POLICY PAPER 166

PATIENT-CENTRED, ACCESSIBLE AND PREVENTIVE: A LIBERAL VISION FOR PRIMARY HEALTH CARE

Policy Paper 166

Liberal Democrats

Autumn Conference

BRIGHTON 2026

Contents

1 Introduction

1.0.1 Health has often been the second most important issue to voters over the past 15 years, behind only the economy. General practices, dentists, and pharmacies are the front door to the rest of the NHS and they collectively deliver 90% of the interactions between the NHS and the public. This means that people across England have a particularly strong awareness of the problems that these services are facing. They see it when they try to book a GP appointment and either have to wait two weeks for an appointment or have no flexibility over when it is, if not both. They see it when they experience toothache and are told that their local dentist isn't taking any NHS patients. They see it when they go to pick up their prescription, only to find their pharmacy is closed during the day. These services play a frontline role in treating patients and their visible shortcomings are both a representation of the failings that exist throughout the entire system and a problem in and of themselves. This weakens people's confidence in the NHS, and the problems they face are frustrating, can be dangerous, and they erode real freedom and human dignity.

1.0.2 This could have and should have been avoided. Successive Conservative governments presided over a decade in which primary care became harder to access, more unequal, and less sustainable. General practice was left with fewer fully qualified general practitioners per patient, dentistry became out of reach for millions, community pharmacies closed in record numbers, and the share of NHS spending going to primary care shrank even as demand rose. No part of the primary care system was immune to the Conservatives' reckless mismanagement. Over the past decade, England lost 1,327 NHS general practices, while the average practice list grew by 30%. By June 2024, just 40.3% of adults had seen an

NHS dentist in the previous two years, compared with 50.9% before the pandemic and there were 1,180 community pharmacy closures over the past decade, even as ministers increasingly looked to pharmacies to deliver services such as Pharmacy First.

1.0.3 The Labour Government's 10-Year Health Plan acknowledged that a decade of Conservative neglect has left patients struggling to access basic primary care. However, since entering office Ministers have chosen to make hospital waiting lists the political test of NHS recovery, while leaving the front door of the health service without the same urgency, grip or guarantee of improvement. Reducing elective backlogs is important, but it cannot be at the expense of primary care. Primary care is where most patients first seek help and where early treatment prevents illness from escalating into a problem that adds to demands on hospitals.

1.0.4 Labour's lack of focus and courage has led to a lack of real change. In the 2025 GP Patient Survey, only around 53% of those who tried to contact their practice by phone found it easy. The CQC has warned that demand is still rising, with more than 700,000 additional registered GP patients on average in 2024/25 compared with 2023/24. At the same time, the number of fully qualified full-time equivalent GPs per 100,000 patients has fallen compared with 2022/23. Continuity remains poor too. Among patients with a preferred healthcare professional, 43% said they only got to speak with them "sometimes", and nearly one in five said they "never" or "almost never" did. The King's Fund warned that the plan is more detailed on what should change than how it will be delivered. We believe this is unacceptable at a time when GP access remains one of the public's clearest health priorities.

1.0.5 As liberals, the state of NHS primary care matters. If people cannot get a timely appointment, cannot access contraception, cannot receive the continuity of care needed for a long-term condition, or cannot receive advice to prevent a minor condition from becoming serious, their formal freedom is worth less. Liberal Democrats exist to champion the freedom, dignity and well-being of individuals. A dignified human life requires the capability to be healthy, and the quality of our primary care system determines how many people have this. A good primary care system should treat people as individuals with individual needs rather than as a number in a backlog that needs to be cleared. We should be wary of systems that only respond once people have reached crisis point because a health service that waits until people are acutely ill fails to empower people to live a life of their choosing. Finally, as liberals, we recognise that quality means different things to different people: speed, continuity, face-to-face care, digital access, prevention, reassurance, or a trusted long-term relationship.

1.0.6 These problems are also an affront to our liberal values of fairness. Ethnic minority patients in England experience well-documented racial disparities in primary care. Over 50% of ethnic minority patients reported lower trust in NHS primary care, with 25% citing direct ethnic discrimination. They also experience lower access to care, poorer diagnosis for skin conditions in non-white patients, and structural barriers. Racial inequality also affects the NHS workforce: although more than four in ten doctors are from ethnic minority backgrounds, they continue to face disparities in recruitment, promotion and pay, bullying and harassment, and representation in senior positions. Similarly, despite using health services more than any other group, services for older people are hard to access and navigate. Age UK data shows that 30% are concerned about their ability to access services to help them stay well or recover, and that

one quarter of people 55+ with a long-term condition say they don't receive enough support. Older unpaid carers are filling the gaps that the system isn't meeting, but often at high personal cost. Nearly half say they don't get enough support and 81% have never been offered respite care. Finally, GP surgeries in England's most deprived areas received 9.8% less funding per needs-adjusted patient than those in the most affluent areas, despite higher rates of illness and greater need.

1.0.7 Different people have different priorities for primary care. For most patients, particularly those with straightforward or episodic needs, the main priority is fast and convenient access: Healthwatch England found that the most commonly desired general practice appointment choice was when the appointment takes place, wanted always or most of the time by 68% of patients, and selected as the single top priority by 25%, which is more than twice the 12% who chose seeing a named healthcare professional. Other access-related choices also ranked highly, with 66% wanting choice over booking method and 62% wanting choice over whether the appointment is face-to-face or remote. However, a second group of patients place much greater value on continuity. Among people aged 65 and over, 39% put choosing a specific doctor in their top three priorities, and among people unable to work due to health issues or disability, 23% said a named healthcare professional was their single most important choice, nearly double the average. Similarly, many think tanks working in health policy stress the relationship between continuity of care and improved outcomes.

1.0.8 We have transformational plans that will deliver all of these priorities for patients across England, irrespective of their age, class, gender, income, ethnicity, or postcode. However, this real transformation will take time, and we recognise that a decade of Conservative and Labour

overpromises - followed by no change - has eroded the public's trust. That is why we have divided the policies contained within this paper into two categories. The first are our quick fixes. These are the easily achievable policy levers a Liberal Democrat government would pull as soon as it enters office that would immediately improve primary care. These changes will not wholly fix primary care but they will deliver improvements that people can feel. These include:

- **General practice**: Guarantee that patients can express preferences about their booking. This would include the option to either have an appointment within a week at a time most convenient for them (or within 24 hours if urgent), or for a longer-duration appointment with a healthcare professional they already have a relationship with.
- **Pharmacy**: Expand the Pharmacy First model to include eight new services, and better integrate pharmacy into the NHS App.
- **Dentists**: End dental deserts including by removing the administrative barriers that are preventing qualified overseas dentists that are already living in England from entirely filling the 2,500 FTE dentist vacancies, with appropriate safeguards and without impacting quality or safety.

1.0.9 Our sustainable solutions would deliver transformational change to workforce retention and recruitment, NHS efficiency, and permanently improve access, choice, and continuity of care for patients. By listening to healthcare professionals and understanding the broken systems that are driving them out of the NHS, we would end the chronic vacancies across the country. These changes include:

- **General Practice:** Get general practice, community and neighbourhood services, and hospitals working together under a place-based, home-first model of primary and community care,

with general practitioners and nurses at the centre of wider multidisciplinary teams. Better utilise spare 111 capacity to support GP receptions at peak times and create pathways for senior paramedics to join GP teams. Reform the Carr-Hill formula so that funding more fairly reflects need, and require developers to ensure there are enough healthcare professionals when people move into new developments. Finally, we would introduce regular "MOTs" for older people, and expand existing support for low-income patients to primary care.

- **Pharmacy:** Ensure pharmacies are better rewarded for delivering an expanded Pharmacy First service that is integrated into the NHS App, and make the model fairer for rural and coastal communities whilst boosting uptake with an awareness campaign.
- **Dentists:** Replace the current dental contract model with one that better rewards prevention, rather than units of dental activity. Double the funding of the Dental Recruitment Scheme and widen its focus to include retention in underserved areas.

2 General Practice

- **Quick fix:** Guarantee that patients can express preferences about their booking. This would include the option to either have an appointment that week at a time most convenient for them (or within 24 hours if urgent), or for a longer-duration appointment with a healthcare professional they already have a relationship with.
- **Sustainable solution:** Get general practice, community and neighbourhood services, and hospitals working together under a place-based, home-first model of primary and community care with general practitioners and nurses at the centre of wider multidisciplinary teams. Better utilise spare 111 capacity to support GP receptions at peak times and create pathways for senior paramedics to join GP teams. Reform the Carr-Hill formula so that funding more fairly reflects need, and require developers, local authorities and the NHS to work together to ensure there are enough GPs when people move into new developments. Finally, we would introduce regular "MOTs" for older people, and expand existing support for low-income patients to primary care.

2.1 Quick fix: empower patients with quality services that are right for them

2.1.1 Patients in England deserve NHS general practice services that can deliver both timely access and continuity of care. Our extensive policies, explained in detail later in this paper, would deliver this. However, given the current level of strain that NHS general practice is under, successfully delivering these policies and investment will require root and branch reform, which may take some time, and patients have had their healthcare

priorities ignored for too long. That is why we would implement an immediate change to how patients access general practice in order to immediately ensure their top priority for healthcare is being delivered for them.

2.1.2 Data from Healthwatch England, the statutory body that gathers and champions the views of users of health and social care services, clearly shows that a large cohort of the population care more about having a choice over when they have their appointment and that they care about having the option to be seen online, whilst another cohort of the population prioritise being able to have a face-to-face appointment and seeing the same professional each time. Despite these clear preferences, 48% of people who got a choice of a named healthcare professional said they had to ask for the choice, compared to 40% who got the choice without asking. The same was true for requesting a longer-duration appointment, which 47% got by asking for it, while 37% got it without having to ask. It is clear that there is an inter-surgery disparity in how many people feel able to access their rights, with many having to fight to have their preferences recognised.

2.1.3 We would introduce a Patients' Charter, which would be enshrined in the NHS Constitution and would give patients in England powerful new rights, including the right to see a GP within seven days or 24 hours if urgent. Additionally, the existing NHS Constitution provides patients with some rights, including the right to express a preference for a particular doctor. We would ensure those rights are being proactively met by changing parts of the appointment booking process, because existing safeguards are too weak.

2.1.4 The choices that patients have access to when booking a general practice appointment are governed by NICE clinical guidelines on patient experience in adult NHS services and the contractual requirements of the NHS GP contract. Together, these are supposed to ensure that people get an individualised approach to healthcare services that is tailored to their needs and circumstances, taking into account their ability to access services, personal preferences and coexisting conditions. However, this stated goal does not match reality. Data from the GP Patient Survey (GPPS) and analysis from Healthwatch England found that more than two in five people (41%) are not being offered these choices, which are a contractual requirement.

2.1.5 We would update the NHS GP contract to better capture patient choice and ensure patients' rights are met, while working with NICE, NHS England, patient groups and clinicians to ensure that wider guidance on patient experience and shared decision-making supports these changes. The first update would require that every patient be proactively asked whether they would prefer to have a same-day appointment at a time most convenient for them, or to wait for a longer-duration appointment with a healthcare professional they already have a relationship with. Secondly, we would also add a requirement to capture accessibility needs, communication and language needs, and chaperone preferences, to help GP teams consistently deliver what patients and their carers require. These changes would be equally available for everyone irrespective of whether they are making their appointment in-person, via the telephone, or through the NHS app or other online services. A healthcare professional would then take these preferences into account when triaging their appointment request, and balance it against other factors including patient safety and staff capacity. Equally, the patient would retain the ability to immediately

change this preference at any time in their journey through the primary care system.

2.1.6 Access to general practitioners and their teams has been the top concern raised with Healthwatch since 2013, when they were created, and a choice over when appointments take place remains the most popular patient demand. Our change would deliver this for more people, more of the time. This change also reflects that, for many older and/or chronically ill people, having to frequently re-explain their needs and situation is a frustration at best and at worst a potentially harmful barrier to receiving the right care. This change would also be important for patients whose care is shared between general practice and specialist services, including younger patients with long-term physical or mental health conditions who rely on shared care arrangements for prescribing and/or ongoing monitoring.

2.1.7 This system already successfully exists for some people in England. A growing number of GP surgeries are moving to this model. GP Pathfinder Clinics (GPC) surgeries are divided into acute and chronic sites to ensure the right specialist sees the right patient and that urgent care doesn't overwhelm chronic management. After careful scrutiny and examination of GPC's system, NHS Providers endorsed their approach and noted that "GPC has completely reimagined primary care for a young, digitally enabled, and mobile urban population". GPC's implementation of this model has seen high patient satisfaction and significantly fewer 999, 111, and emergency department visits, despite having gone from 14,000 patients to over 100,000 - almost nine times the size of the average GP practice. This model exists and is proving to be extraordinarily effective, safe, and well liked by patients and healthcare professionals alike.

2.1.8 Our plans for a third update to the NHS GP contract would be to require all GP teams to keep online booking platforms, such as eConsult, open 24 hours a day, seven days a week. Those requiring urgent care must be signposted to NHS 111, 999, or A&E as part of this process. GP practices in England are currently required to keep their online consultation tool open during core hours from Monday to Friday. However, patients feel that this does not reflect the realities of people's lives. Healthwatch England have highlighted that patients who cannot take calls at work, who have caring responsibilities, or who need to manage appointments outside normal working hours can be disadvantaged by rigid booking systems. Making appointment booking more accessible is a way of tackling health inequalities as many who struggle to book appointments are from groups with worse health outcomes. Requiring online consultation platforms to remain open at all times would not mean requiring GP teams to respond outside contracted hours. Instead, it would allow patients to submit non-urgent requests when it is convenient for them, while ensuring urgent cases are safely redirected to NHS 111, 999 or A&E. This would reduce the frustration of the "8am scramble", support people who find it difficult to contact their practice during the working day, and give GP teams more options for managing demand when they reopen.

2.1.9 However, digital access must be effective, not just available, and we recognise that some patients find existing online consultation systems difficult to use. We would therefore require online booking platforms to meet clear standards on usability, accessibility, clinical safety, and patient experience. Furthermore, we believe that evidence-based and effective digital tools should be embraced, but that patients must also continue to have the choice to use non-digital routes to book appointments. We would ensure that digital access does not exclude patients who lack the skills or confidence to use online systems, including by encouraging local

authorities, where possible, to use libraries and other community spaces to provide quiet places and basic support for video consultations.

2.1.10 Finally, we would also add questions to the GP Patient Survey that will allow us to monitor patient choice, and track which GP teams make patients feel that their rights are being respected. The GP Patient Survey currently has relatively few questions on choice, and does not ask about what choices people wanted, only what they received.

2.1.11 Our changes would give patients greater agency and allow them to always have the option of prioritising what parts of general practice matter most to them, when safe and medically appropriate. They are also firmly rooted in evidence, and follow recommendations from The Patients Association and the Royal College of General Practitioners (RCGP) to make patients and GPs equal partners in designing user-friendly systems, and Healthwatch England's recommendation to embed patient choice in all booking approaches.

2.2 Sustainable solution: address the root causes of inequity and poor satisfaction for patients and the workforce

2.2.1 The Liberal Democrats will give people a new legal right to see a GP, or the most appropriate member of practice staff, within seven days or within 24 hours if their need is urgent. This would be delivered by increasing the number of full-time equivalent GPs by 8,000: half through boosting recruitment, including more training places and better career development routes into general practice; and half through retaining experienced GPs and encouraging doctors and nurses who have left the NHS to return.

2.2.2 We would support this commitment by making NHS general practice a better, more sustainable, more supportive, working environment for general practitioners, nurses, and other members of practice teams. We understand and lament the fact that many GPs and their teams are unhappy and are leaving the NHS, with 54.9% reporting having low or very low morale. We care about this not only because of its impact on services that patients rely on, but because we care about healthcare professionals as people themselves. One study found that just 26% of UK GPs are satisfied with their work-life balance and that 70% of GPs are experiencing difficulties in their personal relationships because of this. Our plans to address this include freeing up GP time, increasing the amount of rewarding work GPs engage in, giving practices the flexibility to hire the staff they need, ensuring GPs have the professional support they need to be team leaders, and making better use of other qualified professionals where they can safely and appropriately support patients. We would restore the role of the GP to being an expert team leader who can focus on complex care, continuity, diagnosis and clinical leadership, rather than being overwhelmed by bureaucracy, poor triage and unmet demand. The existing Liberal Democrat plan would enshrine the seven-day and 24-hour right in the NHS Constitution and deliver 8,000 more full-time equivalent GPs by the end of the Parliament.

2.2.3 Access to general practice cannot be fixed by practices acting alone, because too much GP time is lost to poor coordination and problems that could be better managed elsewhere in the NHS or social care system. The Liberal Democrats will roll out a model of primary and community care across England that brings services together around patients in their local area, with a clear focus on helping people stay well at home wherever possible. Building on the success of models demonstrated across England,

including by the Harrogate and Rural Alliance, and Surrey Downs Health and Care and Epsom and St Helier, this would bring hospitals, general practice, community nursing and therapy, mental health services, social care, hospices, local authorities and voluntary organisations into closer local teams. For patients with more complex needs, the GP would help coordinate this support so that care is joined up rather than fragmented. In Surrey Downs, integrated neighbourhood teams have been developed around local primary care networks, helping services work together to provide more proactive support close to home. This has reduced duplication, cut average waits for therapy services from 18 weeks to 3 weeks, and contributed to a sustained reduction in overnight hospital admissions of more than 30% compared to pre-pandemic levels. For older residents receiving proactive support from these teams, Surrey Downs reported 35% fewer A&E attendances, 31% fewer non-elective hospital admissions and 11% fewer GP contacts. Not only would this approach mean that patients are less likely to fall between different parts of the system, but it would also support our retention and recruitment targets by giving staff more rewarding roles in teams where responsibility is shared and care is better coordinated.

2.2.4 We would have every Integrated Care System develop a person-centric care plan, built around neighbourhood teams and designed jointly with local GP leaders. These plans would identify how community services can be devolved to neighbourhood level, how community nursing, therapy, clinical pharmacy, paramedic and mental health staff can be embedded around general practice, and how hospitals can invest in services that prevent avoidable admissions and accelerate safe discharge. Alongside general practitioners and registered nurses, these teams should explicitly include clinical pharmacists, whose expertise in medicines review and long-term condition management frees up GP time while improving

patient care. The model would preserve the time-tested role of family GP practices, while giving the wider team the infrastructure they need to keep people well at home. This would be done by breaking down organisational boundaries between care delivered at home, in GP surgeries and in hospitals, and creating better coordination between GPs, community nurses, therapists and hospital staff together to support frail and elderly patients and those with complex conditions. Each local plan would also set out how it will reduce inequalities in access, experience and outcomes, including racial inequalities in primary care where necessary. This could include better use of local data, working with trusted community organisations to deliver more effective outreach, and training and support to ensure symptoms are recognised and treated appropriately for patients from ethnic minority communities.

2.2.5 As part of this model, the Liberal Democrats will expand the "game-changing" NHS 111/GP telephone support pilot across England. In 2023, London Ambulance Service and GP practices serving around 1.5 million patients developed a pilot under which patients calling practices at busy times could be diverted to NHS 111 call handlers, with paramedics and other trained staff, using NHS 111's 24/7 telephony infrastructure, supporting simple clinical concerns and navigation. The reported results from the south London pilot were highly promising. At Wide Way Medical Centre, ambulance call handlers helped more than double call capacity, cut waiting times from around 30 minutes to under five minutes, and reduced avoidable A&E use. On the latter point, Labour themselves said in opposition that 18% of patients attending A&E did so because they could not get a GP appointment. Our approach therefore offers a serious solution that would address one of the root causes of pressure on secondary care and give patients better access to primary care. We would develop this into

a national NHS 111 primary care support offer, available to practices that want it and backed by clear safeguards.

2.2.6 From the Additional Roles Reimbursement Scheme changing the professional makeup of general practice teams to our proposed person-centric, place-based, home-first model of primary and community care that has GPs acting as conductors of care, a modern GP is now expected to be both an expert clinician and a team leader. We believe that this is appropriate and necessary, but we recognise that this requires skills beyond those taught at medical school. We would create a new GP Leadership Training Allowance, offering up to £500 per GP for leadership development through the Clinical Leaders Network, RCGP, NHS Leadership Academy, regional leadership academies, training hubs or ICB-backed schemes. We recognise that time is as big of a barrier for GPs, so this would be matched by up to £500 per GP for protected learning time and backfill. This would support around 2,000 GPs a year at an indicative cost of £2 million annually, helping doctors develop the skills needed to lead multidisciplinary teams without reducing patient access or adding pressure to already stretched practices.

2.2.7 General practice is already a multidisciplinary service, and registered nurses are central to its delivery, and they now deliver almost one in five general practice appointments. Yet while nurses' clinical responsibilities have expanded considerably, the workforce structures, career pathways and investment underpinning their work have not always kept pace with what is now expected of them. General practice and community nurses provide a wide range of support, including prevention, vaccinations, and screening. Experienced nurses also help induct, support and supervise other clinicians joining practice teams. Their experience and leadership will be central to the future of multidisciplinary general practice and

neighbourhood health services, particularly as more care is delivered closer to home.

2.2.8 We would further strengthen the general practice workforce by making better use of the existing healthcare professionals. There are limited senior, sustainable career pathways for paramedics later in their working lives, making frontline emergency response a less attractive long-term role for some. This presents an opportunity to retrain senior paramedics that would otherwise look to retire or pursue a different career as GP assistants, embedding them within practice teams as a ready-made, highly skilled workforce. These are professionals with decades of experience in dealing with patients, especially with chronic disease management, social care needs and mental health support, as these conditions are amongst the most common reasons for call outs. 93% of patients strongly agreed they were treated with dignity and respect by South East Coast Ambulance crews with 92% strongly agreeing that the care arranged or carried out was appropriate. New research from the University of Lincoln suggests that this level of satisfaction is the same across England, noting that feelings of fear and uncertainty experienced by patients and their family members eased when the ambulance crew arrived on scene. In this role, they would undertake home visits, urgent face-to-face assessments, post-discharge follow-ups, and the management of patients with complex or multiple conditions, working under the close supervision of general practitioners and registered nurses. Giving ambulance crews and paramedics a pathway that utilises that experience in a less physically demanding environment will encourage more to remain a part of the NHS workforce, reduce avoidable hospital admissions, and improve continuity of care in the community for patients who struggle to access surgery-based appointments.

2.3 Rurality

2.3.1 To ensure GP surgeries have the workforces they need to serve rural and deprived communities, we would reform the Carr-Hill formula. This is the funding formula that estimates how much core funding each GP practice should receive based on the needs of its registered patients. It helps decide how much money follows each patient into general practice, adjusted for factors such as age, sex, health need, and local circumstances. The current formula has not been updated from 1991 census data and does not adequately reflect the additional workload created by deprivation, unmet need and complex population health. As a result, practices in more deprived areas are receiving less funding than they need relative to the amount of ill health they are expected to manage. Many GPs and practice teams serving the most deprived, coastal and rural communities are currently managing higher levels of need with fewer resources, and that is contributing to unsustainable workloads, burnout, and difficulties recruiting and retaining staff. A fairer funding formula would help ensure that practices with more complex patient populations have the funding to employ more practice staff and support more stable and attractive working environments.

2.3.2 This would also help improve access for patients and support earlier intervention. By better matching core funding to need, high-need communities would no longer be reliant on services under exceptional pressure. Our updated Carr-Hill formula would more accurately reflect deprivation, morbidity, population growth, unmet need, rurality and unavoidable workload. We recognise that this commitment would need to be paired with additional funding and we would work towards this when possible.

2.4 Empowering patients

2.4.1 We would review and expand the Healthcare Travel Costs Scheme so that eligible low-income patients can receive help with the cost of travelling to essential primary and community care appointments. The scheme is currently only available to patients travelling to access secondary care, but it is vital in allowing people on low incomes in rural communities to travel for the secondary care they need. The same financial barriers exist for accessing primary care, especially when there are 19% fewer GP practices in England than there were a decade ago. Given the scheme's very low cost to the government, and its role in allowing people on low incomes in rural communities to travel for the care they need, it is appropriate to look to expand the service to primary healthcare. This in turn would reduce the number of missed appointments, saving the NHS money and boosting access.

2.4.2 We would consult on and introduce a new system of proactive regular check-ups, delivered through general practice and targeted at older patients with the greatest health and care needs. Rather than waiting for people to deteriorate and then treating them in crisis, multidisciplinary practice teams including GPs and nurses, would be supported to offer more personalised, regular check-ins for a smaller group of patients that bring together physical health, mental health, medicines reviews, and frailty prevention, whilst reducing loneliness. Older people would receive more dignified care, and because problems would be identified before they become crises, this would also help reduce avoidable ambulance and A&E visits usage which would save the NHS money over the long term by addressing the root causes of ill health rather than waiting for them to worsen. We are confident that this would also make general practice more

rewarding for GPs, as it would give them the time, continuity and relationships needed to meaningfully help people.

2.4.3 We would also strengthen patients' rights when things go wrong. Liberal Democrats would end the General Medical Council's five-year rule, so that serious concerns about a doctor's fitness to practise are not prevented from being investigated simply because more than five years have passed. This is important because some patients only later understand the significance of what has happened to them, and later cases can reveal a wider pattern of substandard care. This reform would retain robust safeguards to ensure fairness for healthcare professionals, but the starting point should be that patients' concerns must not be ignored simply because of an arbitrary time threshold.

2.4.4 We also recognise that more patients are using private general practice alongside NHS care, including through high street and digital providers. Our priority will always be to provide timely access to NHS general practice, but, where patients have chosen to use private primary care, the NHS should have clear and safe rules for how relevant information is shared back into the NHS record, with the patient's consent. We would work with professional bodies, patient groups and regulators to ensure that the interface between private and NHS general practice better matches the dynamics that currently exist for dentistry and pharmacy. In practice, this would mean that patients are not left to coordinate their own care, NHS GPs are not asked to take responsibility for decisions they cannot verify, and important clinical information such as diagnoses, medicines, tests and referrals does not fall through the gaps.

2.5 Appropriate distribution of doctors

2.5.1 We believe that new housing developments should be accompanied by the primary care capacity needed to serve the people who will live there. Therefore, we would introduce a new requirement that GP services are available before residents move into new homes, an approach endorsed by the Royal College of General Practitioners, either by funding and building new surgeries or by expanding existing practices in time for the arrival of new residents through developer levies, billions of which are currently unspent. Local authorities and NHS boards would have a new duty to identify the additional GP provision needed to support new developments, so that new housing is planned alongside the practical healthcare infrastructure required to make it sustainable.

2.5.2 This would help boost access to general practice by ensuring that new residents are not simply absorbed into already stretched local surgeries without additional capacity. Developer contributions can already be used to fund health and social care facilities, but promised surgeries are frequently delayed or left unfunded. Liberal Democrats would therefore ensure that developer levies are used not only for physically building new or expanded surgeries, but also, where necessary, to help fund GP contracts and salaried GP provision while new communities are becoming established. This would avoid the inefficient outcome of buildings being built without the healthcare professionals to staff them and make them operational.

2.5.3 Linking new housing more directly to general practice capacity would help offset new pressures on appointment availability and waiting times. It would also give general practice professionals a clearer basis for workforce planning, premises planning and patient-list growth, rather than expecting existing practices to absorb large increases in demand without commensurate resources. In turn, it would support a more stable working

environment for GPs, nurses, and other members of practice teams, reduce the risk of sudden surges in workload, and help ensure that new developments contribute to stronger local primary care rather than increasing pressure on services that are already under strain.

2.5.4 We would also address the root causes that have led to some parts of England being chronically underdoctored by using targeted local schemes and better distributing training practices. For the Liberal Democrats, localism is one of our core tenets. We believe that power ought to reside as close as possible to people themselves, and that is demonstrated, both historically and currently, by our strong and proud tradition in local government. That is at the heart of this approach. Rather than reviving a model like the Medical Practices Committee, which saw local areas have to ask central government for permission to hire additional GPs, we would trust local communities to make the right decisions for them and their healthcare needs. We would promote the usage of targeted local schemes, also referred to as "golden hellos", to incentivise new GPs to choose to practice in areas that are underdoctored. The five new medical schools in England were deliberately placed in areas with regional doctor shortages because the evidence shows us that doctors are more likely to remain and practice in areas where they trained. However the distribution of training practices remains regionally and socioeconomically imbalanced, leading to fewer doctors where they are most needed. The Liberal Democrats would expand the number of GP training places in under-doctored, rural, coastal, and deprived areas. This would include a paired training scheme, in which experienced GP trainers are funded to work alongside non-training practices, helping them meet approval standards while supporting an existing GP to become an accredited trainer. This would grow training capacity where it is needed most, expose more trainees to the rewards of working in high-need communities, and support

long-term recruitment and retention in the areas currently worst served by general practice.

3 Pharmacy

- **Quick fix:** expand the Pharmacy First model to include eight new services, and better integrate pharmacy into the NHS App.
- **Sustainable solution:** we would increase the amount of funding that pharmacies receive for delivering NHS Pharmacy First service, and make Pharmacy First more accessible with a booking system in the NHS App.

3.1 Quick fix: expand the successful Pharmacy First model further

3.1.1 Unlike general practice and dentistry, patient satisfaction rates for pharmacy are high (88%) and rising each year. 85% of people in England have access to a pharmacy less than a 20 minute walk away. Therefore, the quick fix that we would make to the pharmacy system is expanding Pharmacy First. This would allow pharmacies to ease the burden on general practice, building on the 38 million GP appointments that are avoided annually with the existing Pharmacy First model.

3.1.2 Pharmacy First was launched in January 2024 and allows community pharmacists to diagnose and supply prescription-only medicines for seven common conditions, such as sinusitis, sore throat, and earache, without visiting a GP. In return, pharmacies get £17 per consultation, and a lump sum once they surpass a threshold of consultations each month. Since then, 98% of pharmacies have signed up, and millions of consultations have been delivered, and polling suggests Pharmacy First is popular with patients who use it. 86% of people reported a positive experience of visiting their pharmacy for support with one of the seven conditions covered by the scheme.

3.1.3 We would immediately move to expand Pharmacy First to include the following services:

- Smoking cessation support. Community pharmacies are well placed to provide accessible stop-smoking advice and treatment, helping prevent future ill health and reduce pressure on NHS services.
- More NHS vaccinations. Expanding NHS vaccination delivery through pharmacies would build on an established, trusted model and make it easier for patients to access routine and seasonal immunisations.
- Weight management: Pharmacies can support weight management through advice, measurement, behavioural support and referral into NHS services, without immediately requiring more complex prescribing responsibilities.
- Women's health services within existing pharmacy competence: Pharmacies can improve access to women's health support by expanding services such as contraception, emergency contraception, UTI advice and appropriate signposting.
- Blood pressure checks: Expanding pharmacy blood pressure checks would support earlier detection of cardiovascular risk and improve access to prevention in local communities.
- Menopause advice: Pharmacies can offer accessible menopause advice, medicines counselling and signposting, while more complex prescribing decisions remain subject to appropriate clinical pathways. This would help widen access to timely support in the community, given that women are currently facing long and dangerous waits in some areas, with the British Menopause Society highlighting waits sometimes exceeding two years.

- Discharge medicine service: Supporting patients to understand changes to their medicines after leaving hospital and reducing the risk of errors.
- New medicine service: Providing early follow-up and advice to patients starting a new long-term medication.
- Adherence support services: Helping patients take their medicines correctly and consistently.

3.1.4 This would involve working with the Centre for Pharmacy Postgraduate Education to produce a self-assessment framework to help identify knowledge gaps. It would also include nationally standardised service specifications, clinical pathways, Patient Group Directions and clinical protocols where required, and funded training for pharmacy teams. This would follow the model used for the original Pharmacy First rollout, where pharmacists were supported through CPPE resources, self-assessment, implementation checklists and webinars.

3.1.5 For patients, this would mean faster and more convenient advice, treatment, medicines support and preventative care for a wider range of health needs without needing to wait for a GP appointment, while ensuring that those with more complex needs are referred safely to the right part of the NHS. By making better use of pharmacists' clinical expertise, patients will have greater access to support for managing conditions and avoiding preventable complications. Healthwatch England data shows that the public supports an expansion of Pharmacy First. Over six in ten people said they would use a pharmacy for conditions not covered by Pharmacy First, including the management of high blood pressure. It would be particularly valuable for people in rural, coastal and deprived communities, where pharmacies are often one of the most accessible parts of the health service.

3.1.6 To boost the impact of our Pharmacy First reforms, we would ensure national campaign work continues with updated campaign materials. Healthwatch England found that 29% of people who said they were unlikely to use a pharmacy for the seven conditions currently offered in Pharmacy First were unaware that pharmacies can provide treatment and advice for them. Two out of three people, when made aware, said they would be open to using Pharmacy First, which would reduce GP demand, increase the amount of Pharmacy First consultations delivered by pharmacists, and ensure patients are getting support sooner. This would also be coupled with proactive outreach to communities and groups less likely to be aware of, or able to access, Pharmacy First, including through translated and accessible materials where language or literacy barriers exist.

3.1.7 Additionally, we are confident that a properly funded Pharmacy First model would also strengthen the wider primary healthcare system. If community pharmacies are responding to many common and medicines-related issues that would otherwise fall to general practice, this will help to free up GP appointments for patients with complex or acute needs. We are also confident that better pharmacy support for smoking cessation, vaccinations, blood pressure checks, and weight management would help prevent avoidable problems or deterioration and reduce the number of repeat contacts across the NHS. With clear referral pathways, pharmacists would work alongside GPs, which would ease GP workload pressures and make better use of the skills of every healthcare professional.

3.1.8 Finally, we remain committed to making NHS prescriptions free in England for people with chronic mental health conditions. People with diagnosed mental illnesses currently face prescription charges of £9.90 per

item, despite many needing ongoing medication as an essential part of staying well in the community. The current system is both unfair and counterproductive: medication is free in hospital, and people who have been involuntarily admitted can receive free prescriptions afterwards, while people who voluntarily seek help may not be able to. This risks creating a perverse incentive for people to delay treatment until they become more seriously unwell. When people stop taking medication, their condition may worsen and lead to hospital admission, lost productivity, and in some cases serious restrictions on liberty. Therefore, we remain committed to having free prescriptions for chronic mental health conditions to boost parity of esteem between mental and physical health.

3.2 Sustainable solution: keeping pharmacies open in every community

3.2.1 There are serious concerns about the long-term viability of the community pharmacy network. Community pharmacies have experienced around five years of flat funding in real terms, rising workload and operating costs, and this is leading to a sustained increase in both permanent and temporary pharmacy closures. Only 6% of the sector is profitable, 60% of owners are taking no salary, and 78% of pharmacies report that NHS service costs exceed NHS income. Whilst public satisfaction with pharmacy remains high, patients are increasingly affected by unexpected closures, reduced opening hours, and difficulties getting prescriptions dispensed on time, particularly in rural and coastal areas. These pressures risk undermining the accessibility that makes community pharmacy such a valuable part of the primary care system.

3.2.2 The clinical role of community pharmacists has been massively expanded, but the underlying contractual and funding framework has not kept pace with these expectations. Pharmacy funding remains heavily

weighted towards medicines supply, and there is limited flexibility to address rising clinical workloads, complexity, or local population needs. This is driving a confused system in which pharmacies are incentivised to deliver more patient-facing services without the long-term financial certainty or staffing capacity required to do so sustainably. As Liberal Democrats, we are concerned that this "do more with less" mindset is contributing to recruitment and retention problems. There are additional complexities to the workforce challenge that go beyond pharmacist numbers. Community pharmacies are reliant on a wider team of professionals including pharmacy technicians, dispensing assistants and trainee pharmacists, yet career progression, training pathways, and retention strategies for these roles remain underdeveloped.

3.2.3 We would model, pilot, and, if cost effective and beneficial for pressure on general practice, implement a two-part Pharmacy First funding reform, which would include a universal uplift in the Pharmacy First consultation fee, and lower fixed-payment thresholds for rural, coastal and underserved pharmacies. Whilst this is only our first step towards closing the whole community pharmacy funding gap, it would make the service more sustainable and ensure that essential-access pharmacies that serve dispersed or deprived populations are fairly compensated. Additionally, by massively increasing the number of conditions and services available on Pharmacy First, this would increase demand and make the Pharmacy First model a more reliable source of funding. Finally, we would ensure that pharmacies are properly remunerated for the drugs that they buy, and we would explore options to give pharmacists increased flexibility over prescribing and dispensing medicines. One in four people are being impacted by medicine shortages, one in five people report that their prescriptions are not ready on time, and there is evidence that these shortages are undermining trust in pharmacies. Therefore, it is essential

that the financial and bureaucratic barriers that reduce medicine availability are urgently addressed.

3.2.4 We would also update the NHS App so that patients can book Pharmacy First consultations directly with a community pharmacy, giving people a simple digital route to care while preserving walk-in access for those who want it. One of the benefits of this booking system being within the NHS App is its potential for interoperability. It could allow pharmacy professionals to understand patient needs ahead of the appointment and, when appropriate, refer or signpost them to GP services instead. This would reduce the amount of erroneous Pharmacy First appointments, saving patients and pharmacists from wasted appointments.

3.2.5 A Liberal Democrat government would also update the NHS App to give healthcare professionals the ability to add key medicines safety information to a patient's NHS record, such as allergies, previous adverse reactions, or known pharmacogenomic information where a person cannot safely metabolise a particular medicine. Used properly, this would help healthcare professionals make safer clinical decisions and ensure that Pharmacy First expands in a way that is convenient for patients while remaining clinically robust.

3.2.6 Finally, we would review the entire schedule of exemptions from prescription charges. The current list of exempt conditions was created in 1968, before most modern antidepressants and antipsychotics existed and before the shift towards treating more people in the community. Although cancer was added in 2009 to reflect changes in outpatient care, no equivalent update has been made for mental health, and the wider system remains overly complicated, particularly for people on Universal Credit, whose entitlement depends on monthly earnings thresholds and confusing

paperwork. A review should therefore consider whether new exemptions are justified for conditions where regular medication is essential to prevent serious deterioration, hospitalisation or wider public cost. The most reasonable candidates would include chronic mental health conditions, long-term respiratory conditions such as asthma and COPD, cardiovascular disease requiring ongoing medication, autoimmune conditions requiring regular treatment, and other long-term conditions where adherence to prescribed medicines is central to preventing acute crises, disability or expensive NHS intervention.

4 Dentistry

- **Quick fix:** remove the barriers that are preventing qualified overseas dentists that are already living in England from entirely filling the 2,500 FTE dentist vacancies. For patients, this would mean fewer children missing check-ups, faster help for people in urgent pain, and a clearer route back into NHS dentistry for families who have been shut out of care.
- **Sustainable solution**: reform the dental contract to properly reward dentists for doing necessary work, and introduce a dental rescue package that guarantees urgent and emergency dental appointments to anyone who needs it, and access to free dental checkups for vulnerable groups like children and new mothers.

4.1 Quick fix: unlocking more qualified overseas dentists

4.1.1 The current state of oral health in England has fallen to dangerously low levels, and has been driven by an inability to access appropriate and timely care. A Liberal Democrat analysis of the ONS Health Insight Survey found 12.2% of people in England (one in eight) do not have a dentist at all while just 52.8% have an NHS dentist, and that, of those people that need treatment but do not have a dentist, 79.7% simply just do not receive any treatment at all. Clinical oral health statistics from the Office for Health Improvement and Disparities found that 93% of dentate adults have at least one indicator of gum disease. There has also been a 12 percentage point increase in the prevalence of obvious tooth decay between 2009 and 2023, from 23% to 35%, and rates are now fast regressing to 1998 levels.

4.1.2 The severity of the dental crisis is not being evenly experienced across England. 8% of adults in the highest income households currently have extensive obvious decay, compared to 35% of adults in the lowest income households. This uneven distribution correlates with an uneven distribution of NHS dental practices in England. Recent Local Government Association (LGA) analysis found that rural and deprived areas are more likely to have fewer NHS dental practices, despite having poorer health outcomes and greater need.

4.1.3 Children are being particularly badly failed by the collapse of NHS dentistry. Liberal Democrat analysis has found that four in ten children, amounting to more than five million children in England, had not seen an NHS dentist in the past year. This is especially dangerous because childhood dental problems are often preventable, but can deteriorate rapidly when families cannot access routine check-ups. The right that children have to get free NHS dental care means very little if parents cannot find an NHS dentist who is able to see them.

4.1.4 At the same time, England is experiencing another different but related dental crisis: recruiting and retaining the workforce. 21% of NHS general dentist positions were vacant in March 2024, amounting to nearly half a million days of lost NHS activity, with 87% of all general dentist vacancies reported within the NHS. The headline number of dentists also masks the scale of the problem. While 25,367 dentists were recorded as doing some NHS work, this equated to just 10,539 full-time equivalent NHS dentists, due to a growing shift of dental capacity away from the NHS and into private practice.

4.1.5 The workforce crisis is also geographically uneven: England had only 26.2 FTE dentists per 100,000 people, falling to 24.3 in the East of England and 24.4 in the South West, where the vacancy rate for fully

qualified dentists was highest at 22%. Similarly, more dental nurses left than joined in every NHS region in 2023/24, with the South West losing two dental nurses for every one who joined.

4.1.6 It is essential that both the symptoms and the underlying causes of these crises are addressed. We welcome the government's decision to boost workforce-access by providing one-off grants to temporarily expand the number of places on the ORE (Overseas Registration Examination) and LDS (Licence in Dental Surgery), but note that this was only necessary because they have failed to reform both pathways, which led to this significant backlog. We would deliver further reforms to the system that would allow a greater number of qualified overseas dentists already in England to practice, and to prevent backlogs from redeveloping again. Data from the General Dental Council (GDC), which is the body responsible for the ORE, shows that around 30 per cent of all dentists on the register qualified outside the UK. Of these, around one third qualified for registration by passing the ORE, so the current administrative blockage represents a significant barrier to increasing the number of dentists working in the United Kingdom.

4.1.7 We would continue to automatically recognise EU dental qualifications, which is currently due to end in 2028. 18.4% of all registered dentists on the General Dental Council register qualified in a European Economic Area (EEA), and we have no reason to believe that the quality of dental schools in the EEA is going to fall, and committing to automatically recognise these qualifications now would prevent EEA-qualified dentists from unnecessarily applying for the ORE.

4.1.8 We would also fund the GDC to perform rigorous and regular inspections of overseas dental schools that are well represented on the

ORE waiting list. For example, if a significant number of ORE applicants were trained at Melbourne Dental School, the GDC would evaluate if Melbourne Dental School is delivering training to UK standards. If the GDC found that it was, we would automatically recognise that qualification for a reasonable period of time, which would instantly unlock additional dentists for the UK primary healthcare system, and free up space on the waiting list so other ORE applicants can take their tests sooner. Crucially, this would also prevent another ORE backlog from building, so it is also a preventative measure that would remove the need to have additional one-off government grants in the future.

4.1.9 Finally, we would also work with the GDC to improve the ORE booking system, which has been identified as a source of frustration and barrier to being able to practice in the UK. These measures would immediately allow more qualified dentists to provide NHS care, creating more NHS appointments and reducing waiting times. All of these solutions would also require a Liberal Democrat government to make the UK dentistry sector be seen as an attractive place to work by overseas dentists, which are detailed below.

4.2 Sustainable solution: reforming the dental contract

4.2.1 As referenced above, NHS dentistry is being undermined by a crippling recruitment and retention crisis, driven by a broken contract model. Workforce data shows that there are 36,000 dentists on the GDC register but only 10,727 FTE dentists in the NHS in England. This is despite the fact that 21% of NHS general dentist positions were vacant as of March 2024. We have not even hit rock bottom yet. 44% of practice owners and 41% of associates intend to reduce their NHS commitment in the next five

years, and 20% of practice owners intend to leave NHS dentistry as soon as possible or within 12 months.

4.2.2 Introduced in 2006, the Units of Dental Activity (UDA)-based NHS dental contract is no longer fit for purpose and has become a central reason why dentists are leaving the NHS, and the profession more widely. The contract prioritises activity targets ahead of what patients actually need, and it fails to properly reflect the time spent and the cost of providing treatment. As a result, dentists can be paid the same amount for delivering treatments that have very different levels of complexity, and practices are hugely disincentivised from taking on new patients with high levels of unmet need. As a result, many practices are effectively delivering NHS care out of goodwill and dentists are walking away from the service, which has created "dental deserts". The British Dental Association has called for the UDA contract to be replaced with a properly funded, prevention-focused blended model, built around weighted capitation for routine care, activity-based payments for high-needs patients and sessional payments for urgent care. The Liberal Democrats would end the unpopular, unsuccessful UDA model that is driving qualified dentists from the NHS, and replace it with a model that sustainably rewards dentists for treating patients as individuals. When we do replace the UDA model, we are clear that these discussions should not be behind closed doors. We would also extend this principle by making it a requirement for Integrated Care Boards (ICBs) to engage with Local Dental Committees (LDCs), whether that be by recognising them as key local stakeholders or by making LDCs into statutory members of committees.

4.2.3 We welcome the Government's decision to make sticking plaster changes to the NHS dental contract from April 2026, including new care pathways for high-needs patients, mechanisms that begin to recognise

prevention, and modest funding for team development. However, we strongly condemn the fact that these changes remain confined within the discredited UDA framework, meaning they can only work around the flaws of the system rather than fix them. We agree with the British Dental Association, who have warned that this is a package designed to make a broken contract "slightly better" while buying the government time from having to actually deliver real reform.

4.2.4 Children's dentistry should be at the heart of dental contract reform because keeping children waiting in pain is cruel, more expensive for the NHS, and leads to poorer health outcomes. The UDA model actively undermines this goal because it fails to properly compensate dentists for the time needed to manage patients with higher levels of need, including children. We would therefore ensure that a reformed NHS dental contract supports early intervention, routine check-ups and preventive care for children, rather than forcing practices to choose between meeting activity targets and spending the time that patients actually need.

4.2.5 Alongside long-term contract reform, our £750m dental rescue package would introduce an emergency scheme to guarantee access to free NHS dental check-ups for those already eligible, including children, so their existing rights will be matched by a real service that families can actually use. We would take direct action to prevent tooth decay before children need treatment at all by supporting supervised toothbrushing training in nurseries and schools, targeted especially at communities with the poorest oral health outcomes, and by scrapping VAT on children's toothbrushes and toothpaste, because basic tools for preventing childhood tooth decay should not be classed as a luxury.

4.2.6 We would back reform of the contract with £750m investment to guarantee anyone with urgent or emergency dental needs can be seen, and to ensure vulnerable groups like children and new mothers can always access NHS dental checkups. For urgent dental care, we would look to expand the success of Cumbria's model of urgent dental care centres, which have significantly expanded access to urgent dental care. This is delivered using sessional payments, which buy seven dedicated appointment slots for a 3.5-hour session. Payments are made provided that a patient is booked in against the appointment slot. It is flexible and can be delivered in dedicated urgent dental care centres or by practices alongside other dental provision. The scheme, as it operates in the North East and North Cumbria, allows, where clinically appropriate and the patient wishes to receive the care, for dentists to deliver 'stabilisation' within these sessions. This allows for patients with greater need to access some further care to stabilise the condition of their mouth and their oral health.

4.2.7 We would expand the existing Dental Recruitment Incentive Scheme, sometimes referred to as a "golden hello", into a Dental Recruitment and Retention Incentive Scheme that supports qualified dentists to move to high-need areas or continue delivering NHS care in dental deserts. Open both to new recruits and existing NHS dentists at risk of leaving, payments would be staggered over three years and linked to a clear NHS activity commitment, so we can be confident that this is unlocking additional access for high-need communities, including across rural and coastal areas across England. Where the existing scheme has treated recruitment as a type of one-off transaction, our improved scheme would be larger, simpler, more flexible, and be designed around both retention and recruitment as its central goals. Combined with our reforms

to the dental contract, this would ensure communities not only get the dentists that they need, but that they keep them too.

4.2.8 We reiterate our commitment to protect NHS dental practices from the impact of the Government's employer National Insurance rise. Although NHS dentists are independent contractors, they deliver essential NHS care and cannot simply pass higher costs on to patients. We would therefore ensure NHS-commissioned dental practices are exempted from the rise or fully compensated through contract funding.

4.2.9 For patients, these reforms would mean that NHS dentistry is a service they can actually use. Children would be able to get the free routine check-ups they are already entitled to, rather than waiting until tooth decay becomes painful or requires hospital treatment. Pregnant women, new mothers and people on low incomes would have a clearer route to preventive NHS dental care, helping problems to be identified earlier and treated before they worsen. Patients in urgent pain would no longer be left ringing practice after practice in the hope of finding an NHS appointment, and those needing dental checks before surgery, chemotherapy or a transplant would be guaranteed timely care so that avoidable oral health problems do not delay other essential treatment. Liberal Democrat reforms would move NHS dentistry away from a broken, regionally uneven model, to a preventive service that works with patients to support their oral health.

5 Eye and Ear Care

5.0.1 We would make better use of community optometry as part of our wider commitment to shift care closer to home and invest in prevention, which would reduce pressure on overstretched hospitals. Around 6,000 optical practices across the UK already provide accessible care in local communities, and the Association of Optometrists estimates that community optometry could free up around two million NHS appointments annually if properly integrated into NHS pathways. We would tackle the postcode lottery which sees patients in some areas have to go to hospital for eye care, while others can access it more easily on the high street.

5.0.2 Under a Liberal Democrat government, ongoing care would default to the community, including high street optometrists, including reviewing the merits of certain prescribing rights for optometrists, with step up care by hospitals. We would also support further provision of care for Ear, Nose and Throat from opticians, including commissioning ear wax removal, hearing aid fittings and treatment of minor ear infections from appropriate community and high street providers across the country, rather than sporadically.

5.0.3 With ophthalmology one of the largest NHS outpatient backlogs, major eye conditions projected to rise far faster than population growth, and avoidable delays risking irreversible sight loss, Liberal Democrats would support a national framework for community eye care in England. This should enable optometrists to play a greater role in glaucoma monitoring, cataract pathways, urgent minor eye care, and early detection of conditions such as age-related macular degeneration, backed by fair funding, referral pathways, and proper NHS IT links. This would reduce unnecessary GP and hospital appointments, help people remain in work

and independent for longer, and ensure that technology, including AI, supports rather than replaces accessible, face-to-face clinical care where patients can ask questions and receive reassurance.

6 Glossary

Additional Roles Reimbursement Scheme – An NHS scheme that funds general practices to employ additional professionals, such as clinical pharmacists, social prescribers, physiotherapists and paramedics, as part of wider primary care teams.

Carr-Hill formula – The funding formula used to estimate how much core funding each GP practice should receive based on the needs of its registered patients, adjusted for factors such as age, sex, health need and local circumstances.

CQC – Care Quality Commission; the independent regulator of health and social care services in England.

Dentate adults – Adults who have retained at least one natural tooth.

Dental desert – An area where patients struggle to access NHS dentistry because too few practices are accepting NHS patients.

Discharge medicine service – A pharmacy service that helps patients understand and manage changes to their medicines after leaving hospital.

EEA – European Economic Area; EU member states plus Iceland, Liechtenstein and Norway.

GDC – General Dental Council; the UK regulator for dentists and dental care professionals.

GMC – General Medical Council; the UK regulator for doctors.

GP – General Practitioner; a doctor based in general practice who provides primary medical care.

GP contract – The national contractual framework that sets out what general practices are expected to provide and how they are funded.

GP Patient Survey/GPPS – A large annual survey of patients' experiences of general practice in England.

Healthwatch England – The statutory body that gathers and champions the views of people who use health and social care services.

ICB – Integrated Care Board; an NHS organisation responsible for planning and commissioning health services in a local area.

ICS – Integrated Care System; a partnership of NHS organisations, local authorities and other bodies responsible for improving health and care in an area.

LDC – Local Dental Committee; a statutory representative body for dentists in a local area.

LDS – Licence in Dental Surgery; a route for some overseas-qualified dentists to demonstrate that they meet UK standards for registration.

Medicines review – A structured review of a patient's medicines to check they are safe, effective and still needed.

NICE – National Institute for Health and Care Excellence; the body that produces evidence-based guidance and advice for health and care.

ORE – Overseas Registration Examination; an exam used by overseas-qualified dentists to show they meet the standards required for UK registration.

Patient Group Direction – A legal mechanism allowing specified healthcare professionals to supply or administer certain medicines to defined groups of patients without an individual prescription.

Pharmacogenomic information – Information about how a person's genes affect their response to medicines.

Place-based care – Health and care services organised around the needs of a local area, rather than around separate institutions or organisations.

Primary care – The first point of contact with the health system, including general practice, community pharmacy, dentistry and optometry.

RCGP – Royal College of General Practitioners; the professional membership body for GPs in the UK.

UDA – Unit of Dental Activity; the activity measure used in the NHS dental contract in England to determine how much NHS dental work a practice has delivered.

Patient-Centred, Accessible and Preventive: A Liberal Vision for Primary Health Care

Policy Paper 166

This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 7.4 of the Federal Constitution.

Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom.

The Party in England, the Scottish Liberal Democrats, 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.

The Party in England has chosen to pass up policy-making to the Federal level. If approved by Conference, this paper will therefore form the policy of the Federal Party on federal issues and the Party in England on English issues. In appropriate policy areas, Scottish, Welsh and Northern Ireland party policy would take precedence.

ISBN: 978-1-915375-46-9

Primary Healthcare Working Group

The members of the working group who have prepared this paper are listed below.

Dr Kate O'Kelly (chair)
Helen Maguire BEM MP
Lord Scriven
Dr James Booth
Meadhbh Keating Fitzpatrick
Ian Johnson
Cllr Mike Hewitson
Cllr Nancy Jiria
Oliver Jones-Lyons
Dawn Logan
Dr Giovanni Masala
Cllr Stephen Mercer
Cllr Ellen Nicholson
Steve Sollitt
Dr Pramod Subbaraman
Rebecca Taylor
Cllr Dr Wendy Taylor

Note: Membership of the working group should not be taken to indicate that every member necessarily agrees with every statement or every proposal in this paper.

Staff
Alexander Payne
Cosmo Lupton

Further copies of this paper can be found online at
https://www.libdems.org.uk/members/make-policy/primary-healthcare

Join in Online!

@libdems

www.libdems.org.uk/conference

Printed by William Pollard & Co Ltd,
Oak House, Falcon Road, Sowton, Exeter EX2 7NU
Published and Promoted by Mike Dixon on behalf of the Liberal Democrats,
First Floor, 66 Buckingham Gate, London, SW1E 6AU

Liberal Democrats

Autumn Conference

BRIGHTON 2026