsh health and social care system should operate on some basic and fundamental principles. The Welsh Liberal Democrats propose that:

- ❖ The Welsh Liberal Democrats will always be guided by the founding principles of the NHS - **providing free care, when you need it, regardless of your ability to pay**;
- ❖ **Patient needs must be at the core of the NHS.** Patient care must be centred on dignity, compassion, choice & control within a clean, safe & well-managed environment.
- ❖ The staff who make our NHS what it is deserve to be well-trained, respected and fairly remunerated.
- ❖ Patients should be guaranteed the **best treatment, in the right place, at the right time** to cover their healthcare needs. Community-based services should be maintained wherever there is a clinical case for that service to remain. However, for some services, especially acute care and specialist services, there is clinical evidence that care can be improved by concentrating expertise.
- ❖ We will **tackle the inefficiencies** of the present organisation to achieve higher standards of care.
- ❖ **We will focus on prevention and local service delivery.**
- ❖ **There should be a presumption that people should receive care as close to their home as is clinically safe and appropriate.** We would place an emphasis on primary and community care and seek to invest in new and existing technologies to enable some local services to continue as Telemedicine.
- ❖ **Mental health should be taken as seriously as physical health.** For too long, those suffering from mental ill health have been stigmatised. We are determined to give it the equal attention it deserves and commit to achieving parity with other forms of care.
- ❖ We will encourage a culture of cooperation between health, social services and the third sector, to support improved service delivery in the best interests of patients.
- ❖ We need to **bring our social care system into the modern age.** We believe that social care must ensure that people are looked after in ways appropriate to their needs and maximising their independence. If you need social or nursing care, we will allow you to decide what best suits your needs.
- ❖ **We need more cooperation between health and social services**, but no mass re-organisation. We will enable local integration on demand.
- ❖ Ensure proper accountability for senior managers and those who provide care. Ensure robust inspection and quality assurance for all services, to make sure people receive the care they deserve and need.
- ❖ **Improve public education on the health service** regarding what they should expect from the NHS and where they should go for care.
- ❖ Ensure transparency in the system and provide patients and the community with the information they need to make their own choices. We will empower patients with better information and allow them to make the right decisions about their care, rather than being in passive receipt of treatment. We will develop the values of co-decision making between patients and clinicians and prioritise reablement.
- ❖ We will ensure services are open and available to all, making them accessible to those with disabilities. People should have equal access to services irrespective of condition, geography, age, gender, socio-economic status, ethnicity, faith or disability.

A Commission for the NHS' Future

The future of the NHS and the health of the people of Wales are too important for party politics. Recently, the BMA has called for a full-scale independent inquiry into all NHS health services throughout Wales in their report *Creating a Healthier NHS for Wales*. The reality is that, while the BMA is calling for a Keogh-style review, many of the elements of such a review have already been carried out in Wales. There have been elements of Keogh that we have not looked at, and we are particularly concerned about issues relating to the recruitment and retention of staff, staff morale, and whistleblowing. We need to go further than an inquiry. **The Welsh Liberal Democrats call on the Welsh Government to set up an all-party and non-party Commission to be established to ensure Wales has an NHS that is clinically and financially sustainable, and to secure a historic and long-term plan for health and social care.** ⁷

We need to look at what kind of services we need to meet the needs of our ageing population, where these services should be, how they should be staffed and how it would be funded. A Commission with professional and patient representatives and an independent chair would be able to work together and deal with the strategic problems facing our NHS in Wales. It should have representatives of the Welsh political parties, to ensure long-term political buy-in across the political spectrum and from different administrations, The Commission, led by experts for the benefit of the public, will be able to stop politicians meddling and playing political games with one of Wales' most important services, our NHS. From the outset, the Commission would ensure the valuable experiences of those using our front-line health services feed into the efforts to reform our NHS. There should be representatives from all healthcare professions. We would ensure it engages with the third sector, to develop new and innovative ways for government and third sector to work together to support patients. It should include representatives and advocates for patients and carers as an integral part. The Commission's work would greatly benefit from incorporating lay people into its work. In particular, we would ensure that it benefits from the experiences of people living with conditions and those who are looking after friends and family members.

Its first task should be to detail the challenges facing Wales in supporting a health population over the next few decades. We need to understand the future of healthcare in Wales, in terms of an aging population, a rural population and rising levels of chronic conditions and mental health issues. We will also need to forecast the future impact of technology and new developments on our NHS and ensure we can keep up with the speed of progress. It will produce recommendations regarding what kind of services we must provide to meet population needs, where the services should be, how these services should be staffed, and how these services would be funded. It should examine examples from the other three NHS systems in Britain, and healthcare systems abroad, in order to understand what works and what doesn't. We would task such a commission to respond with the utmost urgency. We would commission it to report early on measures that could be taken quickly to increase efficiency and cooperation in the NHS. There are several potential models. Commissions have been used for higher education funding and devolution, and reviews such as the Commission on Funding of Care and Support (the Dilnot Review) and the Pensions Commission (the Turner Review) have been influential in the field. The London Health Commission is an independent inquiry established in September 2013 by the Mayor of London. It is examining how London's health and healthcare can be improved for the benefit of the population.

⁷ <http://welshlibdems.org.uk/en/article/2014/908572/establish-a-commission-to-plan-for-future-welsh-nhs-says-kirsty-williams>

Managing health delivery, at a reasonable cost, in a more restricted environment

A new model of healthcare for older people

The population of Wales is gradually aging. In 2008, 18% of the Welsh population was over 65; by 2033, this is expected to rise to nearly 26%.⁸ Wales also has the highest percentage of the population over retirement age in the UK, notably higher than the UK average and the other constituent countries.⁹ People are also living longer. In 1981, men aged 65 could expect on average to live a further 14.0 years and women aged 65 a further 18.0. By 2051, life expectancy for men aged 65 is projected to be 25.9 years; for women aged 65 it is projected to be 28.3.¹⁰ Older people now have more years of healthy life after retirement than ever before.

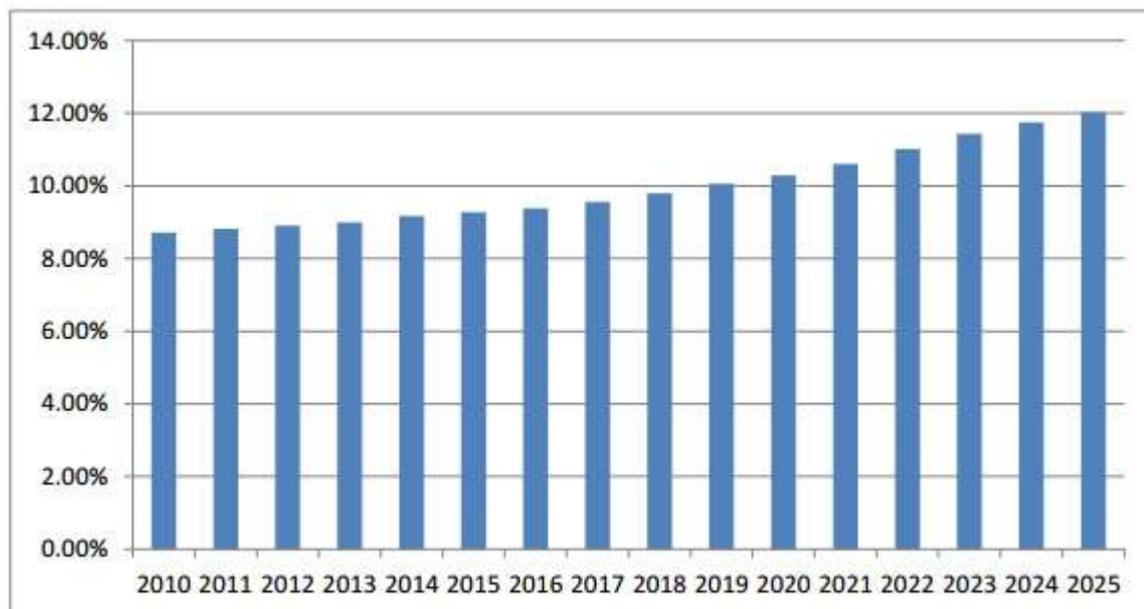


Figure 4: Percentage of Population in Wales over 75 - source <http://www.walespublicservices2025.org.uk/wp-content/uploads/2013/09/Mark-Jeffs-WPS2025-Full-Report1.pdf>

While older people are a true asset to Wales and Welsh society, not least in terms of contributing almost £40bn more to the UK economy than they receive in state pensions, welfare and health services through tax payments, spending power, caring responsibilities and volunteering,¹¹ there are undoubtedly challenges for our health service that are raised by an aging population. As people age, they tend to become more susceptible to disease and disability.¹² There may be a rise in the prevalence of age-related illnesses, and dementia is specifically cited as an example. Older people are more at risk of falls, which can often require hospitalisation to treat. Incidence rates increase with age for most cancers.¹³ Social isolation

⁸ National Assembly for Wales Research Service (2011) *Key Issues for the Fourth Assembly*, p.66

⁹ *Ibid.*, p.66

¹⁰ Office for National Statistics (16 February 2012), *Part of Pension Trends, Chapter 3: Life Expectancy and Health Aging*, p.1

¹¹ <http://www.theguardian.com/society/2011/mar/02/older-people-net-contributors-volunteering>

¹² <http://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/data-and-statistics/risk-factors-of-ill-health-among-older-people>

¹³ <http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/age/>

increases the risk of death for older people.¹⁴ According to the *Understanding Wales' Future* “all other things remaining unchanged, the projected increase in population and ageing demographic profile means the number being treated for illnesses will increase”.

Research from the Royal Voluntary Service¹⁵ shows that 75% of over-65s say that they are rarely or never consulted on services that have an impact on their lives, and 58% feel that society sees them as a burden. Older people, particularly older men, are the loneliest cohort of people in the UK,¹⁶ with loneliness and isolation being linked to depression¹⁷ and alcohol abuse¹⁸. Tackling loneliness needs to be a priority for Welsh health services. We must work to uphold the dignity and independence of older people through our health service, and preserve their independence and engagement with society.

It is clear that the NHS must adapt to the needs of older people in the population. **The Welsh Liberal Democrats call for a new model of healthcare for older people.** We must recalibrate the system to make sure that the NHS looks after our older people.

The *Securing the future of excellent patient care* report recommended that the NHS across the UK needs “greater flexibility, better preparation for working in multi-professional teams and **more generalists.**” **We believe that “postgraduate training must focus on preparing doctors with generic clinical and professional competencies** that can be adapted and enhanced to support local workforce and service requirements.”¹⁹ **We would train clinicians in the care of elderly people and tackling age-related illnesses,** dedicated to promote health and prevent diseases and disabilities in older adults. They should be trained in general practice and specific age-related illnesses, diseases and disabilities. This will require **new investment in cottage hospitals and community care,** specifically designed to ensure that there is **flexible capacity** during times of increased pressure like the winter months. We would **task GP practices to lead multiagency care teams that would be tasked with identifying people at risk of needing unscheduled care and pro-actively managing their care and health,** in particular as part of **contingency planning for winter weather conditions.** **Our commitment to a reablement approach and to preserving the independence and dignity of older people** will support this method.

¹⁴ <http://www.bbc.co.uk/news/health-21929197>

¹⁵ RVS (2013) *Shaping Our Age*

¹⁶ Campaign to End Loneliness (2011) *The Health Impacts of Loneliness*, Campaign to End Loneliness.

¹⁷ Kane, M. & Cook, L. (2013) *Dementia 2013: the hidden voice of loneliness*, London: Alzheimer's Society

¹⁸ Goldhill, O. & Hughes, B. (2012) “Lonely pensioners falling into alcohol abuse is Wales' ‘hidden epidemic’”, *Western Mail*, 30th December 2012.

¹⁹

http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_5397788_7.pdf

Mental Health

One in four people experience a mental health problem in any given year. Nine out of ten people with mental health problems experience stigma and discrimination.²⁰

Mental health has been traditionally viewed with less gravity than more physical forms of health. Welsh Liberal Democrats strongly believe that mental health should see equal parity with other forms of health care. Improved mental health and wellbeing is both a worthwhile goal in itself; and leads to better outcomes, for example in physical health, health behaviours, educational attainment, employability and crime reduction.²¹

Mental health is a broad topic, and covers a wide variety of conditions such as anxiety; depression; dementia; schizophrenia; bi-polar disorder; eating disorders and more. There are a range of definitions and there is ongoing debate about what constitutes mental health beyond simply an absence of clinically defined mental illness.²²

The overall cost of mental health problems was estimated for 2007/08 to stand at £7.2 billion a year – including the costs of health and social care provided for people with mental health problems; the cost of output losses to the Welsh economy resulting from the adverse effects of mental health problems on people’s ability to work; and a monetary estimate of the human cost of mental health problems and their impact on quality of life.

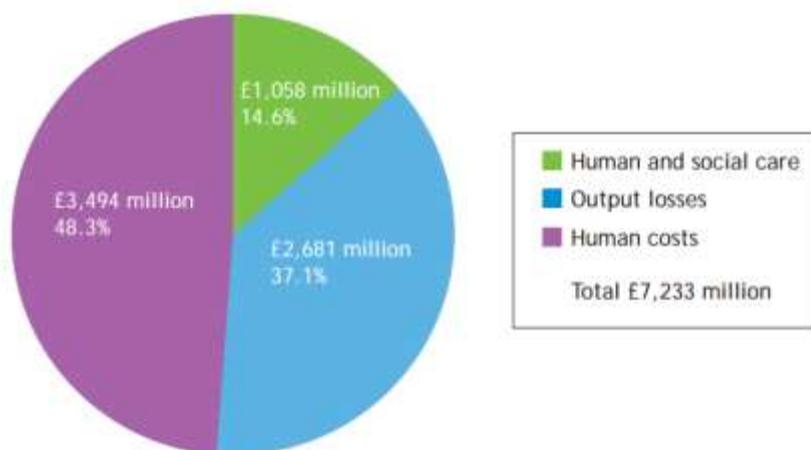


Figure 5: Costs of mental illness in Wales - http://www.centreformentalhealth.org.uk/pdfs/Promoting_mental_health_Wales.pdf

In October 2012, the Mental Health (Wales) Measure came into force, designed to improve mental health support services in Wales. This was a major step forward in mental healthcare in Wales. We have been supportive of this Measure and emphasised the need to ensure it is working well, with effective scrutiny of how it is used.

²⁰ <http://www.gofal.org.uk/policy-and-campaigns/>

²¹ All Wales Mental Health Promotion Network (2009) *Promoting mental health and preventing mental illness: the economic case for investment in Wales*, available at http://www.centreformentalhealth.org.uk/pdfs/Promoting_mental_health_Wales.pdf p.22

²² *Ibid.*, p.15

Parity with Physical Health

The Welsh Liberal Democrats are committed to the principle that mental health should be taken as seriously as physical health and given equal priority. For too long, mental health has been stigmatised and ignored. We are determined to give it the equal attention it deserves and commit to achieving equal parity with other forms of healthcare.

As a first step, **Welsh Liberal Democrats in government would enshrine parity of esteem between mental and physical health on the face of future legislation.** The Health and Social Care Act 2012 which requires NHS England to work for parity through the NHS mandate could be used as a model.

The next step is to **ensure that mental health receives a level of funding that matches the needs of the population. We would like to see funding for mental health within the overall NHS budget, including prevention, shift over time to reflect the relative size of the health challenge in relation to physical health.** Doing this would make a major difference in maintaining and improving the mental health of Wales.

The World Health Organisation estimated 20% of the "burden of disease" in the UK is represented by mental illness, including suicide.²³ However, mental health services in Wales only received 11.4% of NHS Funding in 2012-13.²⁴

We would need to undertake research in government to deliver a suitable Wales-specific figure, but the disparity is clear. **Welsh Liberal Democrats in Government would seek over the course of an Assembly term to increase the relative size of mental health spending to match the needs of the population.**

This would be cost-effective in the long term. Mental health conditions such as depression or anxiety disorders raise the costs of physical health care by at least 45% for a wide range of conditions such as cardio-vascular disease, diabetes and chronic obstructive pulmonary disease. Nearly a third of all people with long-term physical conditions also suffer from such mental health problems. By spending more on mental health, we can save even more, as well as relieving one of the main sources of suffering in our community.²⁵

The Minister for Health should report annually to the Assembly on progress towards the goal of parity between mental and physical health.

²³

[http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20\(English\).pdf](http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20(English).pdf)

²⁴ Statistics for Wales (2014) *NHS Expenditure programme budgets: 2012-13*,

<http://wales.gov.uk/docs/statistics/2014/140611-nhs-expenditure-programme-budgets-2012-13-en.pdf>

²⁵ <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>

Multiple Conditions

Improving mental health will be of huge benefit to physical health. Mental health presents issues of co-morbidity, usually defined as when people suffer from multiple co-existing conditions. Mental health problems can interact with physical health and trigger or exacerbate other conditions. Mental illness reduces life expectancy: by 7-10 years for people with depression and by 10-15 years for people with schizophrenia.²⁶ Depression has been associated with a four-fold increase in the risk of heart disease.

Improving the way we respond to co-morbid mental health problems would have a high impact in terms of patient outcomes and experience. In terms of cost, co-morbid depression costs health services between 30% and 140% more than equivalent patients without co-morbid depression and integrated models of disease management have been found to deliver savings four times greater than the investment.²⁷ In England, it has been estimated that co-existing medical health problems including medically unexplained symptoms cost the NHS around £13 billion a year in extra spending on physical health services.²⁸ In hospitals, “around half of all inpatients suffer from a mental health condition such as depression, dementia or delirium.”²⁹

The Welsh Liberal Democrats would expand liaison psychiatry in the NHS. Liaison psychiatry services provide “immediate access to specialist mental health support for people being treated for physical health problems, most often in general hospitals and in some cases in the community.”³⁰ Every NHS hospital in Wales should have such a service as standard, the scale and nature of which should vary according to local needs. The Centre for Mental Health and NHS Confederation have found that such service can save an average hospital £5 million per year by reducing the number and length of admissions to beds.

*In those hospitals where liaison psychiatry support is currently limited or non-existent, the initial priority should be to set up a rapid-response generic service, which focuses on assessment, the day-to-day management of patients during their time in hospital and onward referral to community services as appropriate.*³¹

These teams will need to “take a leadership role in changing the culture of the hospital so the central importance of psychological factors is more widely recognised and embedded in the routine care of patients” and have “a strong focus on the education, training and supervision of acute hospital staff”.³²

We would ensure public health messaging on issues such as smoking, obesity, alcohol consumption and physical activity actively consider the impact of co-morbidities on an individual's mental health.

²⁶ http://www.centreformentalhealth.org.uk/pdfs/BriefingNote_parityofesteem.pdf

²⁷ The King's Fund (2013) *Transforming our health care system*, available at, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf, p.7

²⁸ The King's Fund and Centre for Mental Health (2012) *Long-Term Conditions and Mental Health - The Cost of co-morbidities* http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

²⁹ NHS Confederation (2012) *Liaison psychiatry – the way ahead* http://www.centreformentalhealth.org.uk/pdfs/Liaison_psychiatry_the_way_ahead.pdf

³⁰ http://www.centreformentalhealth.org.uk/publications/liaison_psychiatry.aspx?ID=665

³¹ http://www.centreformentalhealth.org.uk/pdfs/Liaison_psychiatry_the_way_ahead.pdf

³² http://www.centreformentalhealth.org.uk/pdfs/Liaison_psychiatry_the_way_ahead.pdf

Children and adolescents

Child and Adolescent Mental Health Services (CAMHS) are of particular concern, with the Welsh Government burying its head in the sand, amid regular warnings that CAMHS in Wales is in a state of crisis. The number of vulnerable young people in Wales waiting more than 14 weeks to access child and adolescent psychiatric services has almost quadrupled recently, from 199 in January 2013 to 736 in January 2014. It is recognised that 1 in 10 children and adolescents will experience a mental health issue and many will continue to have mental health problems into adulthood.³³

Despite action plans, frameworks, strategies such as 'Everybody's Business' in 2001 and even the Mental Health Measure 2010, there remain significant concerns that cannot be ignored. It is saddening to look back at the Annual Report of the Children's Commissioner 2005-06, which noted that CAMHS provision was 'in crisis across Wales.' Almost a decade on, and child health experts warn that mental health services for children and young people in Wales are still in a state of crisis.³⁴ In Government, Welsh Liberal Democrats would:

- **Train every GP and general practice nurse in child mental and physical health.** Every one of these primary healthcare professionals will have frequent contact with children and young people, so we should make sure they have the skills necessary to help improve child patient outcomes and this would also help reduce unnecessary hospital visits and admissions by dealing with health needs earlier.
- **Train professionals with a high degree of contact with children such as teachers and youth club workers with basic mental health support for young people.** This should cover child development, mental health and psychological resilience. This would improve early identification of children who are vulnerable and prevention of mental health problems. According to the UK Chief Medical Officer, three-quarters of adult mental disorders are in evidence by age 21, but three-quarters of children and young people with these disorders are not detected or treated.³⁵ Schemes such as MindEd can be used to provide a basis.³⁶ Such schemes should also ensure liaison with parents and guardians, helping them identify the best way to support their children.
- **Include teaching children and young people how to look after their mental health and build emotional resilience in the national curriculum,** though approaches such as mindfulness. On average, three children in each classroom are experiencing a mental health problem, including behavioural issues.³⁷
- **Address the inequitable variation in the availability and accessibility of CAMHS in Wales and investigate the waiting times** between a child or young person's first assessment with CAMHS and their subsequent service referral.
- **Review the governance arrangements** for CAMHS inpatient units and out of area placements

³³ Oral evidence: Children's and Adolescent Mental Health and CAMHS, HC 1129 Tuesday 4 March 2014
<http://data.parliament.uk/writtenevidence/WrittenEvidence.svc/EvidenceHtml/7277>

³⁴ BBC 'Young mental health service in Wales in crisis, say experts' 10 March 2014
<http://www.bbc.co.uk/news/uk-wales-26505314>

³⁵ <https://www.minded.org.uk/mod/page/view.php?id=18>

³⁶ <https://www.minded.org.uk>

³⁷ <http://www.theguardian.com/society/christmas-charity-appeal-2014-blog/2014/dec/10/-sp-mental-health-manifesto-five-things-that-need-to-change>

- **Introduce a national framework to ensure continuity of treatment in the transition between CAMHS and Adult Mental Health Services**, including a streamlined information sharing system between providers.
- **Ensure readmission statistics are routinely published** to help inform trends in the patient discharging system.
- **Ensure that all clinical staff within CAMHS have undertaken appropriate safeguarding checks.**
- **Establish a firmer procedure for health boards to report on inappropriate placements** on adult mental health wards
- **Clarify the status of the National Service Framework for Children, Young People and Maternity Services.**
- **Ensure that all children receive child development assessments at key stages.**³⁸
- **Publish a national framework to ensure continuity of treatment for young people transitioning from adolescent to adult services**, including a streamlined information sharing system between providers.

³⁸ <http://www.centreforum.org/assets/pubs/the-pursuit-of-happiness.pdf>

Workplace

Mental health at work is of great concern. Over half of those surveyed in recent research by Mind to mark National Stress Awareness Day³⁹ found work very or fairly stressful, more so than debt or financial problems, health or relationships. While mental health is still a taboo in the office, with 30% of people saying they wouldn't be able to talk openly with their line manager if they were stressed, 53% of people agreed that stress affects their sleep, 27% said it affected their physical health, and 22% said it affected their appetite. 12% of people have drunk alcohol during the working day to cope with workplace stress.

We will work with employers to create a more open culture where people feel able to discuss their wellbeing and tackle the causes of stress among their staff.

We acknowledge that mental health problems can be caused or exacerbated by conditions in the workplace, e.g. by insensitive management practices or bullying, yet, mental health is usually not considered in the context of health and safety measures. We will work towards giving mental health parity in this area, raising awareness of risks to mental health in the workplace and working towards parity in health and safety legislation.

All organisations should work to become mental health friendly employers, with larger organisations of over 500 employees being the priority. Welsh Liberal Democrats in Government would take the lead by **ensuring that all public sector enterprises become mental health friendly employers.**

We will bring forward a strategy for rolling out mental health support in the workplace, similar to that used to monitor physical health such as blood cholesterol, weight, and blood sugar levels. We would provide accredited training to people in workplaces on issues such as Mental Health First Aid.

Programme's and campaigns such as Time to Change Wales have made great strides in improving the way employers respond to mental health problems in the workplace. We would **work with organisations like Time to Change Wales** to tackle stigma in the workplace and elsewhere.

We would offer dedicated support for new employees to make sure they can stay in work and cope with anxiety and other ongoing problems.⁴⁰

There also needs to be support in educational and other types of institution for counselling services. We would work with employers, universities and other institutions to determine the provision available for their staff or students.

³⁹ <http://www.mind.org.uk/news-campaigns/news/stressed-out-staff-feel-unsupported-at-work-says-mind/#.VJBZ9iusWD8>

⁴⁰ <https://www.gov.uk/government/news/nick-clegg-holds-first-mental-health-taskforce-meeting>

Crisis Care

The need to treat people with compassion, dignity and respect is an area of particular concern for inpatient services treating people with acute mental health problems, and treatment for individuals experiencing a mental health crisis.

Acute and Crisis care should shift from a model of medical wards to one of a retreat; providing humane, respectful, personalised care in a comfortable environment.

To achieve this, **Welsh Liberal Democrats in Government would situate mental health units in more holistic settings** than simply attaching them to general hospitals. We would also ensure local health boards and local authorities are complying with **guidelines banning the use of face down restraint** in health care settings and **improve training for staff in order to reduce harmful restrictive practices**.

For emergency situations, a suitable short-term response is needed. **The Welsh Liberal Democrats in Government would introduce a new Crisis Care Concordat between police, paramedics and health services in Wales** to ensure that health based places of safety are available 24/7 for someone experiencing a mental health crisis, so that no-one is placed in police custody because appropriate services are not available. In England, this national agreement was introduced by Liberal Democrat Ministers in order to support people in crisis and set out how organisations will work together to make sure that people get the help they need when they are having a mental health crisis.

We would also **develop the use of street triage**. Street triage is new initiative in which a mental health nurse accompanies police officers responding to calls about someone experiencing a crisis. It helps prioritise cases, and direct individuals to the right kind of support. They are currently being piloted by the Department of Health in England⁴¹ will need to be evaluated fully. It will be important for street triage to work alongside rather than replace liaison and diversion services and crisis resolution teams.⁴²

⁴¹ <http://www.crisiscareconcordat.org.uk/inspiration/get-inspired-2/>

⁴² http://www.centreformentalhealth.org.uk/pdfs/BriefingNote_parityofesteem.pdf

Leadership

We will provide better leadership of Mental Health Services by setting up Mental Health Taskforce. We recognise that mental health is too large an issue for the NHS alone and the whole of Welsh Government needs to combine its efforts and pool its resources to help those with a mental health condition.

It will include a range of Ministers and portfolios. The model in England includes Secretaries of State and for Health, Communities, Education, Justice, Business, Work and Pensions, and the Chief Secretary to the Treasury, and Ministers from Education, Health and Defence.⁴³ Welsh Government could include Ministers and Deputy Ministers for Health and Social Services, Education, Skills, Communities, and Finance.

We will provide better leadership of Mental Health Services by appointing a director of Mental Health within the Government who will be responsible for working closely with physical health directorates to address issues of co-morbidities and links between physical and mental health.

Each LHB should appoint a Wellbeing Champion to advocate and monitor parity between mental and physical and promote wellbeing.

The Welsh Liberal Democrats in Government would:

- Bring forward a mental health strategy to radically improve treatment and access to mental health services, including tackling waiting times across Wales through a rigorous review of all LHB provision.
- Invest to ensure that every adult that requires it should have access to talking or psychological therapy to treat anxiety disorders or depression. These services may include Cognitive Behavioural Therapy (CBT), Counselling for Depression, and Interpersonal Psychotherapy
- Emphasise early intervention to help tackle underlying causes of mental health.
- Introduce a new scheme to identify mental health and substance abuse issues of offenders when they enter the criminal justice system in Wales and seek proper treatment for them. Mental health nurses and other mental health professionals will work with police stations and courts so that people with mental health and substance misuse problems get the right treatment as quickly as possible. This will help reduce re-offending rates.
- Ensure sufficient provision of extra capacity in mental health intensive care and forensic units to divert people in need of treatment away from prison and to assist those already in prison.
- Work to establish a treatment centre in Wales for eating disorders. At present, those serious enough to have to be hospitalised are either sent to a local psychiatric ward, or are sent to a specialist centre miles away in England.
- Dementia awareness and dementia care training should be mandatory for healthcare professionals.
- The NHS estate should engage in further work to make healthcare settings as mental health and dementia-friendly as possible.

⁴³ <https://www.gov.uk/government/news/mental-health-taskforce-announced>

Future Workforce

Here in Wales we have a worrying shortage of healthcare professionals, a problem particularly evident in rural areas of Mid and North Wales. It is not a new situation, and the Welsh Liberal Democrats have been pressing for action for some years. We are very much aware of the pivotal role these professionals play within the NHS and the increasing demands they face. We need to acknowledge that the continuation of health care services is dependent on recruiting and retaining personnel within those services. The Welsh Government must do more to address the issue of workforce planning and tackle the challenges that are faced in relation to recruitment.

In 2011, the NHS had approximately 72,000 directly employed full-time equivalent staff, an increase of almost a quarter since 2000. There were 2,022 GPs working in 483 GP practices, of whom 43% were women. Some 13 per cent of GPs work in single-handed practices, although they may employ a salaried GP or a GP trainee.⁴⁴ In 2012, Wales filled only 72% of posts at the core medical training level. To compare, the UK average was 98%, and only North Western (97%), Northern Ireland (97%) and Peninsula (98%) deaneries did not achieve a 100% fill rate.⁴⁵

As the RCP have said, “without a strategic approach, workforce planning in Wales has become patchy and uncoordinated”.⁴⁶ It is time for a national medical workforce and training plan for Wales, including a new strategic approach to recruitment. Workforce planning must be a key priority in the next Assembly term and going forward. Welsh Liberal Democrats in government would work with NHS bodies, the Wales Deanery and key stakeholders such as the royal colleges, to **develop a national medical workforce and training strategy** to ensure that staff are deployed and trained effectively, now and in the future.

The problem is particularly clear in GP numbers but we must remember that all professionals in Wales’ health and social care settings, from nurses to dentists, physiotherapists to optometrists, speech and language therapists to hospital porters, play a vital role and we must understand how best to support them all. The development of the health and social care workforce is vital, and we must attempt to recruit and sustain staff at all levels.

We would also examine the role of substitution (i.e. some professions undertaking the role of others) and delegation (i.e. not doing work which could be done by others under supervision). Nursing and Allied Health Professions are well placed to be involved in substitution over issues such as triage and prescribing. Delegation to Advanced Practitioners and to Health Care Support Workers also needs to be considered.

Considering the training regime for medical professionals is also vital. With the inevitable increases in dementia, more dementia-friendly wards and staff trained in helping individuals with dementia will be vital. Similarly, all staff should be trained in mental health care, in order to help detect instances of poor mental health and co-morbidities at an earlier stage.

Additionally, Welsh Liberal Democrats in Government would:

- **Introduce caps on the payoffs** of hospital managers. Resources should be spent on care, not executives.

⁴⁴ Ibid., p.62

⁴⁵ Royal College of Physicians (2013) *The Internal Medicine Workforce in Wales*, p.3

⁴⁶ Royal College of Physicians Wales (2014) *Rising to the Challenge*.

- **Promote the development of core common competencies** by all doctors and have all trainee doctors on acute speciality programmes rotate through the emergency department. This will create a medical workforce with the interspeciality skills to meet future challenges.
- **Encourage and support staff through regular supervision, reflective practice, adoption of easy wins and celebration of good work.** Reinforce boundaries that allow for warmth and ordinary social interaction as well as professionalism
- **Ensure hospitals designate a clinical lead for internal medicine** to champion the medical registrar and provide professional support for the role and **provide adequate facilities and working environment, including dedicated space to work and rest.**
- **Recruit and develop staff on the basis of their values and personal qualities as well as their skills.**
- **Encourage junior doctors to stay in Wales through offering them innovative new training pathways, an improved workload and more opportunities to take part in clinical leadership and quality improvement programmes.**
- **Improving mental health skills in general practice** using training programmes developed specifically for primary care professionals.⁴⁷
- Developing a Welsh 'locum bank' to save money on hiring locums from agencies and making it easier for the health service to fill temporary gaps in provision.

The Welsh Liberal Democrats are campaigning for safe nurse staffing levels, so that nurses have more time to spend with patients and can provide better care. This will help to cut expenditure on overtime and reduce workload and stress, providing better outcomes for our patients and nurses across Wales. Kirsty Williams AM recently introduced her Safe Nurse Staffing Levels (Wales) Bill to the National Assembly which seeks to enshrine an obligation for safe nurse staffing levels in law, to ensure sufficient numbers of nurses within our health service to provide safe care at all times.

There is increasing evidence from across the world that nurse staffing levels have a significant impact on patient care and the recruitment and retention of staff. Nurses who have fewer patients to tend are able to spend a greater amount of time with each patient and as a result can provide better care. If they are more easily able to identify potential problems with a patient's care, then they are able to play a preventative, rather than a simply reactive, role and consequently reduce the level of treatment needed and the cost of this care to the NHS. Our nurses in Wales have more patients to care for than any other part of the UK, with an average of 10.5 patients per nurse compared to 8.5 in England or 7.2 in Northern Ireland.

We would expand this approach to other professions by **working with the NHS and royal colleges to provide guidance on acceptable staffing levels**, including the optimum number and appropriate grades of junior doctors necessary for a given volume of admissions, case mix, number of inpatients covered, and support for other specialities.

Urgent action must be taken to transform internal medicine into a high-status specialty. The workload of the acute take should be distributed more evenly between the medical specialties

⁴⁷ Ibid., http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf p.7

and not just in the few specialties that currently cover internal medicine. Health boards must take swift action to prioritise the acute take and ward cover in consultant job plans, although this will need careful planning to ensure that it does not come at the expense of specialty commitments. More consultants with training in internal medicine would allow a more flexible acute service and would prevent the unmanageable workload of acute medicine falling on the few. In the future, **consultants should be required by their employers to complete continuing professional development in internal medicine as well as their specialty and the majority of medical trainees should train dually in internal medicine and their specialty, supported by consultant supervision and feedback.**

Access to medicines

Too often we read that patients in Wales are being denied access to medicines. It is particularly tragic when those treatments are available over the border. The Rarer Cancer Foundation's report '*Nations Divided?*'⁴⁸ highlights cross-border inequalities in access to medicines. At the time of the report, there were 24 treatments available in England not routinely available in Wales on the grounds that they had not been recommended by National Institute for Health and Care Excellent (NICE) or the All Wales Medicines Strategy Group (AWMSG). The report found that people in Wales were five times less likely to gain access to a cancer drug which is not routinely available than people in England.

The Welsh Labour Government needs to change its mind-set with regards to medicines: they should be seen as an investment, rather than a cost. In Wales, the Welsh Liberal Democrats created the £25 million Health Technologies Fund⁴⁹ to offer patients better access to innovative treatments that are not routinely available on the Welsh NHS. The purpose of this fund was to give Welsh patients access to the latest innovations in health, but instead the Welsh Government used the first year of the fund to replace old equipment. **The Welsh Liberal Democrats call for the Health Technologies Fund to be extended to support the take up of new medicines** and in particular to support research into a stratified medicine approach. This could adopt more of the model of the Scottish Government's New Medicines Fund, for innovative medicine which expands and replaces the Rare Conditions Medicines Fund. The Fund is worth £40m, paid for by utilising payments to the Scottish Government made by the pharmaceutical industry under the UK-wide branded drug pricing scheme, the Pharmaceutical Price Regulation Scheme (PPRS).

The total spent on new medicines in primary care in 2011 accounted for only 0.5% of NHS Wales' expenditure. **The Welsh Liberal Democrats believe the spend on new medicines must be higher** if we are to compete effectively for clinical trials at a global level and make Wales' NHS a more attractive place for clinicians to work in.⁵⁰ From 2011-2015 it is estimated that Wales will gain savings of around £186million due to Loss of Exclusivity of branded medicines. We need to **invest some of this saving back into the Health Technology Fund, to support engagement with the AWMSG and NICE so that more patients in Wales can benefit from the latest medicines and treatments.** Charities and patients often won't have the resources or expertise to engage with the NICE or AWMSG process, even pharmaceutical companies themselves can struggle to meet the demands of either body to prove population cost effectiveness. Support for better engagement with NICE and the AWMSG could result in more medicines having the evidence base they need to be approved and reduce reliance on Individual Patient Funding Requests (IPFR).

The CentreForum Mental Health Commission recommended that NICE adopts Subjective Wellbeing as part of its evaluation methodology, in order to properly weight mental health. We would explore this mechanism for AWMSG evaluation.⁵¹

Under the current IPFR process, patients can suffer from vastly different outcomes under different LHBs. An All-Wales IPFR panel could provide a consistent and suitably responsive

⁴⁸ http://www.rarercancers.org/images/stories/news/8011/nations_divided_final_complete_report.pdf

⁴⁹ <http://welshlibdems.org.uk/en/article/2013/712828/welsh-lib-dem-health-technology-fund-bringing-benefits-for-patients>

⁵⁰ <http://welshlibdems.org.uk/en/article/2014/795317/health-technology-fund-must-include-new-medicines-kirsty-williams>

⁵¹ <http://www.centreforum.org/assets/pubs/the-pursuit-of-happiness.pdf>, pp.24-25

service for patients seeking high cost treatments. It would also give a more representative national view of emerging patient cohorts which could trigger further appraisal by AWMMSG.

The Welsh Liberal Democrats in government would develop an all-Wales IPFR panel and remove the 'exceptionality' hurdle which prevents many patients access to drugs which their clinician thinks could help them. Exceptionality excludes some individual patients and disqualifies multiple applications.

Stratified Medicines

Stratified medicine means looking at large groups of patients to try and find ways of predicting which treatments diseases are likely to respond to. Stratified medicines, sometimes known as 'personalised' or 'genomic' medicines, enable targeted treatments specifically to patient sub-populations most likely to respond. This is not creating medicines unique to a patient, but rather, utilising the ability to classify individual into sub-populations, who differ in their susceptibility to a particular disease or their response to a specific treatment. Patients with the same disease often respond to treatment differently because of subtle differences in their underlying disease mechanisms. Specific gene mutations may mean patients respond differently to patients without such a mutation. It has been estimated that only 30-70% of patient respond positively to any particular drug.⁵² Stratified medicine groups patient into different 'strata' based on these mutations and offers them more tailored treatment.

Wales will benefit from a pro-active approach to adopting stratified medicines, where all stakeholders work together with a single co-ordinated ambition.

The Welsh Liberal Democrats believe that stratified medicines could have a dramatic impact on survival rates. In Government, we would seek to support the development of such stratified medicines by:

- Supporting research to understand the genetic and molecular basis of diseases.
- Introducing flexible and novel approaches to regulatory assessments of innovative stratified medicine products.
- Developing a system-wide approach to information dissemination, education and training, and implementation of stratified medicine.
- Developing standardised disease classifications for all healthcare practitioners.
- Ensuring healthcare professionals are at the heart of the patient and public dialogue that will be crucial to ensure that stratified medicine products are developed and implemented in a way that considered the needs and concerns of all these groups.⁵³
- Coordinating with Westminster, Holyrood, Stormont and industry stakeholders to make the UK the best place to develop, and have adopted, stratified medicine.⁵⁴

This will benefit patients, provide cost-effective solutions for the NHS and other healthcare providers and create opportunities for business.

⁵² Technology Strategy Board, *Stratified Medicine in the UK: Vision and Roadmap*

⁵³ The Academy of Medical Sciences (2013) *Realising the potential of stratified medicine*

⁵⁴ Technology Strategy Board, *Stratified Medicine in the UK: Vision and Roadmap*

Supporting People with Cancer

Cancer is one of the biggest causes of premature death in Wales and the UK, accounting for nearly a third (29%) of all deaths in 2013. Around 18,000 people are diagnosed with cancer each year in Wales.⁵⁵

The variation of care between LHBs in Wales is of great concern. If you compare the most deprived areas of Wales to the least deprived, the incidence of cancer rate is 20% higher and the cancer mortality rate is over 50% higher in the most deprived areas.⁵⁶

We have previously called for implementing, as a priority, a National Comprehensive Cancer Plan, using money currently in the NHS budget to fund the most effective medicines and therapies. Better facilities will help cut waiting times and improve patients' quality of life.

The Welsh Liberal Democrats in government would:

- Close the gap between the best and the rest - target efforts to reduce variation of cancer incidence and outcomes across Wales.
- Fully implement the Cancer Delivery Plan, including stages of the cancer pathway from prevention, early detection through treatment and beyond to living with cancer and survivorship.
- Improve public awareness of ways to reduce cancer risks and highlighting common signs and symptoms, highlighting the importance of presenting to a GP early. Wales is the only UK nation without a cancer awareness campaign. Scotland and England have had cancer awareness campaigns to improve knowledge of signs, symptoms and risks amongst the general population. Northern Ireland have just launched their own campaign, focussing strongly on overcoming barriers which stop people from seeking help at an early stage.⁵⁷ It is high time for a Welsh cancer awareness campaign.
- Ensure that following diagnosis, a patient
 - Has a face-to-face consultation with a doctor or specialist nurse
 - Is given written information about the type of cancer they have.
 - Has access to a specialist nurse to provide consistent support and co-ordinate your care, along with their partner and family.
 - Is given a care plan that sets out what follow-up tests and care they should expect to receive, which should be under regular review.
- Introduce a centrally co-ordinated initiative to improve early diagnosis of cancer
- Improve access to specialist nurses.
 - It has been highlighted to us that several specialities of nurse, particularly around cancer care, are only available in certain parts of the country, or are available nationally but far under-resourced and under-staffed. This is would likely be an emerging issue that a workforce strategy for Wales would deal with but in the mean-time we need accurate information on what specialities are available and to whom.
 - Prostate Cancer UK's paper *Research into Wellbeing Services for Men with Prostate Cancer* highlights that there is poor access to Clinical Nurse Specialists (CNSs) and a resultant lack of signposting to support services.

⁵⁵ Wales Cancer Alliance *Closing the Gap: Addressing Cancer Inequalities in Wales*.

⁵⁶ Wales Cancer Surveillance and Intelligence Unit (2014) *Cancer in Wales*.

⁵⁷ Prostate Cancer UK (2014) *Prostate cancer in Wales: priorities for the next Welsh Government*

- Review access to diagnostic and screening services for people in Wales as often a major barrier to overcome and identifying cancer early-on increases the chances of survival substantially.
- Abolish age limits on invitations to cancer screenings. A particular concern for the health of older people is the implementation of upper age limits on cancer screening. For example, women over the age of 70 are not automatically called for screenings despite the fact that the probability of developing breast cancer does not reduce. Unless clinical justification can be made, these age limits should be abolished and invitation letters sent out as normal.

HPV is a common sexually transmitted virus and in most cases, infection is transient and harmless. However, it is also associated with several strains of cancer, most notably cervical cancer. The incidence of HPV associated tonsil cancer has more than doubled over the last 20 years, and this increase appears to be due to higher levels of HPV infection. A vaccine against HPV is common for girls in schools, which prevents 7 or more of 10 cancers of the cervix. This was a progressive step in the fight against cervical cancer.

It is often thought that vaccinating girls will also reduce the number of men getting HPV and thus being at risk of other cancers. However, this assumption rests on the fact that infection occurs through sexual contact. Such an assumption excludes men who have sex with men from the protection of a vaccine only administered to girls and women. Incidences of oral and oropharyngeal cancers associated with HPV (and alcohol intake) are growing in men, including a 44% increase among men aged 45-54, and an increase of 124% in men aged 35-44. "These increases in the younger age groups are more likely to be due to increases in oral HPV16 infections".⁵⁸

The Joint Committee on Vaccination and Immunisation published their Interim Statement on HPV vaccination of men who have sex with men in November 2014, concluding a programme for men aged 16 to 40 should be implemented, subject to a cost-effective price.

Subject to a vaccine available for commissioning at a cost-effective price, **the Welsh Liberal Democrats in Government would introduce a new vaccination programme against HPV for men and boys.**

⁵⁸ Welsh Cancer Intelligence and Surveillance Unit (2013) *Mouth and Throat Cancer in the Population of Wales*.

Palliative Care

About 32,000 people die in Wales each year. Roughly three-quarters of these⁵⁹, around 24,000 people, will need some form of palliative care. This is a holistic form of care which helps people to manage pain and symptoms. Palliative care can enable terminally ill people to stay at home or in their care home towards the end of their lives, if this is their wish. Over 60% of people express the wish to die at home.⁶⁰ This both empowers patients and reduced unnecessary hospital admissions. Over a million hospital bed days in Wales in 2012 were occupied by people in their final year of life; almost a quarter of all hospital bed days.⁶¹

However, the number receiving this is far lower - in 2013, only 7,152 people were registered on a primary care palliative care register prior to death. This is less than a third of those we estimate would need such care.

Improving standards in palliative care is likely to mean improving standards in community services, and numbers of community nurses. We would make this a key element for our workforce strategy.

The Welsh Liberal Democrats in Government would:

- Increase the focus on palliative care
- Require the NHS to demonstrate clearly how they plan to improve access to palliative care.
- Aim to reduce the number of emergency bed days spent by people in their last year of life - a 10 % reduction over a three year period may be a reasonable target.
- Ensure that front-line medical staff are properly trained in how to talk to and provide care for terminally ill and dying people and their families. They must be prepared to have difficult conversations with people, to ensure that people are aware of the full range of services and support available to them. Even if they see just one dying person a year, they should be prepared for that encounter and know where to go for help.
- Ensure health and social care professionals can identify carers of people at the end of life so they can be provided with the necessary support and information to fit their needs.
- Require local authorities to fast-track applications for social care for terminally ill people and their families and carers.

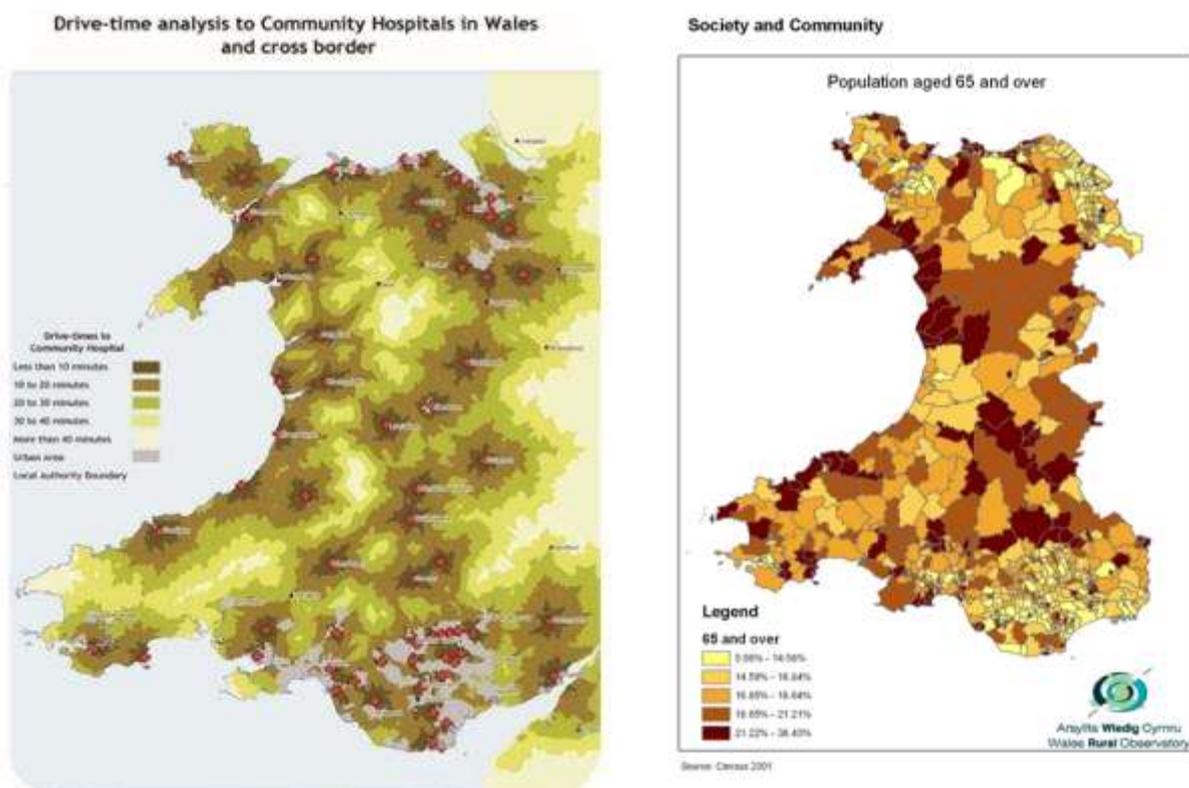
⁵⁹ Murtagh FM et al. (2013) 'How many people need palliative care? A study developing and comparing methods for population-based estimates', *Palliative Medicine*, 28 (1):pp.49-58.

⁶⁰ Wales Cancer Alliance, *Priority Policy Calls*.

⁶¹ Marie Curie (2014) *Death and Dying in Wales*.

Rural Health

Wales is a deeply rural country. Powys Local Authority/Local Health Board, for example, contains around 4.4% of the population of Wales, but 25% of our area.⁶² This rurality complicates many issues faced by the health service. Rural areas are disproportionately older and aging faster, raising the complications seen above such as chronic conditions. By 2020, the population of older people in rural local authorities is projected to rise by an average of 33%, in comparison to 28% in urban authorities. Rural areas have a higher proportion of Welsh speakers than urban areas which will require better provision of Welsh language care. In particular, sufferers of conditions such as dementia may be far more comfortable speaking their first language with doctors and nurses. Rural areas can also see higher social isolation and higher travel times, due to their low population density and poor infrastructure.



There is a consistent problem with understaffing in rural hospitals and practices. Rural hospitals, surgeries and communities are suffering from a lack of junior doctors. This is affecting health inequalities and standards of care in rural areas.

As we can see above, there is a general lack of hospitals in rural areas. We believe in using local facilities, such as small hospitals and health centres, to provide 24-hour GP and nurse-led care to treat minor injuries and illnesses, so avoiding long waits in the A&E departments of major hospitals and unnecessary long ambulance journeys. Paramedics could be located at these local facilities to treat patients and to respond quickly to emergency calls. Instead of

⁶² <http://www.walesruralobservatory.org.uk/unitary-authority/powys>

closing local hospitals, we would seek to use such facilities wherever possible to provide better service - while also reducing costs.

Marcus Longley, Mark Llewellyn, Tony Beddow and Rhys Evans of the Welsh Institute of Health and Social Care at the University of South Wales has recently published the Mid Wales Healthcare Study report.⁶³ Recommendations included:

- Establishing a joint governance healthcare collaborative
- Re-doubling efforts to address pressures facing local primary care
- Organising clinics and other services to recognise the difficulties of transport - that access from Mid Wales may necessitate, for example, a later appointment. This may not necessarily be immediately apparent to a specialised hospital which has relatively few patients from Mid Wales.
- Develop a centre of excellence in rural healthcare

The importance of Bronglais General Hospital to services in Mid-Wales was especially noted. It should remain a key centre for secondary care for the foreseeable future. The Welsh Liberal Democrats are committed to the future of Bronglais General Hospital, and would implement the reports key recommendations regarding the hospital, as the future sustainability of Bronglais is paramount. These include:

- Senior staff should not be expected to work in relative professional isolation
- There should always be sufficient, appropriate staff readily available
- Cover must be provided for key staff when they are away
- Good quality facilities must be available to deal with the unpredictable
- Staff should not be expected to work outside their areas of expertise
- It must be possible to sustain the service into the foreseeable future

There are also concerns about the potential relocation of some hospital services from Shrewsbury to Telford, making it harder to access for patients in Wales. We would work together with NHS England to ensure that services remain accessible for Welsh patients, and Welsh patients are treated with equal importance as English patients when planning for the future of hospitals and GPs on the English side of the border. We believe that A&E and support services should be "retained at Shrewsbury until at least there is proper Mid Wales provision".⁶⁴

Focused recruitment into rural GP surgeries

Medical students and professionals need to see rural practice as a positive career option. They should be encouraged and appropriately trained to work in rural areas. Several international schemes exist as models for encouraging medical students into rural practice.

- The Rural Health Initiative in Indiana began in 1997 as over a quarter of counties had a shortage of GPs. The initiative includes Indiana State University and Indiana University School of Medicine **focusing recruitment on students from rural areas** - areas with a population of 10,000 or with a shortage of medical practitioners - who have shown a desire to practice medicine in a similar setting.

⁶³ http://wihsc.southwales.ac.uk/media/files/documents/2014-10-23/MWHS_Report_-_WIHSC_for_Welsh_Government.pdf

⁶⁴ Ibid., p.60

- The Highland Schools Medical Mentor Scheme was established in rural Scotland in 1998 in order to **support high school students understand what it takes to be a doctor and provide mentoring in applying for medical school**. It was felt that pupils in the Highlands may not have family members who were existing or former medical professionals to support them, and their schools may lack the career guidance that urban schools may have.⁶⁵
- Students who undertake a placement in a rural area at undergraduate level also makes it more likely they'll want to take up a career post in a rural area. Research from New Zealand evaluated the effect of seven week rural placements at Dunedin School of Medicine, where students are exposed to rural general practice and rural hospital work. Results are shown in the box below. The results show that rural placement can produce attitude changes in students from either rural or urban backgrounds, with a **rural placement making students far more likely to indicate they would or probably would enter rural general practice**.
- Many medical schools have **separate rural health faculties and training**. These courses often focus more on practitioners supporting a community holistically.
- Most trainees “would like to gain a consultant post in the area where they have undertaken their specialist training.”⁶⁶ A rural practice is likely to provide a range of specialist services, for example in minor surgery and more specialist treatment of minor injuries, a range of ‘hands on’ clinical work and experience in dealing with emergencies.⁶⁷
- Social isolation and loneliness can often be a concern for students and graduates moving into rural practices. More experienced professionals may be concerned about their families moving to a new area. **New South Wales' Rural Medical Family Network has develop a 'friendship network'** to lessen these feelings and support medical families in rural areas. It also helps students interested in rural living, offers CPD opportunities and runs initiatives such as meet-and-greet sessions and spouse retraining/education grants.⁶⁸

	Before the placement (%)	After the placement (%)
Students from a rural background	6	22
Students from an urban background	1.1	13

Figure 8: Influence of a seven week rural placement on the percentage of Dunedin School of Medicine students indicating that they would or probably would enter rural general practice. Taken from BMA (2005) *Healthcare in a rural setting*, p.12

⁶⁵ <http://www.rcgp.org.uk/~media/Files/RCGP-near-you-DNT/HSMMS%20Scheme%20Details.ashx>

⁶⁶ Royal College of Physicians (2013) *Census of consultant physicians and medical registrars in the UK, 2011*. www.rcplondon.ac.uk/resources/2011-census-summary

⁶⁷ BMA (2005) *Healthcare in a rural setting*, p.9

⁶⁸ BMA (2005) *Healthcare in a rural setting*, p.24.

It is clear that there are many possible interventions to encourage more high school students from rural areas into medical schools, medical students into placements in rural areas, and new graduates and experienced practitioners into rural practices and hospitals. **In Government, the Welsh Liberal Democrats would introduce a scheme for targeted recruitment into rural GP practices** including:

- **Introducing a scheme to encourage high school students to attend medical schools.** It could include work observation and shadowing, careers visits by doctors to rural high schools, and
- Working with universities to **develop departments of rural medicine including rural and remote medicine training pathways**, provide **placement opportunities in rural practices and hospitals**, and **"preferentially admitting students from rural backgrounds"**.⁶⁹ All medical students should have the opportunity to choose a rural placement. Appropriate funding should be provided to cover additional costs of travel and accommodation incurred by students.
- **Developing e-learning for students on placement in rural areas**, to expand the opportunities for specialism.
- **Establishing a network for students and new practitioners in rural areas to provide comprehensive personal and professional support** for doctors in shortage areas. This could include "assistance in finding housing, financial support for relocation, funding for continuing medical education, local provision, and the establishment of rural practice networks."⁷⁰

Such strategies should emphasise the benefits and incentives for working in rural areas. These range from developing a range of specialist skills, the opportunity to contribute to the holistic care of the community and be regarded as a leading figure in your local community to lower costs of living and good quality of life.⁷¹

Third sector organisations can provide support and reach areas where government healthcare alone cannot. For example, Tenovus Cancer Care has set up two Mobile Support Units; one providing chemotherapy, and the other acting as a specialist Mobile Lymphoedema Clinic, the first in the world. Such Mobile Support Units can help people nearer to where they live, saving time and money for all and thus easing the stress of the experience.

The Welsh Liberal Democrats would work with third sector organisations and raise the profile of third sector providers within primary and secondary care. All NHS and care staff should be given guidance on relevant organisations which act locally and in neighbouring areas. This will be of especial use in rural areas, where voluntary organisations may be flexible enough to provide support in hard to reach areas for government.

⁶⁹ Sibbald, B (2005) *Putting general practitioners where they are needed: an overview of strategies to correct maldistribution*, p.6

⁷⁰ Ibid., p.7

⁷¹ British Medical Association (2005) *Healthcare in a rural setting*.

Local Provision and Accessible Services

The Welsh Liberal Democrats have always focused on local service delivery and it has always been one of our core principles. We believe that patients should be guaranteed **the best treatment, in the right place, at the right time to meet their health needs**. We believe that community-based services should be maintained wherever possible and wherever there is a clinical case for that service to remain in the community. Local provision is often inherently beneficial for patients - travel time for patients to the point of care has been shown to affect access to care in England.⁷² We must bear in mind for some services, especially acute care and specialist services, there is evidence that care can be improved by concentrating expertise. We must also remember the constrained cost environment. Rural areas in particular pose a problem regarding local provision. Some geographic areas may not have the critical mass of population to make certain services feasible. The distance from a patient's home to the point of service may be so large that it becomes an active barrier to an individual accessing proper health care.

The Welsh NHS needs to find new ways to get more provision into Welsh communities. Various solutions have been proposed such as increases in telemedicine,⁷³ an enhanced role for Community Pharmacies, and improvements to the transport network.

The Liberal Democrats in Government in England have introduced extended opening hours for GPs,⁷⁴ alongside the £50m GP Access Fund. When the Welsh Government tried to introduce the same, they did not fund it properly. Our Welsh Liberal Democrat GP's survey found that 98% of GPs said that they did not believe the policy could be implemented without additional funding.⁷⁵ **The Welsh Liberal Democrats would introduce a properly funded Access to GPs Scheme, funding GP practices to make sure people can get the appointments they need. This would ensure that GP practices can employ more GPs so your practice will have more appointment slots available, or introduce extended GP opening hours, making it possible for you to see your GP at evenings and weekends. We would let GPs themselves decide the way forward, depending on local need.**

We believe GPs should collaborate with each other in federations to provide a fuller, all-round, including out of hours, service. Federations would also help GPs to work more closely with other health services and keep GP practices from being isolated from the rest of the health community. We would support a move to community-based multi-professional teams based around general practices that include generalists working alongside specialists. We would support GP networks being given real decision making powers with "delegated budgets, accompanied by resources to support their training and development needs".⁷⁶

In Government, Welsh Liberal Democrats would seek to:

- Introduce 'street triage' schemes with professionals such as nurses working with police on the front line, to help people to get the medical attention they need, and release resources currently tied up in treating such patients wrongly. We would deploy these

⁷² Damiani M, Propper C, Dixon J (2005) Mapping choice in the NHS: cross sectional study of routinely collected data, *BMJ*.

⁷³ <http://www.pifonline.org.uk/report-highlights-value-of-telemedicine-to-improve-quality-of-healthcare-services-in-rural-wales/>

⁷⁴ http://www.libdems.org.uk/millions_to_benefit_from_improved_gp_care

⁷⁵ <http://welshlibdems.org.uk/en/article/2012/597546/gp-opening-hours-key-labour-health-pledge-in-disarray-kirsty-williams>

⁷⁶ BMA (2014) *General Practice – a prescription for a healthy future*, p.4.

teams at pressure points, times when there's likely to be a high demand for health care on the street - Saturday nights or after sports match - and potentially base them out of community centres.

- Make it easier for working people to access their GPs and register at a surgery close to where they work so they can easily access their GPs
- Use local facilities, such as small hospitals and health centres, to provide 24-hour GP and nurse-led care to treat minor injuries and illnesses.
- Trial a radical programme of healthcare, successfully developed in New Jersey, based around a network of doctors, nurses and social workers who will work with the neediest patients in their area to reduce regular hospital visits and improve those patients' access to more appropriate, and less costly, treatment.

Sexual Health

One service which suffers from particularly poor access is sexual health and well-being. The *Sexual Health and Wellbeing Action Plan for Wales 2010-15* intends to “improve the sexual health and wellbeing of the population, to narrow sexual health inequalities and to develop a society that supports open discussion about relationships, sex, and sexuality.”⁷⁷ While education plays a large role in improving sexual health, there are widespread access issues. Services for those living in rural areas are far less accessible than for those in rural areas, with “long journeys and patch provision” restricting access. Even in urban areas, clinics can have unfriendly opening hours, and GPs are not always properly equipped to deal with issues of sexual health.

Pharmacies in Scotland have become the most used source of emergency hormonal contraception and are being expanded to provide more comprehensive sexual health services, using pharmacist prescribers working in collaboration with existing sexual health clinics to provide out of hours services in the evenings and at weekends. As noted by the Royal Pharmaceutical Society “pharmacies are particularly well-placed to provide Emergency Hormonal Contraception (EHC) to patients because they are accessible in the evening and at weekends with no appointment required”⁷⁸ Consultations regarding EHC are also good opportunities for pharmacists to raise future contraception needs and issues around sexually transmitted infections. Many patients may find it easier to discuss such issues confidentially with a pharmacist than with a family doctor or GUM clinic.

It has been estimated that for every £1 invested in contraceptive services, the prevention of unintended pregnancies saves the NHS £11 as well as supporting people's quality of life.

- Ensure that GUM clinics are accessible and have opening hours that meet the needs of the local community.
- Put community pharmacies at the heart of sexual health strategies.
- Ensure all pharmacies provide for EHS, and STI testing and screening services.
- Roll out a National Chlamydia Screening programme.
- Ring-fence funding for sexual health
- Provide guidance for school nurses to provide sexual health services for high school pupils if necessary. Guidance should also be provided to medical staff attached to further or higher education institutions, or with a high proportion of students.
- Encourage joint working with NGOs and the voluntary sector to improve rural provision of services.
- Healthcare staff should not make assumptions based on age about an individual's sexual orientation or sexual activity

⁷⁷ <http://wales.gov.uk/docs/phhs/publications/101110sexualhealththen.pdf>

⁷⁸ Royal Pharmaceutical Society (2014) *Public Health: Improving outcomes through pharmacies*.
<http://www.rpharms.com/consultation-responses-pdfs/consdoc140618b.pdf>

Preventative care and early intervention

More focus on prevention is vital to “reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS”.⁷⁹ This can be done through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups. The major causes of chronic diseases are known and the WHO estimates that 80% of cases of heart disease, stroke and type 2 diabetes and 40% of cases of cancer “could be avoided if common lifestyle risk factors were eliminated.”⁸⁰ We can also focus on early detection of diseases and interventions before full symptoms develop.

It makes sense to spend money on prevention of disease and the need for hospitalisation. It is highly cost effective, and an excellent use of resources.

*Primary prevention is an excellent use of resources compared with many treatments. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80 per cent cost less than the £30,000 threshold used by the National Institute for health and Clinical Excellence for cost-effectiveness.*⁸¹

There are a range of possible interventions that Welsh Liberal Democrats in government would seek to implement:

- Every emergency department should have a co-located primary care out-of-hours facility, to enable patients to be streamed following a triage assessment. It also enables collaborate working, potentially including sharing diagnostic facilities, reducing administrative duplication, and permitting re-triaging should it be necessary.⁸² This should also be important during winter months, when A&E demand spikes. This primary care facility should also be there to enable a referral to alcohol treatment services, should an individual attend A&E where there is evidence of an alcohol problem.⁸³
- Unscheduled care plans should be available in advance of the period to which they relate, and should be detailed and comprehensive documents.
- Spending money on preventing the need for hospitalisation. Early intervention is better for patients and, when elderly people enter hospitals, their stays often become lengthy and debilitating. So we will invest in projects to reduce the number of elderly people suffering slips and falls by preventive measures and ensure swift home treatment when they do occur.
- Making sure that hospitals are seen as the last resort – prevention and community treatment should be where most healthcare takes place. We will prioritise investment in community facilities to ensure that people get better treatment and at a lower cost.
- Ensuring appropriate coverage of key secondary prevention interventions and processes including managing disease registers systematically by modelling expected

⁷⁹ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf p.4

⁸⁰ http://www.who.int/chp/chronic_disease_report/full_report.pdf p.18

⁸¹ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf p.4

⁸² College of Emergency Medicine, Royal College of Physicians, NHS Confederation, Royal College of Surgeons, Royal College of Paediatrics and Child Health (2014) *Acute and emergency care: prescribing the remedy*. <https://www.rcplondon.ac.uk/resources/acute-and-emergency-care-prescribing-remedy>

⁸³ Crawford M et al (2004) 'Screening and referral for brief intervention of alcohol misusing patients in an emergency department: a pragmatic randomised controlled trial', *The Lancet*.

versus actual prevalence and incidence, and thereby identifying practices where improvement is needed.

- Systematic screening, where appropriate and known to be cost-effective;
- Proactively identifying those in the population at risk of hypertension, cholesterol and diabetes and ensure appropriate treatment and management of those conditions.
- Working systematically with local authorities and other partners to ensure secondary prevention forms part of a broader area-level strategy on public health.
- Working with community and voluntary sector groups to both develop more tailored joint strategic needs assessments and health and wellbeing strategies, and to engage with and provide services to patients who are not reached by mainstream health services.⁸⁴

⁸⁴ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Front-line Pharmacies

Pharmacies can be found at the heart of many of our local communities. Pharmacists are highly, trained and skilled professionals who work as part of the public health professional network. Pharmacies are one of the best sources of public health advice and care, and they can offer easy and equitable access for all patients.

As pharmacies are one of the only healthcare locations likely to be visited by members of the public when they feel healthy, they are well placed to provide public health interventions and ensure a focus on prevention.

96% of the population can access a pharmacy within 20 minutes by walking or using public transport, and 99% can do so by car.⁸⁵

The average cost of a pharmacy consultation (£17.75) against an average GP consultation (£32) is £14.25 less expensive, meaning transferring more services to community pharmacies could potentially mean huge savings for Welsh health and social care services.⁸⁶

Healthy Living Pharmacies (HLPs) are part of a scheme which has the potential to improve patients' information about their health and lifestyle choices. HLPs provide health and wellbeing advice and can be signposted or provided services such as smoking cessation, emergency contraception, weight management, harm reduction, health checks, alcohol use, treatment of minor injuries, or medicines review. HLPs in England have to demonstrate consistent, high-quality delivery of a range of services. They have to have a Health Living Champion on the pharmacy staff. They are provided training accredited by the Royal Society for Public Health. They work closely with other local services and providers and can be commissioned to provide public health services. The concept was originally developed by NHS Portsmouth, and has established ten HLPs in order to reduce health inequalities and prevent disease. Early results include a 140% increase in smoking quits from pharmacies to compare to the previous year.

In Government, Welsh Liberal Democrats would:

- **Create a network of Healthy Living Pharmacies.** We would aim for all pharmacies to become HLPs over time.
- **Ensure all pharmacists provide for smoking cessation services.** Community pharmacies have the potential to reach large numbers of smokers, and pharmacists can provide advice and support on cessation as well as nicotine replacement and other therapies.
- **Accelerate the roll out of the Common Ailment Scheme** across Wales. This scheme ensures that community pharmacy acts as the first point of contact for patients with a common ailment, diverting people from GPs or A&E.⁸⁷
- **Ensure a named pharmacist is available for every care home,** to oversee the use of medicines and undertake medicine reviews to ensure maximum effectiveness and ensure staff are capable of administering and providing necessary medicines.

⁸⁵ Royal Pharmaceutical Society (2014) *Public Health: Improving outcomes through pharmacies*.
<http://www.rpharms.com/consultation-responses-pdfs/consdoc140618b.pdf>

⁸⁶ The Bow Group (2010) <http://www.bowgroup.org/policy/delivering-enhanced-pharmacy-services-modern-nhs-improving-outcomes-public-health-and-long>

⁸⁷ Royal Pharmaceutical Society (2014) *Public Health: Improving outcomes through pharmacies*.
<http://www.rpharms.com/consultation-responses-pdfs/consdoc140618b.pdf>

- Pharmacies can take a lead in combating stroke incidences.
 - Community pharmacists can help raise awareness of the link between high blood pressure and stroke, especially during the Medicines Use Review (MUR) process, and help detect atrial fibrillation⁸⁸ in the community.⁸⁹
 - We would make community pharmacies central to public awareness campaigns. Pharmacies should play a direct role in public health campaigns.

School Nurses

School nurses play a vital role in child and adolescent health. International evidence shows that access to appropriately qualified school nurses brings benefits now and for the future. Finland has an excellent model of school nurses, with nurses helping attain a relatively low level of teenage pregnancy and teenagers are taught to take responsibility for their own health by organising appointments with a school nurse themselves. The school nurse could help identify at-risk students and take appropriate action. School nurses could be the health champion for every school. They could help teach children about health, basic first aid skills and nutrition. They could also help support good sexual health practices.

We would ensure that every secondary school has a dedicated school nurse and work to bring dedicated good help champions to primary schools.

The National Healthy Schools Welsh Network of Healthy Schools Schemes should include aspects of personal healthcare, to promote the concept of self-care with guidance from healthcare professions.

Each school should identify a dedicated local pharmacist to help oversee all issues relating to medicines taken by the school's pupils. Every child should have the opportunity to discuss their medicine and how to take it with a pharmacist, building upon the educative work with children in their classes.

⁸⁸ <http://www.stroke.org.uk/node/5122>

⁸⁹ <http://www.senedd.assembly.wales/documents/s25280/HSC4-09-14%20Paper%201.pdf>

Empowering Patients

Reablement

Reablement is about helping people to do things for themselves; to maximise their ability to live life as independently as possible. It's an outcome-focused, personalised approach, whereby the person using the service sets their own goals and is supported by a reablement team from a range of agencies to achieve them over a limited period. It supports the whole person, addressing their physical, social and emotional needs. It focuses on what people can do, rather than what they can't, and aims to reduce or minimise the need for ongoing support after reablement.⁹⁰

Reablement is an emerging approach in health and social care. It is a fundamentally liberal approach, as it is focused on enabling individuals to get on in life, a belief that people can do more and excel should they be supported and enabled in doing so, and championing the freedom, dignity and well-being of individuals. It is an outcome-focused, personalised approach, not a task-oriented, check-box exercise. It helps meet our objective to ensure that more people are able to live at home for longer, even to the end of their lives, both improving individuals' quality of life and delivering benefits to the public purse. It is highly cost-effective - 70% of people who receive a six-week reablement service no longer need ongoing care, according to the SSIA. It has been estimated that reablement services can halve the length of hospital stays.

We have previously said we would keep "people out of hospitals by introducing self-referral to health professionals such as physiotherapists and occupational therapists and using these professionals more effectively in diagnosis and treatment. We will consult all those involved to ensure a smooth implementation of self-referral."

Welsh Liberal Democrats would embed reablement at the heart of our approach in Government to health and social care.

In Government, we would:

- Ensure a focus on prevention and early intervention in order to avert possible crisis and foster a positive, enabling, co-productive approach by all: a workforce ethos of 'working with' people, rather than 'doing to' them, the active participation of service users and their families.
- Include physical, social, environmental and emotional factors to ensure a person's wellbeing and independence.
- Introduce a National Reablement Steering Group to provide strategic leadership.⁹¹
- Develop training and resources for carers to enable them to support the reablement process.
- Ensure primary care networks include all professionals needed for truly reablement-focused care.
- Provide integrated leadership.

We would seek to introduce, in partnership with local authorities and local providers, dedicated reablement packages. We would aim for these to be provided free of charge, in order to encourage take up. Many local authorities already provide six weeks 'free' home care following

⁹⁰ Welsh Reablement Alliance, *Campaigning to keep people independent*.

⁹¹ <http://www.ssiacymru.org.uk/resource/reablement-position-statement-web-version-e.pdf>

hospital discharge, which often translated into six weeks of reablement. In many cases, a dedicated reablement package can be delivered at similar cost to an ongoing care package. While reablement packages can often last around six weeks, care can last until the end of an individual's life, and indeed increase in cost year-on-year as need increases. Reablement would greatly help support individuals and lower costs.

We would also:

- *Ensure that people with hearing loss have information and access to a range of options for support, including rehabilitation support such as classes in lip-reading which helps people remain socially active and communicate with friends.*
- *Support volunteer-based community services such as Help to Hear, in which people with hearing aids are trained by NHS audiologists to support other hearing aid users in the community.*

Online contact with your GP

An innovation which could save valuable clinician and patient time, is to give the patient the right to communicate with their GP by email and telephone. In so many other walks of life we exchange emails to avoid waiting for a formal meeting. There is no reason why the same logic should not apply in the NHS.⁹²

There are a range of ways in which GP practices can operate to contact patients more quickly by phone, or through e-mail or VOIP systems such as Skype. Clearly it is not appropriate for all consultations with GPs to be carried out in this way, but many simple conversations can be carried out in this way, but many simple conversations can be done much more conveniently for the patient, and cost-effectively for the service in these ways. NHS England has launched an interactive *Patient Online Support and Resources Guidance* to help general practices deliver services online.⁹³ E-mail contact for repeat prescriptions and appointments booking has been mandated in the latest general practice contract.⁹⁴ Additionally, 20 general practices in England are piloting the use of e-mail contact with your GP to provide 'e-consultations'.⁹⁵ In 2009, Kaiser Permanente published evidence showing that introducing e-mail and telephone consultations cut GP visits per patient by an average of 26%.⁹⁶

The Welsh Liberal Democrats would introduce e-mail and VOIP contact with your GP, following a pilot. We would issue guidance to ensure that e-mail contact should include an e-mail triaging system, a secure server and patient consent, as well as ensuring that both patients and practitioners understand the limitations and what kind of inquiries are best suited to this medium.⁹⁷ Services such as NHS Direct could also expand to include communication by text and other modern methods like Skype. This could make the service more attractive to younger people and students.

⁹² Norman Lamb (2010) *The NHS: a liberal blueprint*. <http://www.centreforum.org/assets/pubs/nhs-a-liberal-blueprint.pdf>

⁹³ <https://www.england.nhs.uk/2014/11/04/patient-online/>

⁹⁴ <http://www.pharmafile.com/news/193718/should-patients-be-able-email-their-general-practitioner>

⁹⁵ <http://www.pharmafile.com/news/193718/should-patients-be-able-email-their-general-practitioner>

⁹⁶ Chen, C et al (2009) 'The Kaiser Permanente electronic health record: transforming and streamlining modalities of care', *Health Affairs*,

⁹⁷ <http://www.pharmafile.com/news/193718/should-patients-be-able-email-their-general-practitioner>

Self-Management

Patients are arguably the greatest untapped resources within the NHS.⁹⁸ Self-management by patients of their own conditions can be a valuable tool in empowering patients. It involves assisting individuals to make choices and decisions about managing their condition, in order to improve their health, well-being and quality of life. Self-management support can be reviewed either as a portfolio of tools to help patients choose healthy behaviours or as a more collaborative partnership between patients and caregiver. Self-management has the potential to improve health outcomes and patient experience, with patients reporting increases in physical functioning and confidence, and reduced anxiety.⁹⁹

Empowering patients is particularly valuable for those with chronic conditions. Central to chronic disease management is an informed and empowered individual patient, with access to continuous self-management support. We must ensure that the intervention is tailored to the individual and their specific condition.¹⁰⁰ Possible solutions include offering patients the opportunity to co-create a “personalised self-management plan”.¹⁰¹

Education has a core role to play in empowering patients. Patients should be able to understand what to expect from the NHS and where to go to get care. Too often, people don't know whether to go to their pharmacy or their A&E.

The Welsh Liberal Democrats in government would:

- Provide patients with "a mix of information prescriptions, action plans, structured education and training, and the ability to access specialist advice from trained health care professionals and volunteers or through online or face-to-face peer support when needed."¹⁰²
- Set up a national sector-led programme to support health and social care organisations to **adopt participation and self-management approaches for all who would benefit**.¹⁰³
- **Ensure that every patient is linked to an independent advocate** if they need it, in particular to empower patients with the information they need to make informed choices about health, lifestyle choices and social care services that they may need.
- **Ensure patients who need one have access to a key worker and individual support packages to help patients create bespoke action plans and coordinate existing local support services**. Every cancer patient should have a named key worker. However, according to the recent Wales Cancer Patient Experience Survey, only 80% of lung cancer patients, 78% of breast cancer patients, and 54% of prostate cancer patients were given a name and contact details of their key worker.¹⁰⁴ Patients must

⁹⁸ Corrigan P (2009). 'DIY doctors: patients can boost NHS's value'. Health Service Journal, 30 April, pp 12–3.

⁹⁹ Challis D, Hughes J, Berzins K, Reilly S, Abell J, Stewart K (2010). Self-care and Case Management in Long-term Conditions: The effective management of critical interfaces. London: HMSO. Available at: www.netscc.ac.uk/hedr/projdetails.php?ref=08-1715-201

¹⁰⁰ de Sliva D (2011). Helping People Help Themselves. London: The Health Foundation

¹⁰¹ The King's Fund (2013) *Transforming our health care system*, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf p.3

¹⁰² http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf

¹⁰³ Local Government Association and NHS Confederation (2014) *All together now: making integration happen*.

¹⁰⁴ Wales Cancer Patient Experience Survey

have contact with individuals who can help them best. Every patient should have the opportunity to discuss their needs and concerns in order to put together a care plan. We would examine the key worker concept to see if it should be extended to other conditions.

Patient Records

There are various systems at use in Wales for GPs to record patient data, including Audit+, Individual Health Records and the Secure Anonymised Information Linkage system.¹⁰⁵ There are numerous other systems which are or have been in use in the NHS in Wales.

Patient records are sensitive. We have to ensure that individual's privacy is our foremost concern, and that any data kept on patients is secure. This must be our paramount concern. However, there could be scope for the better use and sharing of this data in order to ensure a smooth and personalised service for patients when moving between wards or services. We should seek to put patients in charge of their own health records wherever possible. The New York Presbyterian Hospital launched an **electronic health records system that gives full control of data to patients, who are then able which information they want to share with which professionals.**

- We would work with stakeholders to **ensure that all various systems can work together.** Data should not be kept in silos. Any renewals of software or new software should have to work with systems used by other professionals. To minimise costs, we would make this a key objective when seeking a new contract.
- **Every patient should be accompanied by an electronic patient record, accessible by both hospital and community healthcare teams.** They should have the most control possible over these records. This should be provided to the patient's named GP on the day of transfer out of hospital. This can be especially important for person-centred care for individuals living with dementia- 'This is Me' forms can help stop people being asked to repeat the same information to every new professional they encounter along their pathway.

For research into new and innovative techniques, such as stratified medicine, patient data is essential. It should be possible for all NHS patients to be involved in medical research if they wish, through the use of patient information and records, in order to inform the next generation of successful therapies. We would only permit such use of data with the express consent of patients, and suitable guarantees of the confidentiality, protection and anonymity of data.

¹⁰⁵ <http://bma.org.uk/practical-support-at-work/ethics/confidentiality-and-health-records/patient-data-systems>

Welsh language

The Welsh Language Commissioner in *My Language, My Health: Inquiry into the Welsh Language in Primary Care*¹⁰⁶ noted that Welsh speakers have varying needs, with some patients unable to receive effective clinical services unless those services are provided in Welsh.

According to Commissioner's survey, on average, only 28% of Welsh speakers' previous experiences with primary care services were through the medium of Welsh. Only 3-6% of people are actively offered services in Welsh – despite the Welsh Government's strategic framework *More Than Just Words* aiming to ensure patients shouldn't have to ask. There is no evidence that the primary care sector makes any systematic effort to establish the language needs of patients; this raises questions about risks to the quality and safety of care.

There is a need to adopt positive and proactive attitudes to ensure that the linguistic needs of Welsh speaking individuals are central to their care. The Commissioner is of the opinion that a **comprehensive view should be taken of how primary care services in Wales should be developed to meet the needs of its bilingual population.**

When an individual comes into contact with primary care, it will often be during a period of frailty when he/she is feeling vulnerable. Having to visit practitioners regarding a health problem may be a difficult and uncomfortable experience. Individuals living with dementia, experiencing distress or a mental health crisis, or a wide variety of health care issues can experience severe difficulty in expressing their needs through their second language. Research indicates that unless a patient receives service in his/her first language, this adds to a feeling of being powerless and vulnerable. The issue of accessibility of the Welsh language in the NHS is inherently an issue of quality of care.

In Government, Welsh Liberal Democrats would:

- Asses the need of the healthcare sector including by conducting a language skills audit, using this to expand the use of the Welsh language, develop access to services in Welsh, with particular emphasis on GPs, nurses and care staff, including consulting on setting targets for recruitment of Welsh speakers. Our proposals for recruiting among rural areas, due to the higher numbers of Welsh speakers in rural areas, would help towards this, and Welsh language provision should be a key element of a national workforce strategy.
- **Publicise the services that members of the public might reasonably expect to receive in Welsh.**
- Take a policy stance **in favour of the 'active offer' model to enable it to be implemented systematically and effectively** across primary care services, in order to ensure a quality experience and safe start to the patients care path. This should be supported by an annual survey to measure the percentage of Welsh speakers who are offered primary care services in Welsh.
- **Ensure that any forthcoming legislation and subordinate legislation reflects the need to promote the Welsh language within primary care services.**

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<http://www.comisiynyddygydraeg.org/English/Publications%20List/Health%20inquiry%20executive%20summary.pdf>

Health and Social Care

Locally-driven integration

We need to see a more whole-system and holistic approach to the health and social care system. We can no longer look at individual services in isolation, and must instead look at whether plans work effectively with acute and critical care medicine, primary care, and community services. Any change to the current configuration of the Welsh NHS must be patient centred and evidence based. Politicians must listen to clinicians and allow them to lead the process.

Welsh Liberal Democrats in government will work towards adopting the Future Hospitals model proposed by the Royal College of Physicians.¹⁰⁷

- **Each hospital should establish a medical division in order to coordinate care for patients.** This new division should be **responsible for all medical services across the hospital** – from emergency departments and acute and intensive care beds, through to general and specialist wards. It should be **led by a senior doctor**, tasked with making sure that teams work together in the best interests of patients and ensuring patient safety, staff deployment, patient movement and access to specialist and support services. They will strengthen links between physicians and the health board.
- Hospitals across Wales should work as a collection of formal, structured alliances operating hub-and-spoke, or integrated care, networks. However, remote and rural areas will still need district hospitals to provide acute medicine services, so health boards should prioritise patient safety by actively investing in these hospitals to secure confidence and attract high-quality physicians. Clinicians should share information and best practice within these networks, and those working at smaller hospitals must be able to access advice and support from colleagues working in the larger centres.¹⁰⁸
- Acutely ill medical patients in hospital should have the same access to medical care on the weekend as on a week day. Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis. The level of care available in hospitals must reflect a patient's severity of illness.¹⁰⁹

We must encourage effective collaboration and break down boundaries between health care and social care services. Lack of proper cooperation between services in and around health and social care can lead to a silo mentality and lack of joined-up services.¹¹⁰ It is patients who suffer when transfers are delayed and patients are simply passed around different wards and organisations.

Our policy so far has been to drive collaboration by using funding measures and incentives to encourage closer working. This has included creating single sources of funding for patients and encouraging joint appointments between local authorities and the NHS.

¹⁰⁷ Royal College of Physicians Wales (2014) *Rising to the Challenge: Improving acute care, meeting patients' needs in Wales*.

¹⁰⁸ Royal College of Physicians Wales (2014) *Rising to the Challenge: Improving acute care, meeting patients' needs in Wales*.

¹⁰⁹ Royal College of Physicians (2013) *Future Hospital: Caring for medical patients*

¹¹⁰ <http://www.nhsconfed.org/blog/2012/11/spreading-the-collaboration-contagion-will-cure-silo-syndrome-says-jo-webber>

We need more cooperation between health and social services, but we do not support mass top-down re-organisation.

The Welsh Liberal Democrats will support further integration between health and social care services. However, it should not be for Ministers in Cardiff Bay to organise top-down restructuring. Any integration must be led by patients and communities, and delivered jointly by LHBs and local authorities. Future approaches should not be based on structural change, but instead should be based on a shared understanding where the provision of care is joined up around the individual. As expressed in the recent work of the Institute for Research and Innovation in Social Services, "the journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future, rather than from structures and organisational solutions".¹¹¹

We will promote joint projects with a single management and budgeting structure to commission and deliver social and community care. We will also encourage the establishment of social enterprise provider models to match the best in Britain.

We would not force the merger of social care into the NHS or healthcare services into local government. However, there are models which can be used to enable local communities to drive integration in their area. We would permit health and social care providers in a local area to form a single integrated health organisation, responsible for managing the provision, cooperation between and integration of services in that area, subject to public consultation, built-in arrangements for rigorous evaluation of effectiveness, and approval by Welsh Government.

In Scotland, the Scottish Government has proposed two options to create integrated health and social care partnerships. The first is by adopting a **Lead Agency Model, which involves one partner delegating some of its functions, and a corresponding amount of its resources, to the other**, which then hosts the services and integrated budget on behalf of the Health and Social Care Partnership. The other option to integrate services would be through the **delegation of agreed functions to a Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority**.¹¹² Any reorganisation must be clinician-led and supported by public consultation.

There are also numerous other options for integration which could be done by local areas on a more ad-hoc basis.

- Support and promote joint projects between community hospitals and a range of other health and social services.¹¹³
- Many areas suffer from poor public transport connections. Lack of transport can affect the ability of people, particularly older people and those in rural areas, from accessing care. Any planning of local health and social care services should actively consider local transportation, and local transport plans should be mandated to consider linkage to care centres.
- Substantial investment in transport and emergency services, including the air ambulance service, will be crucial, and an all-Wales emergency transport plan must be a priority.

¹¹¹ http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/only_connect-apr-2009.pdf.pdf

¹¹² http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-50.pdf

¹¹³ King's Fund (2013) *The four UK Health systems: Learning from each other*.

- The King's Fund¹¹⁴ has recommended a population-based approach to commissioning to tackle the inverse care law, with clinicians shifting their focus “from the patients that present most frequently in their practice to the wider population that they serve.”
- Local areas should engage in more **joined up planning and delivery of preventive services** as these will be more effective if they are integrated services (where appropriate) and there are **clear pathways to other related services**, e.g. information, advice and assistance, including benefits.
- The local hospital's medical division should act to break down barriers with partners in primary, community and social care services. We must encourage **specialist medical teams to work into the community, in collaboration with professionals from primary and social care**. Physicians and specialist medical teams should spend a part of their time working in the community, in particular focusing on people with long-term conditions and preventing crises.
- **Care co-ordinators to support older people following emergency hospitalisation**, helping them receive the intensive support required to enable them to live at home¹¹⁵

The Welsh Liberal Democrats would increase investment in community public health programmes to redesign service delivery around the patient and help prevent long-term illness or to manage existing health problems. The programme of ‘Pioneers’ for integrated care in England, launched by Norman Lamb MP, embodies many of the ways this approach should go forward. Greater integration should depend on local circumstances and local wishes, not be dictated from the centre. Each participant in the Pioneer programme has set out its own way it wishes to do this, and we believe this must continue to be the approach more widely. The way in which NHS England in some areas, for example through local Integrated Care Organisations (ICOs), is starting to bring together different organisations, in an evolving way by local organisations in response to local needs and preferences, points to the way we believe the NHS and those it works with should develop.

We would encourage all newly integrated bodies to undertake population based planning, in order to consider the health of the local population more holistically.

Greater seamlessness and parity between mental and physical health care could often be helped by mental and physical health services being provided together by organisations formally collaborating, for example through something like the New Zealand model of ‘alliance contracting’.¹¹⁶

We would also create a **new public health improvement role for local government**, in recognition that good health is not just the absence of disease and infirmity but a state of complete physical and social well-being. Locating public health functions in councils in Wales would give the public health agenda a new impetus allowing closer working with GPs and linking into the enforcement role that councils have in areas such as food safety. Responsibility and accountability must lie where it is most effective, and local councils with their in-depth knowledge of the needs of the community and experience of integrated planning and services are best placed to achieve the cultural shift that is needed to provide community leadership and

¹¹⁴ The King's Fund (2013) *Transforming our health care*

system http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

¹¹⁵ King's Fund (2013) *Transforming our health care system*, p.9

¹¹⁶ <http://www.hsj.co.uk/home/commissioning/team-effort-commissioning-through-alliance-contracts/5065272.article#.VJdTbV4jOo>

promote joined up thinking and action across health, social care, education, leisure, housing and economic growth. There would need to be an on-going NHS role for services which are intertwined with clinical delivery or primary care.

Centrally, Ministers and Welsh Government should support areas seeking to integrate. In England, **an integrated care value case toolkit** has been created by the Local Government Association and its partners¹¹⁷ to enable Health and Wellbeing Boards and local partners to understand the evidence and impact of different integrated models on service users. We would also develop a **Better Care Fund to ensure transformation. In England, this is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.** It may be commissioned by the NHS on out of hospital services or be linked to a corresponding reduction in total emergency admissions.

However, while integration should be driven locally, Welsh Government Ministers should have the authority to authorise or block an area's integration plan should there be concerns regarding e.g. the fragmentation of services, protection of local democracy and accountability to communities, and transition costs.

¹¹⁷ http://www.local.gov.uk/health/-/journal_content/56/10180/4060433/ARTICLE

Social Care

The need for social care is growing. Demographic change is just one driver. For example, we can see that as between 2001 and 2012, expenditure on social care for adults under the age of 65 in Wales more than doubled from £240 million to £521 million. Expenditure on social care for children grew from £180m to £447m.¹¹⁸ It is clear that dramatic reform is needed in the area of social care.

We have long-argued that social care should provide dignity and independence for people who receive services. We have often also emphasised the need for greater proportions of care to be provided either in the individual's own home (where appropriate) or in smaller-scale local hospitals and care homes. We believe that care services should be defined and shaped by the user, not delivered to the user and done to them. In the past, we have called for:

- Fully implementing the Carers Measure that requires carers to be given quality advice. We will prioritise the needs of children who have caring roles and ensure that our policies on health and social care have to pass a carer's audit.
- Rapidly increasing the use of Personal Budgets for care services - allocating a budget that people can control themselves. They can then decide how to spend this to meet their care needs and achieve agreed outcomes, in line with a personalised support plan. The allocated budget may be taken as cash (a direct payment) or as a service managed on their behalf. It can be used to design and purchase support from the public, private and third sectors, increasing people's autonomy over their care and support.
- Developing an agency to loan money for people to improve their homes so that they can stay there in the future, with the money being repaid when the home is later sold.

Through the Welsh Liberal Democrats and Plaid Cymru's budget negotiations with the Welsh Government, we established the Intermediate Care Fund. This is designed to invest in services that support older people, particularly the frail elderly, to maintain their independence and remain in their own home.¹¹⁹

The recent Social Services and Wellbeing Act has been criticised for failing to properly facilitate collaboration, advocating increased top down micromanagement by Welsh Government, and doing "little more than exhorting everyone working in care services to do better".¹²⁰ While we supported some of the ideas and principles behind the Social Services and Well-being (Wales) Act 2014, it was not drafted in a way that will deliver on those ideas. There were huge issues around eligibility and cost that can't be ignored. We raised concerns about the lack of detail on how the reforms will work and who will be eligible for what kind of help, and the lack of financial information contained in the bill, leaving local authorities in the dark about how much they will have to spend on social care.¹²¹

Following the Dilnot Commission's findings that the insurance industry had the potential to play a larger role in social care and offer people more choice, the Coalition Government in

¹¹⁸ Kaehne, A. and Taylor, H. (2013) *The Social Services and Wellbeing (Wales) Bill: The unmet challenge. A working paper for GORWEL*, p.5.

¹¹⁹ <http://www.freedomcentral.org.uk/2014/06/welsh-labour-government-continues-to-do-too-little-on-social-care.html>

¹²⁰ Kaehne, A. and Taylor, H. (2013) *The Social Services and Wellbeing (Wales) Bill: The unmet challenge. A working paper for GORWEL*, pp.13-5.

¹²¹ <http://welshlibdems.org.uk/en/article/2013/698447/significant-changes-required-if-social-services-bill-is-to-be-a-success-kirsty-williams>

Westminster has indicated it intends to stimulate a care insurance market. Norman Lamb MP, Minister of State for Care and Support and Otto Thoresen, Director General of the Association of British Insurers signed a Social Care Funding: Statement of Intent that they would "work together to ensure people receive appropriate information and advice and to create the right conditions for a larger market in financial products. This will offer people greater choice about how they pay for care - whether it is at point of need or helping those to plan ahead for the possible need for care."¹²²

This will doubtlessly have an impact on the care system in Wales, and it is incumbent on Welsh Government to respond to this in a way that meets the needs of care users in Wales. **We would work with the Westminster Government, of any colour, to build an insurance market that works for the people of Wales** should this policy continue. **We would ensure that there is a public option**, built on a co-operative model, for low income users. This, according to Kaehene and Taylor, would "preserve an element of the solidarity which is likely to resonate with current Welsh sensibilities about collective contributes to individual care needs as insurance systems spread risks across all premium holders. It would also permit users to control the extent to which they would like to contribute to their own care."¹²³

As a part of the Social Services and Well-being (Wales) Act 2014, we called for an end to '15 minute care'. Figures released in June 2013 show 83% of local authorities in Wales commission 15 minute care visits. This can mean care workers are asked to provide personal care to an individual in a timeframe that does not allow them to be supported with dignity or for any meaningful personal contact. Fifteen minutes is simply not long enough to respond properly to the needs of those receiving care.¹²⁴ **Welsh Liberal Democrats in Government would prohibit 15 minute care slots.** Commissioning processes often seem to be driven to absolutely minimise the time that is spent with an individual. This can lead to growing pressures for care workers to be task-oriented, rather than patient-oriented, undermining relationship building and can even increase a patient's sense of isolation.

In Government, Welsh Liberal Democrats would:

- Connecting up social care with health care, as discussed further in integration section.
- Promote as a valued career path training as a domiciliary personal care assistant to a disabled person.
- Provide support for carers who are providing demanding levels of care to family members, friends or neighbours.
- Ensure via the commissioning process that care workers are being paid for time spent travelling, an element of payment has been increasingly under pressure in recent years. Without payment for travel, there is a risk that some care workers will effectively be paid at a rate below the minimum wage. In addition, given the rural

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<https://www.abi.org.uk/~media/Files/Documents/Publications/Public/2014/Social%20care/Social%20Care%20Funding%20Statement%20of%20Intent.pdf>

¹²³ Kaehne, A. and Taylor, H. (2013) *The Social Services and Wellbeing (Wales) Bill: The unmet challenge. A working paper for GORWEL*, pp.16-7.

¹²⁴ <http://welshlibdems.org.uk/en/article/2014/763521/15-minute-care-must-be-a-thing-of-the-past-kirsty-williams>

nature of much of Wales, this creates a huge burden for a workforce already under pressure.

- Work towards a living wage for carers.
- Offer experienced nurses who no longer wish to work in hospitals or as community care nurses an accelerated path to transfer into a carer post.
- Ensure that social care has sufficient capacity and financial resources to enable the rhetoric around greater provision of preventative social care in the community to become a reality.
- Increase public understanding of how care is funded, what care really costs, the options people have, and the importance of planning through regulated long-term care advice. This could lead to better consumer outcomes.
- Introduce a mandatory requirement for local authorities to establish and information service to help people with financial decisions about their care, as in the English Care Bill.
- Develop a suite of performance indicators for social care services to improve transparency and accountability such as missed domiciliary care targets.
- Require care providers to public information regarding staff training and other quality measures.

Cross-Border Relations

The Welsh-English border is permeable, and many people travel across the border to access healthcare. Some patients travel across the border to access a GP, and some English patients also come to Wales. In many parts of Wales, the nearest specialist hospital is in England and the border must not stand in the way of securing the most appropriate treatment. In October 2011, approximately 17,000 Welsh residents were registered with a GP in England, and around 20,500 English residents were registered with a GP in Wales. More than 54,000 Welsh residents were admitted to an NHS hospital in England in 2009-10, while only around 16,000 English resident patients were admitted to NHS hospitals in Wales in the same period.¹²⁵ But the lack of some specialised care means that people have been transferred far from their homes, and their parents cannot visit them. Claire Dyer being transferred from Swansea to Brighton, 230 miles away, and being separated from her family because of a lack of facilities in Wales is just one case.¹²⁶

A protocol between the Welsh Government and the UK Government's Department of Health for cross-border healthcare commissioning was established in 2005. In April 2013, NHS Wales and NHS Commissioning Board England agreed a renewed Protocol supposed to ensure smooth and efficient interaction between NHS Wales and NHS England, but it is not clear how well this has been functioning to date.

The cross-border protocol applies to residents in Wales who are registered with a GP in England. It applies only to residents living along the Wales-England border, covered by Betsi Cadwaladr, Powys or Aneurin Bevan LHBs and West Cheshire, Shropshire, Herefordshire and Gloucestershire Primary Care Trusts.

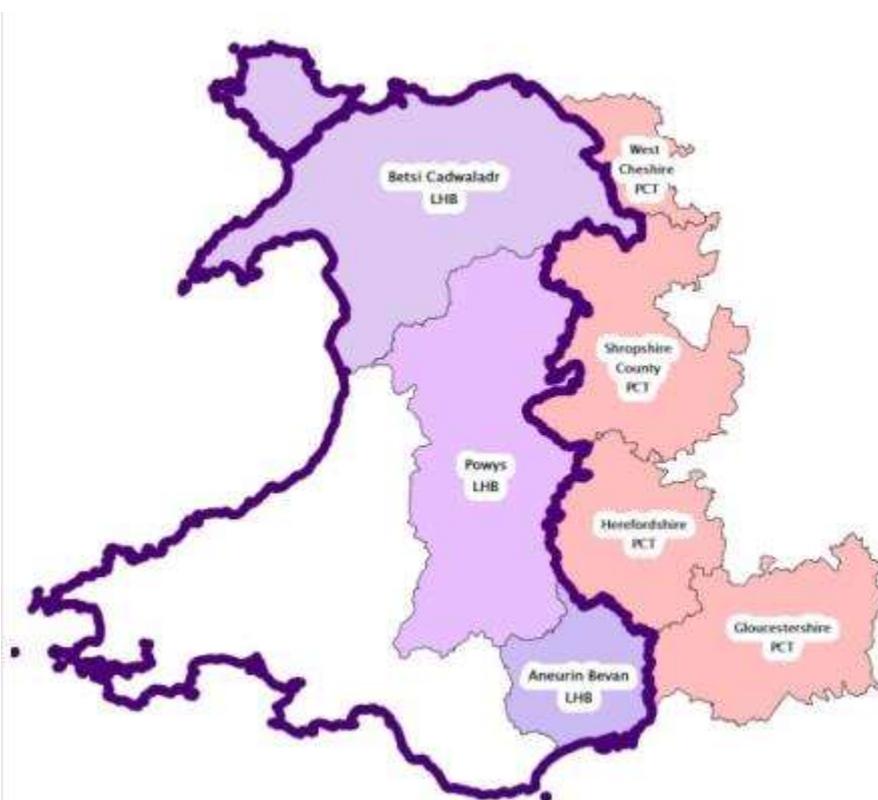


Figure 9: Taken from Research Service (2012) *Cross-border healthcare*.

¹²⁵ Research Service (2012) *Cross-border healthcare*.

¹²⁶ <http://www.walesonline.co.uk/news/local-news/swansea-claire-dyer---disabled-7551215>

The Welsh Liberal Democrats in Government would negotiate a new Compact on Cross-border Health Provision with the Westminster Government to ensure that there is a consistent approach to treatment for Welsh and English patients.

The Silk Commission recommended “developing individual protocols between each border Local Health Board in Wales and neighbouring NHS Trusts in England” and for “the Welsh and English health services to work more closely together to develop better joint strategies in relation to, for instance, highly specialist services and maximising joint efficiency savings”.¹²⁷ We would develop these protocols.

We would also include non-border LHBs in considerations for the Protocol/Compact. It may be necessary for these LHBs to refer patients across the border, and their needs must be considered.

The Welsh Liberal Democrats in Government would also **improve information for patients on differences in care on either side of the border**. Where there is a difference in waiting time targets between the Welsh and English NHS, patients near the border may not be aware of this - something that may make a material difference where the choice of a Welsh or English GP may have implicated for later care.¹²⁸

Medical registrars often have concerns about rotating between north and south Wales, particularly if they have families who may be uprooted. **We would ask the Wales Deanery to work with deaneries across the border to establish rotations with hospitals in England**. If there are closer hospitals across the border then rotation schemes should be developed there as part of any Cross-border agreement.

¹²⁷ Commission on Devolution in Wales (2014) *Empowerment and Responsibility*, p.128

¹²⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/238593/7647.pdf

Monitoring and Assuring Quality

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

A recent report by the National Assembly's Health and Social Care Committee states that "*the committee did not receive the assurances it wanted to hear about the role of HIW in ensuring that healthcare providers are examined properly, meet basic standards, and face sufficient intervention when basic standards are not met.*"¹²⁹ The committee "did not receive assurances that the purpose and role of HIW has been defined sufficiently to provide a clear, robust and understood inspection and regulatory regime" and that "this lack of clarity has undermined HIW's ability to establish itself as an authoritative regulator".

We need a robust, proactive and strong system of inspections in our hospitals and the current system does not seem to provide that. Many hospitals in Wales are only being inspected every three or five years. The report makes clear that the current system of inspection in Wales is not fit for purpose.

Clearly this is not a situation that can continue. We need a hospital inspection system that keeps the people of Wales safe. In the wake of the Francis Report, the UK Government strengthened the Care Quality Commission. A Chief Inspector of Hospitals was appointed. CQC introduced "expert inspection teams that include specialist inspectors, clinical and other experts, and people with experience of care [and] national teams with specialist expertise to carry out in depth reviews of hospitals with significant or long standing problems."¹³⁰

The Welsh Liberal Democrats would:

- Scrap Health Inspectorate Wales and establish a fully independent of Government inspectorate, and appoint a Chief Inspector for Hospitals and health care.
- Introduce clinically led and peer reviewed inspection, with significant patient input, as is the case in the Scottish system with Health Improvement Scotland.¹³¹
- Ensure CMHCs are inspected for quality, as they currently seem to fall between mental health and social services.

¹²⁹

<http://www.senedd.assemblywales.org/documents/s25533/Key%20conclusion%20and%20recommendation%20-%20March%202014.pdf>

¹³⁰ <http://www.cqc.org.uk/content/cqc-highlights-changes-following-francis-report>

¹³¹ King's Trust (2013) *The four UK health systems: learning from each other.*

Democratic Involvement

The Welsh Liberal Democrats believe that democratic accountability and public scrutiny improve the quality of public services and therefore we must ensure that the health and social care services benefit from this scrutiny. In particular, any reforms made to the current system must undergo appropriate democratic oversight and public consultation and scrutiny.

Currently, health services are held accountable to the National Assembly and local authorities are responsible for scrutiny of their local social services. Guidance on the way in which LHBs and Trusts, working with Community Health Councils, are expected to engage with and consult citizens is embedded in the 'NHS Wales Guidance for Engagement and Consultation on Changes to Health Services' (March 2011). Section 183 of the National Health Services (Wales) Act 2006 requires LHBs to consult citizens in:

- planning to provide services for which they are responsible
- development and considering proposals for changes in the way those services are provided; and
- making decisions that affect how those services operate

Despite the raft of legislation that exists on how LHBs, Trusts and CHCs in Wales are to engage with the public over proposed changes to health services, it seems clear from the reaction to the plans unveiled so far that the process has been flawed and although the health boards have consulted – they haven't listened. This is reflective of this government's whole approach to public engagement in transforming services – according to a Wales Audit Office, 'there is no comprehensive national strategy for public engagement in Wales.' The WAO report concludes that "Public engagement activity frequently lacks strategic direction and co-ordination; feedback is rarely provided to the public and monitoring and evaluation of the effectiveness of the public engagement are weak."¹³²

In *The NHS: A New Liberal Blueprint*,¹³³ Norman Lamb proposed that the commissioning of local health services should be democratically accountable, and that the boards of Primary Care Trusts (now Clinical Commissioning Groups which include all the GP groups in their geographical area) should be democratically elected, not appointed "so that they can be held to account at a local level". They should be "under a statutory duty to secure quality and value for money for local people."

Two health boards in Scotland are experimenting with the direct election of a proportion of non-executive directors.¹³⁴ Should this experiment prove successful, we would explore democratically elected representation on health boards.

¹³²

http://www.wao.gov.uk/system/files/publications/Public_Engagement_in_Local_Government_English_2012.pdf p.7

¹³³ Centre Forum

¹³⁴ King's Fund (2013) *The four UK Health systems: Learning from each other*, p.4

Whistleblowing

We must seek to empower patients and medical professionals when things go wrong. The Welsh Government confirmed that there is currently “no whistleblowing hotline for NHS staff”. Instead, staff are expected to contact a number, run by the Royal Mencap Society, which covers NHS and social care employees in both England and Wales. The Welsh Liberal Democrats are calling on the Welsh Government to introduce a free hotline that is available solely for NHS staff in Wales.¹³⁵

Data and Information

A wide variety of data is gathered on health and social care in Wales on a range of topics, including NHS primary and community activity, waiting times, and staffing. More details can be found on StatsWales.¹³⁶ Much is made of statistical differences between the Welsh and English NHS systems.

One on-going debate is regarding mortality data. While mortality figures can never be the only marker of hospital quality (no measure can), such data can act as a smoke alarm for emerging problems. At present in Wales, we use RAMI. England has moved to a system of summary hospital level mortality indicators that focus not just on patients who have died within the hospital, but also include deaths out of hospital within 30 days of discharge. However, mortality data as a whole could be seen as “not a meaningful measure of quality care”.¹³⁷

Welsh Liberal Democrats in Government would:

- Ensure data is presented in a transparent and easy to understand format, so that everyone, including patients, can understand the information.
- Ensure more comparative data is available across the UK, including health data.
- Identify dedicated outcome measures for patient experience.
- Improve data on issues including but not limited to patient quality of life following treatment; economic impact of conditions such as cancer; unclaimed benefits by entitled individuals; and patient movement between England and Wales.
- Develop data on specialist nurse provision - it has been highlighted to us that several specialities of nurse, particularly around cancer care, are only available in certain parts of the country, or are available nationally but far under-resourced and under-staffed. This is would likely be an emerging issue that a workforce strategy for Wales would deal with but in the mean-time we need accurate information on what specialities are available and to whom.
- Ensure that data is published on waiting times specialities such as cardiac rehabilitation or pulmonary rehabilitation. While waiting times are published for certain areas such as therapies and diagnostics, data is not published on waiting times for certain specialities.
- Introduce an all-Wales robust and person-centred way of measuring the quality of care, both specialist and non-specialist, received by people with a terminal illness.
- Bring individual level palliative care data into one national data set that captures activity and outcomes from hospices and specialist palliative care services, including information on demographic details, activity information and patient outcomes.

¹³⁵ <http://welshlibdems.org.uk/en/article/2013/689138/wales-needs-its-own-nhs-whistleblowing-hotline-kirsty-williams>

¹³⁶ <https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care>

¹³⁷ <http://www.wales.nhs.uk/news/33311>

Targets

The monitoring of health bodies' performance is set against a series of Tier 1 and Tier 2 targets. The former are key priorities and include 11 areas such as quality, mortality, access, and efficiency and productivity. Tier 2 targets are either longer term or subject to local monitoring, and include prevention and health promotion, primary care and clinical leadership. Both tiers are a mixture of nationally specified requirements, targets where LHBs are required to develop their own performance targets and targets where the local partnership will agree targets.¹³⁸

The Welsh Labour Government consistently miss the targets they have set themselves, The Welsh Labour Government's targets are often lower than those in England, and are missed more regularly. The mismanagement of the Welsh NHS must end. We would commit ourselves to meeting the targets Labour cannot.

However, targets as a whole have their problems. They can "distort clinical priorities, at least for a time".¹³⁹ Even Welsh Government has admitted that "clinicians have expressed concern about the way the current NHS targets are insufficiently focused on patient outcomes and may lead to a drive to achieve targets which are not necessarily designed around the best interests of all patients".¹⁴⁰ It is aiming to bring forward new developmental, patient-focused targets in for A&E and the ambulance service. We would like to see targets around 'outcomes' from patients. Measuring the waiting time does not necessarily measure the quality of the intervention and the care.

We would trial two new forms of target. Patient-Reported Outcome Measures (PROMs) come from questionnaires filled out by patients. They are asked about their health and quality of life before an operation and about their health and the effectiveness of the operation afterwards.¹⁴¹ They measure real patient experiences and assesses whether treatment has actually benefited a person's physical and mental health. Patient reporting could be a powerful force to drive up standards and improve patient safety in the NHS.

We would work with the health service to develop new ways of measuring performance in a clinically appropriate and meaningful way.

¹³⁸ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf

¹³⁹ King's Fund (2013) *The four UK health systems: Learning from each other*, p.13.

¹⁴⁰ <http://wales.gov.uk/newsroom/healthandsocialcare/2014/140326tar/?lang=en>

¹⁴¹ <http://www.nhs.uk/NHSEngland/thenhs/records/proms/Pages/aboutproms.aspx>