BRIEFING

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NHS resources and reform

Response to the White Paper *Equity and Excellence: Liberating the NHS*, and the 2010 Spending Review

The White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) will be implemented in a period of significant financial challenge for the NHS. This paper responds to the White Paper and Spending Review (HM Treasury, 2010), drawing on national and international evidence.

Introduction

The 2010 Spending Review announced that the NHS will receive 0.4 per cent real-terms growth over the next four years – 0.1 per cent a year. This compares to an average real-terms increase of 5.7 per cent per year from 1997/98 to 2009/10. This is the lowest four years' increase for the NHS since 1951–56 (Emmerson et al, 2010). The Spending Review also allocates £1 billion a year from NHS funding to social care. The real-terms change in NHS funding, net of the social care support, is therefore a *reduction* of 0.5 per cent over the next four years.

The Spending Review also announced important changes to the treatment of past underspends. Health has accumulated underspends of £5.5 billion, of which £3.7 billion is classified as 'resource' (ongoing expenditure on staff, medicines, equipment and the like) and £1.8 billion as capital. There is also a planned underspend for 2010/11 of £1 billion. According to the Spending Review, these accumulated stocks – known as end-year flexibility (EYF) – have been abolished. This means that any previous underspend that is honoured by the Department of Health will have to be made within the settlement outlined in the Spending Review.

The White Paper will therefore be implemented in a period of significant challenge. We welcome the principal goals in the White Paper and the Spending Review: to uphold the values and principles of the NHS (of a comprehensive service, available to all, free at the point of use and based on clinical need and not on the ability to pay); to increase health spending in real terms in each year of this parliament; and of an aim for the NHS to achieve results that are among the best in the world.

The NHS embarks on this period of financial challenge and reform with many strengths. Research by the Commonwealth Fund (2007) comparing seven countries shows that the UK has moved from third position to first across a range of attributes including quality of care, efficiency and equity. The NHS has never been better resourced, waiting times have fallen dramatically and public satisfaction with the service is high (NatCen, 2009). But while funding has risen considerably over the last decade, by international standards the NHS does not look lavishly funded. At the start of the banking crisis spending on health as a share of GDP had grown from 6.6 per cent in 1996 to 8.7 per cent in 2008, just below the OECD average and lower than many other major economies (OECD, 2009). In terms of real resources the NHS

still has fewer doctors, hospital beds and key equipment such as MRI and CT scanners per head of population than the OECD average.

While resources matter, the service should be judged on outcomes not inputs. Life expectancy at birth in England and Wales has increased over the last two decades by 5.3 years for men and 3.8 years for women. Despite this, the UK has a relatively high rate of mortality amenable to health care and compares less favourably with other OECD countries on measures of health status and in critical areas such as cancer survival rates (Anderson and Markovich, 2010; Leatherman and Sutherland, 2008).

Over the next four years the pressures on the NHS will continue to rise. Previous work (Appleby et al, 2009; Wanless, 2002) has identified the following key factors:

- demography – England has a growing and ageing population
- pay and price pressures
- new technologies
- rising expectations and quality standards.

Meeting these challenges so that the NHS can sustain the access to services and quality of care will require the NHS to make substantial efficiency and productivity gains. The Spending Review increases for the NHS are consistent with the requirement for the NHS to make efficiency savings of £15 to 20 billion over the next four years (Nicholson, 2009). This is equivalent to around four to five per cent a year. The Government's proposed reforms to the NHS will be a success if they help the NHS to live within the tighter resources while continuing to improve quality and health outcomes.

While we support many of the proposed reforms set out in the White Paper, on the basis of national and international research evidence we consider that they need refining to make the most of the opportunities they present.

The White Paper emphasises GP commissioning, and enhanced competition and choice, as the main reforms to improve quality and efficiency in the NHS. There is now nearly 20 years of evidence on the impact of primary care-led commissioning. It points to the significant potential of GP commissioning consortia holding real, as opposed to indicative, capitated budgets for the purchasing of local health services, and for these groups to be held to account for health outcomes, patient experience of services, and financial performance (Smith et al, 2010). It also shows that while there has been some success in improving out-of-hospital care (and electives in terms at least of more controlled referrals), commissioners have been unable to have much influence on urgent care or hospital efficiency. Most NHS expenditure occurs in hospitals where much greater efficiencies are urgently needed. GP consortia will need to move on significantly from their predecessors if they are to be more successful in this respect (Audit Commission, 2009).

There is emerging evidence that competition between hospitals, in a *fixed* price market (not using *maximum* prices), is associated with increases in quality (Gaynor, 2006; Cooper et al, 2010; Gaynor et al, 2010; Bloom et al, 2010). The Nuffield Trust believes there is a place for competition within the NHS, alongside other tools to help promote quality, efficiency and equity. We welcome the role of the new economic regulator to promote competition. The regulator will need to think carefully about the unit of competition. Although individual hospitals are an obvious entity for competition purposes, as reflected in the White Paper, they have many different 'product lines'. The evidence for the effectiveness of competition is mostly drawn from cases where there has been increased competition for specific services, such as elective care (Gaynor, 2006; Cooper et al, 2010; Gaynor et al, 2010), including introducing new 'niche' players, rather than from a single institution.

Moreover, perhaps the biggest challenge now and into the future is caring for older people and for those with long-term conditions. As the Department of Health, Royal Colleges and others recognise (DH, 2005; RCP et al, 2004; RCP, 2008), GPs need to work together with specialists so that costly avoidable hospitalisation is reduced and care is integrated and coordinated along a pathway stretching from home to hospital. Although this has been recognised across Europe and the US, many countries are challenged to achieve better value from health care expenditures through better coordination and, in some cases, integrated provider networks (Weeks et al, 2010; Stremikis et al, 2010).

Competition is not an end in itself but a mechanism for achieving further improvements in economy, efficiency and effectiveness in the provision of health care. The statutory objectives of the regulator should reflect this, as they do in other industries such as Ofwat and Ofcom (House of Lords, 2007). The economic regulator will need to consider how it can use its powers and what the unit of competition should be. The aim should be to achieve improvements in unplanned care and for those with long-term conditions as well as elective and community services, drawing on international evidence.

The Government could also consider stronger incentives to encourage coordination between primary and secondary care, which can achieve better quality and value. While competition is a feature between such networks in, for example, the United States, the primary drivers of quality and efficiency within the network appear to be more closely related to peer review of performance using better data, coupled with professionalism, and aligned 'intra-network' incentives (Rosen et al, forthcoming; Thorlby et al, forthcoming; Dixon et al, 2004). Across the NHS there are already many impressive initiatives in this direction, led by clinicians, that need understanding, nurturing and evaluating (Ham and Smith, 2010; Cortese, 2010; Lewis et al 2010). The Government should leave room within its overall national policy for these and similar creative developments drawing both on recent international experience (Weeks et al, 2010) and emerging developments in the NHS (Ham and Smith, 2010; Shaw et al, forthcoming; Ham, 2010; Lewis et al, 2010; Ham, 2009b) and outlined below. To help encourage creativity, consideration should be given to removing some national obstacles, by developing the current policy approach to competition and choice, the incentives associated with Payment by Results, the focus within acute trusts on expanding hospital activity, and barriers to service reconfiguration (Ham and Smith, 2010).

Finally, the fast pace of reform carries significant risks, particularly given the likely constraint on resources for the NHS relative to the recent past. Even if well managed, widespread organisational reform can mean services stand still for a period rather than progress (Dickinson et al, 2006). If managed poorly, services and finances may suffer. There is clear evidence that organisations distracted by reform can experience major financial and service failure (Audit Commission, 2006). Failure can take several forms; these include a lack of control of expenditure, rushed service changes, or more fundamentally, a decline in the quality of care. This is the more worrying because quality is less readily measurable than finance, and in the current financial climate there will be much attention to the bottom line. We strongly support the emphasis on measuring outcomes, but these indicators may not signal quickly enough changes in quality. The Government should consider a set of national indicators as sentinel measures of quality that can more readily identify where service quality may be lapsing. These might include avoidable hospitalisations, measures of access to care and other health care process measures that can signal potential risks to patients. They would need to be monitored regularly and publicly.

This paper now considers in more detail the central reforms outlined in the White Paper.

GP commissioning

Central to the current proposals in the White Paper is the intention to retain commissioning and devolve it to local GP consortia and a national NHS Commissioning Board. The principle of giving clinicians greater responsibility over NHS budgets is a good one, since clinicians are, in effect, responsible for most expenditure in the service through patient referrals and other clinical decisions. However, evidence from less radical but similar policies in the past – GP fundholding, total purchasing, primary care groups, practice based commissioning – shows that such approaches take time to develop and significant management resource is needed to support them (Smith et al, 2010; House of Commons, 2010; Smith et al, 2004).

PCTs have struggled to control expenditure on hospital care (Audit Commission, 2009). GP consortia in their early years will be underdeveloped as commissioners, handling about £70bn of public funds, and subject to the same pressure as PCTs but with much less management resource. The Government needs to consider carefully how they can be supported and the risks of loss of financial control addressed in the early years.

There is a consensus across the developed world that key pressures on demand for health care in future will come from increasing numbers of frail older people in the population, and those with long-term conditions (Sassi and Hurst, 2008). In these population groups there are large numbers of preventable hospitalisations. It has also long been recognised that the way that health systems are organised and financed also has significant impact on expenditure. To achieve better quality and value in health care now and in the future, health systems must be incentivised towards supporting people at home so that costly avoidable hospitalisation is reduced. As recent reviews of commissioning have shown (Smith et al, 2010; House of Commons, 2010), commissioning in the NHS has largely failed to achieve this goal, mostly because of a lack of influence over the activities of hospitals in which most expenditure occurs.

Over one third of all admissions to hospitals are emergencies accounting for some ten per cent of NHS spending (Blunt et al, 2010). Nuffield Trust analysis shows these have risen by 11.8 per cent over five years – faster than the rise in illness levels – mainly due to

very-short-stay admissions (Blunt et al, 2010). Commissioning has largely failed to stem this rise.

To have more effect on expenditure and quality, GPs will need to work together with specialists, patients, and indeed local authority social services to reorientate care. This is a mixture of commissioning and provision. GPs who commission are likely to need to expand their own and other community services and work with hospital clinicians in the provision of care (Lewis et al, 2010). Care needs to be integrated and coordinated along a pathway stretching from home to hospital, with an appropriate degree of patient choice. The Commonwealth Fund's Commission on a High Performing Health System consistently points to integrated care being the route to better value care (Commission for High Performance Health System, 2006), something underlined by Dr Denis Cortese, the outgoing chief executive of the Mayo Clinic, a health system based in the US known globally for providing first-class care (Cortese, 2010), and Dr Glen Steele, CEO of Geisinger, another well-recognised high-performing health organisation (Steele, 2010). Key ingredients of high-performing health systems include good leadership, clinical leadership and peer review, aligned incentives, good use of information technologies for both continuous improvement work and external accountability (Ross Baker et al, 2008).

There is a need for careful consideration of how patients will respond to their GP if and when they know that s/he is responsible for deciding what services are or are not funded locally. It will be important that patients do not perceive a conflict of interest in their GP as both commissioner and provider if public trust in general practice is to be maintained. A particularly sensitive issue in this respect is the extent to which the personal remuneration of GPs is affected by commissioning decisions, and this area needs very careful thought and clarification. Useful lessons may be drawn from the experience in other countries (Cortese, 2010).

There appears to be substitution of social for health care in particular in older people, as recent Trust analysis demonstrates (Bardsley et al, forthcoming). Commissioners will need to work closely with local authorities in commissioning care for older people in order to maximise the effectiveness of expenditure. We welcome the announcement in the Spending Review that £1bn per year of NHS spending is earmarked for social care, although we are concerned that the extra £1bn per year for social services allocated to local government is not ring-fenced and thus may not be used for the purpose intended.

NHS Commissioning Board

The NHS Commissioning Board (NHSCB) will have a critical role as the overall funder of NHS commissioners, undertaking resource allocation, designing templates for services, and holding GP commissioners to account for their performance against the NHS Outcomes Framework. It is as yet unclear how the role of the Board will relate to the economic regulator and the Care Quality Commission, and roles and principles of engagement need to be worked out carefully. The White Paper is clear that the NHSCB will not be the 'headquarters' of the NHS, but its relationship and control over GP consortia will be critical, particularly in a tense financial climate. If a consortium or group of consortia are unable to contain expenditure or manage difficult decisions locally, for example on service configuration (which may include hospital closures), the Board will need to intervene. Such intervention may well demotivate the consortia and reduce clinical engagement.

Therefore a key challenge within the new arrangements is how hard choices will be made, and who will be held responsible for these. We highlight several issues, drawing on previous (Edwards, 2007) and current (Coster, forthcoming) Nuffield Trust analyses of the role and function of national independent health boards. First, whether the NHSCB will be able to remain truly independent of the Secretary of State and the Department of Health when faced with difficult local rationing decisions. We suggest there is a need for formal circumscription of the scope of the Secretary of State and the Department of Health to intervene in the work of the NHSCB, albeit there will need to be arrangements for the NHSCB to account to Parliament in an appropriate and transparent manner. For example, the primary legislation could expressly prohibit the Secretary of State from assuming the powers of the NHSCB, and require fresh primary legislation to redefine the boundary between the NHSCB and the Secretary of State.

Second, there will need to be a similar agreement as to the powers of direction the NHSCB has over GP consortia.

Third, the extent to which there should be public representation on the Board of the NHSCB and/or public involvement in its decisions should also be made explicit (see the section on legitimacy and accountability below).

The NHSCB will need to develop a failure regime for GP commissioners, and the relationship of this to the General Medical Services contract and the role of the GMC will be critical. The NHSCB will hold the individual general practice contracts for GPs as providers, as well as holding GP consortia to account. This poses a question as to whether and how

these two areas of general practice activity will be jointly overseen at national level, and in turn how effective integration of primary care commissioning and provision can be assured. Thought needs to be given as to how the progress that has been made by many PCTs in managing locally tailored practice contracts and developing extended services to meet complex patient needs, is not lost with a greater national focus.

Efficiency – supply-side

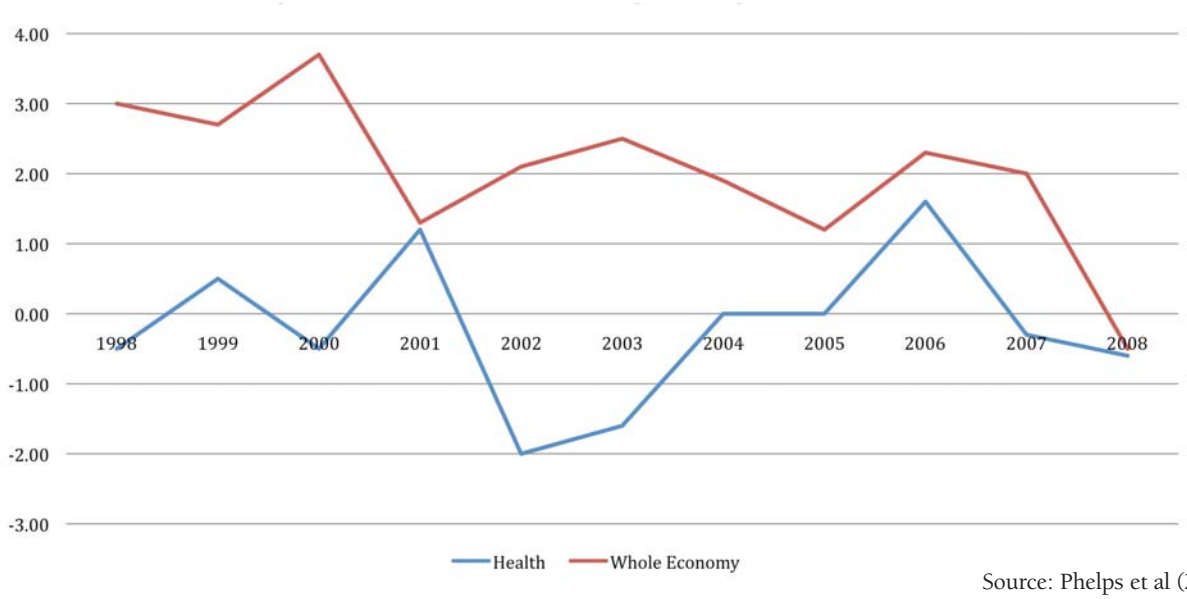
The £15 to 20 billion of efficiency savings required to manage within the Spending Review resource allocations equate to productivity growth of between four and five per cent per year. This is substantially above the rate of productivity growth in the NHS over the last decade (Phelps et al, 2010). Figure 1 compares NHS productivity growth from 1998 to 2008 with productivity growth across the economy. Health Service productivity fell by 0.2 per cent per year over this decade while productivity, measured by gross value added (GVA) output per hour worked, grew by an average of two per cent a year across the economy as a whole.

The Better Care, Better Value indicators developed by the NHS Institute give some idea of the potential for productivity gain in the NHS. Crump estimated that in 2009 across the ten key indicators the NHS could save £3 billion a year if all trusts could improve their performance to the level of the top quartile (Ham, 2009a). As Figure 2 shows, (see page 6), over half of the potential savings come from reducing average length of stay in hospitals and reducing pre-operative bed days. This highlights the importance of hospital services to the overall efficiency performance of the NHS. Estimates of the variation in productivity at regional level find that the NHS could make savings of £3.26bn (at 2007/08 prices), if all regions were as productive as the South West (Bojke et al, 2010).

The White Paper proposes major changes to hospital services over the next four years, completing the conversion of NHS trusts to foundation trusts, extending competition with the introduction of the 'any willing provider' rule and strengthening regulation. Work by the Nuffield Trust and others would suggest that in addition to the changes set out in the White Paper, to achieve the step change in productivity required of hospitals and the wider NHS over the next four years particular attention needs to be give to the following key areas:

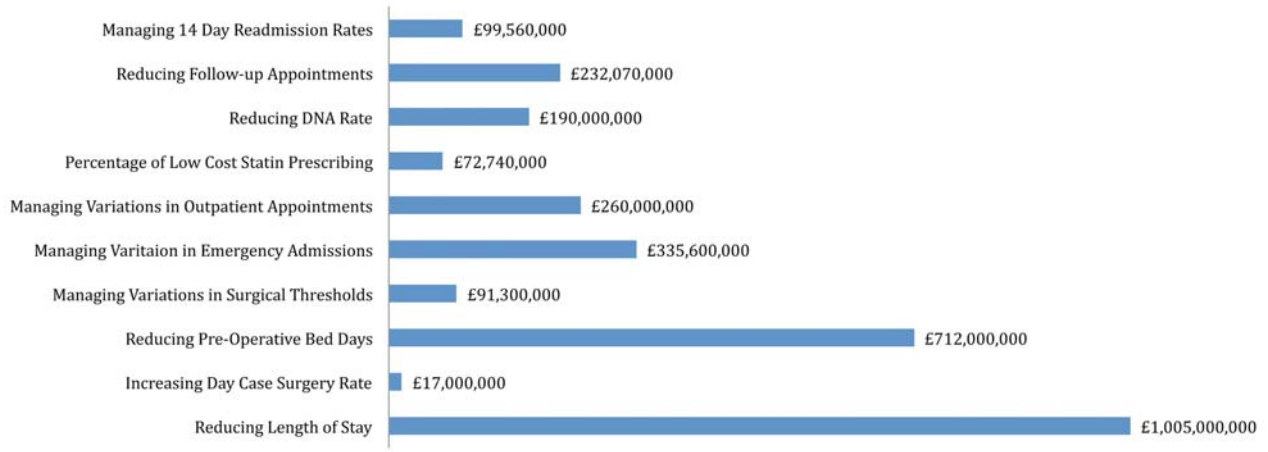
- **Targets and performance management** – the Spending Review set out national requirements for reductions in management costs across the NHS, the Department and its non-departmental public bodies. Administrative budgets will be cut by 33 per cent saving, in real terms, £1.9 billion.
- **The tariff** – the level of the tariff is one of the most powerful system-wide levers to incentivise efficiency. But the tariff is a blunt instrument and careful consideration needs to be given to the balance between driving efficiency

Figure 1. Percentage productivity growth in health and the general economy, 1998 –2008



Source: Phelps et al (2010)

Figure 2. NHS productivity opportunities



Source: Ham (2009a)

and controlling costs, and maintaining quality of care. Econometric studies suggest that if the tariff reduces to below the marginal cost of care in a provider, the quality of care reduces in a competitive environment (Gaynor, 2006). This research also points to the risks to quality if providers compete on price. Moving to a maximum tariff risks reintroducing price competition between providers.

- Cost data and reporting – the NHS needs to continue to improve its data on costs. Monitor has been developing service line reporting with 35 NHS foundation trusts to develop a portfolio of good and poor performance (Ham, 2009a). NHS trusts should be required to introduce service line reporting, to provide more accurate data on the cost of treatments, thus ensuring that pricing changes produce efficiency savings rather than quality reductions. This will enable the NHS to build on the best-practice tariffs that are being piloted in four clinical areas this year. Best-practice tariffs focus providers on scrutinising clinical variations in performance and cost to yield quality-preserving efficiencies. As the *Better Care, Better Value* indicators show, this has the potential to yield substantial efficiency savings.
- NHS pay and price inflation – over the last decade pay and price inflation has risen by an average of 1.5 per cent more per year than whole-economy inflation (the GDP deflator). Pay will be frozen for two years for all public sector workers, including NHS staff, with earnings above £21,000 starting from 2011. To maintain the real-terms value of the Spending Review settlement for health, the Department of Health and NHS will need to continue to manage the pressures on pay and prices. There are pay pressures over the next two years stemming from the increment structures of NHS pay systems and we do not know what will happen to headline pay settlements in the final two years of the Spending Review. Pressures on pay may grow however, as workers are asked to contribute more to their pensions and if consumer inflation continues to be above the Bank of England target. Moreover, the Office of Budget Responsibility's Budget economic forecast anticipated whole-economy earnings growing at 4.1 per cent in 2013/14 and 4.4 per cent in 2014/15. It will be harder to hold down health and public sector pay pressures if private sector pay is growing more rapidly.

Regulation

Based on emerging evidence (Gaynor, 2006; Cooper et al, 2010; Gaynor et al, 2010; Bloom et al, 2010), the Nuffield Trust supports the direction stated in the White Paper of developing competition and choice to help improve quality and efficiency. The economic regulator will need to consider competition between different organisational forms rather than simply the GP practice and the hospital if patient care is to improve and taxpayers get better value. GPs and specialists may wish to come together to hold a risk-adjusted capitated budget for provision of some or all care for a local population. Such an approach may hold more promise to achieve efficiency and quality gains that are urgently needed, in particular for care of older people and those with long term conditions (Lewis et al, 2010; Smith et al, 2009). The

economic regulator will need to take a view on whether such vertical integration would be anti-competitive, or, if it is likely to benefit patients and taxpayers, whether to permit it and encourage competition between such networks.

The Trust supports the establishment of an independent economic regulator with responsibility for regulating prices, promoting competition, and supporting service continuity. We particularly welcome the proposals that will give the regulator the duty to promote competition rather than just prevent anti-competitive practice, although this needs to be clearly in the context of securing more economic, efficient and effective health care. The regulator should draw on or develop an evidence base related to health care to demonstrate that its actions will achieve, or have achieved, this. The Nuffield Trust supports the proposal for Monitor to become the new health and social care economic regulator, since Monitor has built considerable credibility and expertise which will be essential given the complexity and scale of this role.

Regulating the NHS proposes a twin system of regulation with CQC regulating quality and Monitor focusing on economic regulation. We support this – these forms of regulation require different, specialist skills and both are essential. However, for patients it is vital that the two regulators work closely together, share information and coordinate their work so that providers face clear and consistent incentives where improving quality and economic performance are not seen as competing goals but mutually reinforcing (Dixon, 2005). But there may be conflict between, on the one hand, priorities such as improving equity of access to care, or quality of care, and on the other efficiency and the desire to increase choice and competition. In this case it will be important that CQC and Monitor early on make explicit these tensions and try to craft a set of principles they can both work to in the event of a conflict of objectives. There needs to be greater clarity as to how differences will be reconciled and who may be the arbiter. CQC will have a pivotal role to play in ensuring that patients, their GPs and GP commissioning consortia, can compare quality, and thus facilitate choice.

The economic literature on competition between hospitals suggests that competition *with fixed prices* increases quality of care, provided that the price is above marginal cost (Gaynor, 2006). Competition on price is associated with decreases in quality, since quality is less measurable and observable than price. (Gaynor, 2006). The evidence would thus not support moving from a fixed to a maximum tariff. Given the acute financial pressures on the NHS, and the policy over time to 'unbundle' tariffs, the task to ensure that the regulated price is at an appropriate level will become far more complex and politically fraught, and will also require a great deal of accurate information on costs. The new economic regulator will need to be adequately resourced to carry out this task. Its feasibility should be regularly reviewed. The strategy for developing the policy on regulated prices in the NHS – which we understand will be a role of the NHS Commissioning Board – thus needs much more development and should be done in close collaboration with the economic regulator. The strategy should not be insulated from other policy developments.

We are unsure about the relative merits of splitting responsibility for price-setting between the economic regulator and the NHSCB and believe there should be a more explicit debate about the pros and cons of different options. In other regulated industries such as water and gas, the regulator controls both the structure of prices and their level. We believe that the NHSCB and Monitor should undertake a fundamental review of Payment by Results in light of the very different, and difficult, challenges facing the NHS Commissioning Board and providers over the next five years. Previous research has shown the benefits and limitations of the current approach (Audit Commission, 2008; Farrar et al, 2009).

It is essential for all hospitals to be financially viable and well-governed – unless they are, many providers will be unable to cope with the pressures of a tight economy and effective commissioning. However, we are concerned about the requirement for all NHS trusts to become foundation trusts within three years, if this means either that Monitor lowers the bar, or that individual hospitals concentrated on achieving and maintaining foundation trust status and insufficiently on other priorities, as the case of Mid Staffordshire NHS Foundation Trust demonstrated (Healthcare Commission, 2009; Colin-Thomé and Alberti, 2009). Moreover, there may be a disconnect between the timetable for achieving foundation trust status and the development of commissioning intentions by GP consortia. Previous foundation trust applications have been deferred because of uncertainty about local commissioning strategies. Changes in commissioning intentions can also destabilise a trust if it was configured on the basis of an earlier strategy.

We are also concerned that Monitor should be given sufficient resources to discharge its large responsibilities adequately, in assessing foundation trust applications over the next three years, in monitoring access to essential services across the population and in setting appropriate prices. Improving the efficiency of management and eliminating unnecessary waste is important, especially when overall resources are being constrained, but an underfunded regulator may well be a false economy as the inefficiency

from a poorly functioning market and poor access to care would dwarf the running costs of the regulator.

Accountability and legitimacy

The White Paper aims to develop a NHS that is more responsive to local people, something we support. There are at least two broad routes to this goal: devolving power to localities to shape health services locally; and increasing consumer power through market-based mechanisms such as competition and choice. Both routes are pursued in the White Paper; this response focuses on the former.

The need for local legitimacy and accountability in the NHS is growing as the provision of NHS-funded care becomes more diverse, as there is significant restraint on funding, and as patients at present have effectively no choice of commissioner. Even as GP consortia develop, patients will still have limited choice in this area. The development of GPs as service providers, coupled with the expansion of foundation trusts and the increased use of the private and third sectors, creates local health economies with multiple competing providers. It underlines the need to have an impartial local body to 'hold the ring' and take decisions on behalf of local patients.

It has proved very difficult in the past to achieve local legitimacy and accountability in the NHS, as strong lines of accountability reach upwards to the Secretary of State and to Parliament rather than locally. There have been numerous attempts over the past ten years to improve local accountability and legitimacy (the creation of foundation trust governors, local involvement networks, health overview and scrutiny committees and the creation and abolition of patient and public forums) but their impact overall has been mixed at best (House of Commons, 2007; Picker Institute, 2009; Lewis and Hinton, 2008).

'Strong' accountability and legitimacy is needed to set mandatory standards, or to veto/reverse decisions. In relation to commissioning, this has historically been highly centralised in the NHS. If there is to be a transfer of power over NHS commissioning decisions from the centre to localities, as is intended in the White Paper, GP consortia will have to have suitable arrangements to secure both accountability and legitimacy.

The proposed accountability arrangements for GP commissioners appear to be highly centralised (upwards towards the NHS Commissioning Board). The Government needs to clarify its proposals for GP governance and accountability to local people, particularly as to whether there will be mandatory requirements for local representation in the governance of GP consortia. If a 'members council' or similar is proposed, it will be important to examine carefully the evidence on how the membership arrangements for foundation trusts have operated and with what impact.

The proposals to create health and wellbeing boards go some way towards creating a multi-stakeholder local body to help shape local commissioning decisions. However, while the proposals are clear about the importance of needs assessment, the power these boards may have to intervene in commissioning decisions is currently unclear in the White Paper, for example the power to enforce joint or integrated working if it seems to be in the best interest of local residents. This includes joint working, between social care and health, and between NHS organisations. Consideration also needs to be given to any potential conflict of objectives, for example of the economic regulator in encouraging competition, and the preferences of health and wellbeing boards for fostering integration.

We welcome the proposed expansion of Healthwatch, which has the potential to enhance patient voice locally. However, there is not enough detail on how Healthwatch itself will be representative of local communities.

If it is the Government's intention to have centrally defined standards and regulation as key drivers of local commissioning and configuration of services, then, by the same logic, they must also pass muster as 'legitimate', at national and local level. This would apply to decisions made by the proposed NHS Commissioning Board, the economic regulator Monitor, and the Care Quality Commission. The consultation document sets out proposals for the governance of foundation trusts but does not discuss the governance and accountability arrangements for the economic regulator or the NHSCB with respect to public or patient involvement. It is important to recognise that an effective economic regulator and NHSCB will be a very powerful force for influencing the pattern and cost of health care across England. The Government needs to consider how accountability and public engagement are managed. The economic regulator needs to be seen by the public as legitimate particularly as it will manage the challenges associated with the financial failure of some foundation trusts. The economic regulator also needs to be seen to be independent of vested interests when setting national tariffs – an issue which in the US in part resulted in the abolishing of regulated prices across many states (Haas Wilson, 2003). These issues should be explored further.

Measuring outcomes

The Nuffield Trust welcomes moves towards better measurement of outcomes and the assessment of that information in the planning and management of health services. Outcomes measurement offers the potential to move closer to assessing the real benefits that underlie our investment in health care – rather than intermediate outputs or products. Moreover, by using outcome measures it seems possible to hold organisations to account for what they achieve rather than how they do it. This is undoubtedly appealing, yet we believe the reality is more complex and the use of information about patient and population outcomes needs to be developed carefully.

We would suggest that the greater use of outcome measures be seen as an accompaniment to a range of other metrics, not a replacement. For some years people have debated outcome versus process measures – we regard this debate as rather arid as both are needed, and they should be complementary (Lilford et al, 2004).

We recognise that the indicators are prompts for consideration. We advocate building a library of approaches that capture a much wider range of different perspectives, both qualitative and quantitative and including patient experience. Such an approach will encourage open scrutiny and debate particularly where a particular service performs differently according to different measures.

What we have identified as the biggest challenges are set out below:

- To identify sets of indicators that are sufficiently broad to capture experiences of many patients, yet specific enough to be attributable to the effects of health care.
- To find measures that are amenable to change in reasonable timescales. Some process measures are legitimate and valid, particularly where outcomes do not emerge for some time.
- To use measures that have value at different organisation levels – not just at national level but are able to influence change at levels below that. At the same time, to be clear about how they will be used for accountability purposes.
- To develop the ways we use existing information. Outcome measurement should be about tracking health status over time and speculating on whether changes are more or less than would be expected.
- Many indicators fall short of an ideal. There is scope to develop and refine these over time and extend their coverage. Data quality and completeness are important when deciding which indicators to use. The approach needs to be robust enough to cope with the current state of NHS information systems.

Conclusion

The NHS is facing an unprecedented challenge as it will have to deliver far-reaching reforms to patient care at the same time as demand increases and there is effectively a real-terms reduction in NHS funding over the next four years.

The Nuffield Trust commends the decision to protect health spending relative to other areas of the public sector. However, unless the NHS can keep a tight grip on pay and price inflation it will mean a reduction each year in the volume of health care services the NHS can deliver, if current trends continue.

Our analysis concludes that the Government's proposed NHS reforms are broadly in the right direction and that they will be a success if they help the NHS to live within tighter resources, while continuing to improve quality and health outcomes. However, the fast pace of reform carries significant risks, particularly given the constraint on resources for the NHS relative to the recent past.

We conclude that on the basis of national and international research evidence, the reforms need refining if they are to make the most of the opportunities they present.

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