CIPFA The Chartered Institute of Public Finance & Accountancy

Response to NHS White Paper on:

Equity and excellence: Liberating the NHS

- **Commissioning for Patients**
- **Local Democratic Legitimacy in Health**
- **Regulating Healthcare Providers**
- **Transparency in Outcomes – a Framework for the NHS**

11 October 2010

the people in public finance

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies, in major accountancy firms, and in other bodies where public money needs to be effectively and efficiently managed.

As the world's only professional accountancy body to specialise in public services, CIPFA's portfolio of qualifications are the foundation for a career in public finance. They include the benchmark professional qualification for public sector accountants as well as a postgraduate diploma for people already working in leadership positions. They are taught by our in-house CIPFA Education and Training Centre as well as other places of learning around the world.

We also champion high performance in public services, translating our experience and insight into clear advice and practical services. They include information and guidance, courses and conferences, property and asset management solutions, consultancy and interim people for a range of public sector clients.

Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance. We work with donors, partner governments, accountancy bodies and the public sector around the world to advance public finance and support better public services.

11 October 2010

White Paper Team
Room 601
Department of Health
79 Whitehall
London
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Dear Secretary of State for Health

Equity and Excellence: Liberating the NHS – supporting white papers

CIPFA welcomes the opportunity to contribute to the NHS White paper consultation. Given its position as the only professional accountancy body specializing in the public services, CIPFA is well placed to support the proposed transition of the NHS. It is from this perspective that we have sought to identify the key issues and risks that need to be addressed, and to propose solutions that will enable the reforms to be successfully delivered.

The four consultation responses follow.

Liberating the NHS Commissioning for Patients

Q1 In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

A1 The issues we believe that need to be addressed are,

- Resource allocation - the commissioning portfolio has to be defined and split between specialized and other services
- A robust GP consortia allocation model agreed with GPs has to be developed and ownership of the model established
- The rationale for GP consortia commissioning Maternity services has to be explained in more detail.
- Service specific issues focused on clinical specifications, evidence based best practice and improved outcomes need to be taken forward

The first three points can be addressed by asking GP consortia to nominate a representative to sit on the NHS Commissioning Board where they have a special interest in national and regional specialties and maternity services. Consortia within a region should select a representative based on clinical and commissioning experience and work associated with Primary Care Trusts that have hosted specialised services

With regard to service specific issues GPs with a special interest in particular services should be invited to be members of the same service advisory groups.

Q2 How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

A2 Assuming that this is referring to non-specialised services a lead Commissioner and risk pooling approach could be considered

Q3 Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

A3 On a day to day basis – many specialised services could be commissioned by GP consortia within nationally agreed guidelines.

An important issue to be addressed is how change in specialized services is handled.

A significant element of the commissioning role surrounding specialized services is about service reform and change management. This can only be successfully completed by commissioners who are experts in the field with the necessary skillset and resources to complete the task.

The government is already committed to the principles of the Carter report which confirms these principles.

An example would be Renal Dialysis services – given an adequate capital infrastructure, an agreed tariff and adherence to agreed clinical and access standards, then GP consortia could commission these services – with the proviso that they would need to be monitored in this task in order that country wide equity of provision could be demonstrated.

Q4 How can other primary care contractors most effectively commission services to which they refer patients? i.e. primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

A4 GP consortia can establish clinical groups or networks to include Primary Care Professionals and specialists to input into the development of specifications and commissioning volumes.

Professional groups such as dentists should be able to maintain their referral rights, be encouraged to work with GP consortia in a way that promotes service improvement and personal motivation and reduces any bureaucratic burden to an absolute minimum.

A preferred approach would be that this is first completed at a national level and then tailored to local services.

Given the management costs ceiling, “off the shelf “solutions could be adopted locally to provide a cost effective solution.

Duties and responsibilities of GP consortia

Q5 How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

A5 Best practice guidelines developed within primary care, benchmarking of performance and development of improvement plans would be appropriate tools to deliver this objective. Robust and transparent peer review can be the most effective tool in improving quality and aid. Examples such as 'Map of Medicine' can be used to define the expected standard rather than allowing multiple local models to develop

Q6 What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

A6 A single source of information for all GP consortia with a standard format for reporting is recommended, accompanied by a small number of meaningful output measures and clear levers for changing behaviours.

Q7 What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

A7 CIPFA recommends clear rules re the costing and pricing of these services and subsequent sign off by auditors and;

- Published tariffs (and therefore an agreed currency)
- Declaration of interests when taking decisions.
- Oversight by the Local Authority.

The role of the NHS Commissioning Board

Q8 How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?

A8 Consultative processes should be established in a similar way to those established by NICE to seek views and comments before formal adoption.

Q9 Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

A9 The following points are recommended

- It is essential to implement as soon as possible initial and on-going training programmes for local consortia to establish the skills required to support efficient and effective local commissioning

- Promotion of shared service models for delivery – including joint appointments –
- Appointment of high calibre staff –
- Benchmarking of costs and performance
- Sharing of best practice.

Establishment of GP Consortia Organisational Form

Q10 What features should be considered essential for the governance of GP consortia?

A10 Development of staffing structures within management cost limits and;

- Clear identification of an 'Accountable Officer'
- Job descriptions for all staff
- Standing Orders
- Standing Financial instructions
- Protocols that show how consortia manage business on behalf of all practices
- An approved scheme of delegation
- Robust commissioning, financial and support systems
- Systems covering under and overspending of resource limits
- Risk pooling at the appropriate level
- Statutory roles and the requirement for CFOs to be qualified members of CCAB bodies with extensive experience commensurate with their responsibilities

Forming consortia

Q11 How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

A11 It will be very difficult to reconcile the role of LAs if there is not a coterminous geographic boundary as they can only reflect the needs and views of their population.

Also, financial allocations (some of which will be to LAs) need defined boundaries.

Q12 Should there be a minimum and/or maximum population size for GP consortia?

A12 There is a balance to be struck between natural local communities that allow for close integration of health and social care and potentially very large GP consortia that will benefit from advantages of economies of scale, particularly in relation to management costs and the cost of support services.

It is important that Consortia should be of sufficient size to be able to receive an accurate financial allocation, be able to influence the development of local services and providers and be able to manage risk effectively.

Commissioning can only usually be outcome effective and cost effective if it is undertaken at a sufficiently large population level. Therefore, the NHS needs to clarify what the appropriate population levels are for effective commissioning. This links with questions about the level of risk pooling, reserves and availability of competent staff within the available management costs.

If smaller consortia are proposed very clear plans to work in collaboration with other consortia to provide its support services (therefore securing economies of scale) would need to be provided

Equally very large consortia could be considered if they presented a governance structure that demonstrates sensitively to the needs and requirements of localities within in.

Freedoms, Controls and accountabilities

Q13 How can GP consortia best be supported in developing their own capacity and capability in commissioning?

A13 A comprehensive training programme will need to be developed to facilitate this objective

It would be helpful to articulate to GPs;

- the size of the task ahead of them.
- approaches which have proved to be successful in the past,
- options for delivering the agenda – e.g. shared services (CIPFA has significant expertise in this area)
- the role of Local Authorities and their expertise,
- PCT staff and expertise that could be transferred into the new organisations. It is crucial that the existing pool of talent is identified expediently before they leave the NHS. Progress on World Class Commissioning has demonstrated the considerable progress that has been made within these organizations.

Q14 What support will GP consortia need to access and evaluate external providers of commissioning support?

A14 A comprehensive training programme will need to be developed to facilitate this objective and;

- Intelligent commissioning is key to success. This is a major challenge as GPs cannot possibly have acquired this skill set yet.
- The FESC programme is not the solution in isolation – it still requires an informed “intelligent” commissioner who is capable of defining what is required and can ensure that there is a genuine transfer of risk from the NHS to the private sector.
- The NHS Commissioning Board should be asked to provide guidelines confirming that scare resources and expertise should be made available to all consortia.

Managing financial risk

Q15 Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

A15 A comprehensive framework and training programme will need to be developed to facilitate this objective covering

- Concepts of sharing and risk pooling at the appropriate level (otherwise too many reserves),
- Control of activity levels (when FTs are incentivized to act in the opposite way),
- Clarity re how any savings may be handled.

[There will need to be clarity that savings can only begin to accrue once the GP consortia have met all other financial targets and met the costs of transition.]

Transparency and fairness in investment decisions

Q16 What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

A16 Current guidance for investment decisions could be adapted to suit GP consortia and;

- The development of better and standardized information systems to provide comparative information on providers in line with commercial internet systems that compare financial products might provide an answer to this.

- Costing/pricing and tariff policies
- Transitional costs to be included within assessments

Accountability to patients and the public

Q17 What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

A17 Information on the current level of attainment in respect of outcomes, target profiles to reflect an achievable level of improvement and inputs from Social Care / Housing / Education that contribute towards these improvements

Q18 Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

A18 Yes but within the existing resource envelope – not as an additional payment.

Q19 What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

A19 Strong links with and challenge from LAs and the public health function. Plus transparent reporting to the public

Partnership

Patients and the public

Q20 How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

A20 GP Consortia and the NHS Commissioning Board could look to draw from the current pool of patient representatives across their area, in addition to concerted work with leading health charities to improve patient engagement particularly for the improvement of long term conditions.

Q21 How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

A21 Working with Community leaders, particularly those from ethnic minorities can increase the input from seldom heard groups, and developing the LA role re Health Watch

Q22 How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient Participation Groups?

A22 Service users should be offered engagement at times that are convenient to them, meetings during the day tend to attract the more elderly who may not have work or childcare commitments

Q23 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

A23 Publishing the positive outcomes of patient and public consultation can motivate service user input.

Post project evaluation needs to incorporate research on whether groups or individuals have been disadvantaged as a result of the new proposals

Local government and public health

Q24 How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

A24 GP consortia should work with existing patient engagement forums and their PCT to develop new arrangements, it is critically important that the contribution to service development from current forums is not lost where it can be attributed to new GP consortia area. It is also important to

- Build on existing links between PCT DoH, PH and LAS.

- Map out services, financial investment and activity levels/intervention rates at present and learn from Total Place pilots etc on how change can be promoted by organizations working across boundaries.

Q25 Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts,

A25 NHA Wales is doing this currently.

Other health and Care Professionals

Questions

Q26 How can multi-professional involvement in commissioning most effectively be promoted and sustained?

A26 Include these functions in the mapping exercise suggested above – then make a plan for them.

Local Democratic Legitimacy in Health

Q1 Should local HealthWatch have a formal role in seeking patients views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

A1 Yes –Providing information against the commitments within the NHS constitution from independent systems, healthcare commissioners and providers would be a disciplined approach.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

A2 Yes – this could include a role around patient complaints that would complement the scrutiny role

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

A3 Very clear outcomes will need to be specified to test performance against, the option of re-tendering the contract in the event of under-performance should exist.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

A4 Further actions should be reviewed against the experiences of the integrated care pilots, particularly those that follow the Kaiser Permanente principles

Further work should be commissioned to ensure that current guidance on pooled budgets, personalization and other flexibilities (S28/S31) are consistent with the changes in the NHS white paper. CIPFA has significant expertise in this area.

Q5 What further freedoms and flexibilities would support and incentivize integrated working?

A5 Further actions should be reviewed against the experiences of the integrated care pilots, particularly those that follow the Kaiser Permanente principles

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

A6 Yes

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

A7 Yes –It would be preferable to have a statutory service, with specified roles and responsibilities that would be consistent across England. There is a balance recognizing

localism, allowing for the flexibility in the development of local structures to discharge these consistent responsibilities.

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

A8 Yes – It is critical with the proposed movement of health needs assessment from Health to Local Authorities that the NHS does not lose focus on the prevention agenda. Mechanisms to ensure that service development and modernization are underpinned by a comprehensive service needs assessment are also important.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

A9 Yes the new processes should be supported by comprehensive training arrangements

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

A10 If the proposal to repeal the requirement for LA's to set up CT Boards & publish CYPP's is included in the forthcoming Education Bill then the current 'duty to cooperate' becomes one of best practice rather than a statutory obligation. A Health and Well Being Board would however be beneficial to the principles and partnership working which was the intention in creating children trust arrangements.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

A11 The current framework for OSCs could be adopted here

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

A12 Yes

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

A13 Local Authorities can be tasked with developing dispute resolution procedures but in the event of failure referral of disputes to Health Watch England seated within the CQC for mediation or the Department of Health for formal arbitration might be an appropriate mechanism

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

A14 Yes it will be necessary to have streamlined procedures to avoid duplication of effort and expense.

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

A15 Current protocols for the resolution of disputes could be adapted to cover this difficulty

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

A16 Local Authorities have scrutiny panels & internal & external audit that can confirm effectiveness. These arrangements could be applied to new health and wellbeing boards.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

A17 New arrangements should be subject to post project evaluation to confirm whether any parties are dis-advantaged and changed accordingly

Q18 Do you have any other comments on this document?

A18 There is a need for clarity on consultation arrangements for changes to nationally commissioned specialized services.

CIPFA has a range of guidance and training suites around the provision of shared services, personalization, pooled budgets, prudential codes that could support white paper implementation.

Regulating Healthcare Providers:

Q1. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?

A1 The former cap set as a percentage of final NHS Trust year income can be viewed as an arbitrary calculation, set at differing levels across each Foundation Trusts and there is a case for this being removed. It is important however to take on board the lessons of recent litigation that highlighted significant public sensitivity relating to this issue in the light of local access to services and waiting times.

Developments that increase private income that can be demonstrated to benefit NHS funded care should be encouraged and addressed as part of the Trusts business plan endorsed by the Trust Board, Governors and members of the FT. Concerns from the public relating to quality, access or waiting times as a result of these initiatives should be addressed by referral to the Local Authority via Health Watch, Monitor or the Care Quality Commission.

Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?

A2 Foundation Trust Borrowing limits are part of an overall set of financial controls. If an FT has a requirement to borrow substantially more than their limit this could be considered by Monitor and approved or declined on the basis of whether the business case is robust and affordable and enables the FT to keep within its terms of Authorisation. It is critical that borrowing is not secured on essential NHS assets where ownership could transfer to the lender on default. Carefully regulated arrangements that exclude the mortgaging of essential NHS assets could be explored to assess whether these options provide a solution.

Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?

A3 Yes with member, governor and Board support, providing this is consistent with the legal form prescribed in legislation.

Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?

A4 Mergers, acquisitions and de-mergers should be possible where there is a demonstrable benefit to the delivery of healthcare service set out in a supporting business case.

Q5. What if any changes should be made to the NHS Act 2006 in relation to Foundation Trust governance?

A5 Directors of Finance of Foundation Trusts should be qualified members of a CCAB body with a significant depth of experience commensurate with their responsibility

Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

A6 Part of the effective economic regulation of Trusts is the monitoring of the taxpayer interest and without conclusive arguments that this should change it is recommended that the status quo remains. This role could be performed by tender from the audit firms or from bodies such as CIPFA.

Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

A7 The proposal to encourage the social enterprise model for Foundation Trusts can be viewed as moving to a model of lighter touch control to motivate members and reward organizations that are performing well. Pension arrangements are important as well as controls in place to anticipate and address any signs of operational and or financial failure.

Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

A8 No

Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?

A9 Yes providing that there is not a diminution of the standards required to become a Foundation Trust

Q10. Under what circumstances should providers have the right to appeal against proposed license modifications?

A10 As the Provider / Commissioner relationship is a partnership within a competitive internal market both sides should have a right of comment and appeal.

Q11. Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?

A11 This may be appropriate if the current levels of funding are provided to commissioners and this is not simply a further cost pressure for the sector

Price increases could be linked to percentage increases for other similar regulatory bodies

Q12. How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

A12 The Department of Health could retain a role in agreeing with Monitor an overall cap uplift for tariff prices.

Q13 Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

A13 There is potential for conflict of interest in ensuring Foundation Trusts continue to be sustainable and setting the tariff prices they charge Commissioners. The approach outlined at Q12 should assist in mitigating the requirement for appeal or arbitration

Q14. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

A14 By the development of normative tariffs based on best practice evidence based care pathways – with due regard to quality standards

Q15. Under what circumstances should Monitor be able to impose special license conditions on individual providers to protect choice and competition?

A15 In relation to the continued provision of specialized services or the creation of such a service in an area that is recommended by a Health Needs Assessment but is not supportable by a Foundation Trust

Q16. What more should be done to support a level playing field for providers?

A16 A set of clear principles should allow for any exceptional or special circumstances to be considered on a case by case basis

Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

A17 It is important that the provision of services is quality assured and that new providers are licensed by the CQC. Any perceived anti-competitive behaviour by GPs as providers of service should be reviewed by the NHS Commissioning Board.

Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

A18 Yes – in the instances where a Foundation Trust may review providing services because it may be providing those services above national tariff and there are no established further providers to carry out this work.

Q19. What may be the optimal approach for funding continued provision of

services in the event of special administration?

A19 A risk pooling approach by levying charges on regulated providers is an approach that could be adopted, providing this was proportionate to the level of risk within the Market for Health Provider Failure.

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

A20 No

Q21. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

A21 New proposals need full post implementation review to assess whether there are any individual or groups that become disadvantaged as a result.

Transparency in Outcomes – a Framework for the NHS

The Framework concentrates on developing a balanced set of outcome goals covering effectiveness, patient experience and safety over five domains as below

Domain 1	Preventing people from dying prematurely	Effectiveness
Domain 2	Enhancing the quality of life for those with long-term conditions	Effectiveness
Domain 3	Helping people to recover from episodes of ill health or following injury	Effectiveness
Domain 4	Ensuring people have a positive experience of care	Patient Experience
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

Each domain has

- An overarching indicator(s) allowing progress of the NHS to be tracked across the breadth of NHS activity covered by the domain.
- A small number of specific improvement areas with a corresponding outcome indicator
- A suite of supporting quality standards developed by the National Institute of Clinical excellence

The outcomes framework consultation covers a number of specialist areas of expertise where it is applicable to receive responses from clinical professionals, statisticians, public health and information experts.

As a result The Chartered Institute of Public Finance are pleased to address a number of questions within an abridged consultation response below consistent with the financial discipline making a contribution to the broader objectives of NHS service reform.

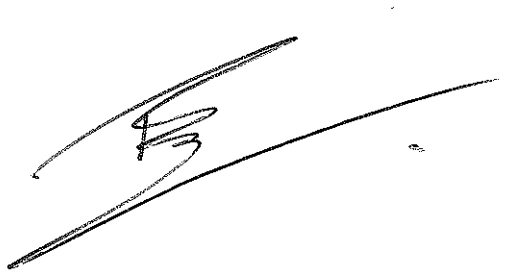
- The movement to outcome targets from process targets to measure improvement in the NHS is a very positive and welcome change recognising that a range of robust and comparable indicators across all areas will need some time to develop.
- The case for clinical prioritisation over waiting times is understood, however there remains a case for retaining a small number of process targets, including waiting times. A defining achievement of the NHS over the last decade has been the significant reduction in waiting times to a maximum of 18 weeks, as these are an integral part of patient experience (Domain 4 above) it is important to retain this focus.
- In relation to premature death the approach of looking at major causes such as heart disease, stroke and cancers to then set overarching indicators, specific improvement areas and quality standards is logical.
- There is a recognition that in selecting the improvement areas based on age-standardised death rates that clinical coding needs significant improvement. This is particularly the case where there are significant underlying health factors such as diabetes that are major contributing factors to heart disease and strokes that are not recorded on death certificates and are not present in the current death statistics.
- In relation to premature deaths in the young, the incidence is very low and therefore statistically significant comparisons may be difficult to achieve.
- It would appear that the framework as it stands is not capable of providing information on avoidable deaths for older people that would stand up to rigorous scrutiny.

- Health promotion and prevention outcomes are not currently covered within the Framework. It is recognised that a Public Health framework is due to be published shortly but in ensuring that the NHS and Local Authorities have an integrated focus on prevention and well as treating illness, it may be necessary to consider the two documents together to focus on the complete cycle of health improvement.
- It will be necessary to have clarity on definitions used within the framework, i.e. how do you measure improvement in "quality of life"
- Given the significance of the chosen health improvement indicators, the robustness and the quality of data feeding into the outcomes framework should be tested and piloted where practical.
- It has been suggested that long term conditions (LTC) are aggregated together. It is recognised that 30% of individuals with a LTC have a multiple long term condition but there is a view that the approach suggested will reduce the focus on specific long term conditions and undermine national service frameworks that have been developed and agreed by major stakeholders and service users.
- Charities specialising in long term conditions should be asked to input into the outcome indicators for their area of expertise to ensure these are robust and provide a basis for forward planning with stakeholders.
- To ensure that no-one is significantly disadvantaged by these proposals it will be necessary to ensure that consultation responses are actively pursued from all groups including those that are difficult to reach.
- Implementation of the outcomes framework will need to be carefully monitored to assess the implications for each group.
- Domain 3 has been suggested to be a catch all and will require a significant number of overarching indicators, specific improvement areas and quality standards.

Conclusions

Our response has highlighted the major risks involved in implementing the most significant components of the Government's proposals. Many of the detailed arrangements necessary for successful implementation remain to be developed and CIPFA stands ready to play a part in this process. Given the interdependence of all the components of the NHS system, change on this scale will need to be carefully coordinated during the transitional period in order to achieve the desired aim of liberating the NHS.

Yours faithfully



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