BMJ 2016;354:i4204 doi: 10.1136/bmj.i4204 (Published 1 August 2016)

EDITORIALS

NHS funding in England: money's too tight to mention

What prospects for better quality care in the NHS?

Jennifer Dixon *chief executive*, Will Warburton *director of improvement*

Health Foundation, London WC2E 9RA, UK

The NHS in England is halfway through its tightest ever decade of funding growth. If plans set out in the spending review last autumn hold true to 2020, real term growth in the NHS will average around 1% a year over this decade—relative to the long term average of just under 4%. This is equivalent to just 0.3% growth in spending per head of population.

The pips are squeaking. In 2015-16, NHS provider organisations were £2.8bn (€3.32bn; $3.69bn) in the red, with more than two thirds of NHS trusts not balancing their books. Recently published accounts show the Department of Health overspent the total health budget (excluding capital) by £207m.[1] This is despite the fact that growth in health spending was "frontloaded"—higher allocations in 2015-16 and 2016-17 before dropping from 2017-18 to 2020-21.[2] "Brexit" could introduce additional risks to even this historically low rate of funding increase. Uncertainty after the EU referendum has threatened the stability of the economy, which in turn poses a real threat to NHS funding. Spending on the NHS consumes £1 in every £5 of the taxes we pay in the UK, so if slow growth reduces tax receipts, it is unrealistic to expect that the NHS can be immune from the consequences.

The prospects for extra funding in the short to medium term look dim. Figures from the Organisation for Economic Cooperation and Development show the UK is in the middle of the pack of comparable countries, with 9.9% of national wealth devoted to health expenditure.[3] And if additional funding were available, social care would have a strong case for first call on the money.

This tough outlook explains why on 21 July 2016 NHS England and NHS Improvement, the national bodies responsible for commissioning and provision of healthcare, announced a long planned "reset" for NHS financial performance. For this read "get tougher." No NHS trust will receive any growth money in 2016-17 unless it is living within its means (or "control total"). Five NHS acute providers and nine clinical commissioning groups were placed into a regime of financial "special measures" and will receive targeted intervention from central bodies to reduce their rate of expenditure. Senior leadership may be replaced if national bodies deem progress insufficient.[4]

What about quality?

Thirty per cent of growth money for trusts will be contingent on meeting three targets: the four hour emergency department target, the 62 day target for cancer treatment, and the 18 week target for routine operations. Instead of being fined for missing national standards, hospitals consistently missing targets will be able to access funding if they make improvements against a trajectory agreed with national bodies.[4]

The risks are plain to see. The 2013 Francis inquiry into Mid Staffordshire NHS Foundation Trust found a focus on access targets and financial savings contributed to the stark failings in care, which included inadequate staffing. With the pay bill comprising the majority of provider expenditure, attention is already focused on workforce costs. Robust monitoring of the effect of any change in staffing levels on quality by provider boards and regulators—the Care Quality Commission and NHS Improvement—will become more critical.

Meanwhile, if quality of care is not to go backwards, and with rationing unacceptable, a large part of the solution must be greater productivity and efficiency. Ongoing plans to rationalise and integrate services across geographical areas—such as those set out in *Sustainability and Transformation Plans*,[5] centralisation of specialist care,[6] and the pursuit of innovation and reduction in variations[7 8]—are all on the right lines.

But these are mostly national initiatives, if locally driven. And the approach can often seem more about exerting regulatory control than supporting improvement.[9] We should be focusing on engaging, training, and supporting those at the front line—clinicians and patients—to make the changes that only they can see are needed through their daily experience; this is where synergies between efficiency and quality can best be realised. More national and local support for education and training in quality improvement methods would help,[10] but there are good examples of progress. For example, NHS trusts such as Salford, Sheffield, and East London that have supported quality improvement over several years can now see dividends.[11] Efforts by the royal colleges are helping their members develop the skills to make change.[12] There is a range of support from other bodies, such as our own.[13] NHS system leaders must now use their powers, such as the forthcoming National Leadership

Correspondence to: W Warburton will.warburton@health.org.uk

and Improvement Strategy, to bring improvement back in balance with regulation.

National "shock and awe" action, as in last week's reset, will go only so far. Unless more clinicians can extend their purview from treatment to services and find ways of mobilising resources and scaling up improvements more effectively, expect more desperate measures.

Competing interest statement: We have read and understood BMJ policy on declaration of interests and have none to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Iacobucci G. Hunt is accused of "underhand" cover up over health department finances. *BMJ* 2016;354:i4109. http://www.bmj.com/content/354/bmj.i4109.
2 Health Foundation. Health Foundation responds to the Department of Health's annual end of year accounts. Press release, 21 Jul 2016. http://www.health.org.uk/news/health-foundation-responds-department-health%E2%80%99s-annual-end-year-accounts
3 OECD. Health expenditure and financing. 2016. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT
4 NHS Improvement, NHS England. Strengthening financial performance and accountability in 2016/17. 2016. https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf
5 NHS England. Sustainability and transformation plans. 2016. https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/
6 NHS England. Congenital heart disease: NHS England takes action to deliver consistent and high quality services now and for the future. Press release, 8 Jul 2016. https://www.england.nhs.uk/2016/07/chd-future/
7 Department of Health. Operational productivity and performance in English NHS acute hospitals: unwarranted variations. 2016. www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
8 NHS Right Care. Population healthcare—improving value for patients and populations. 2016. http://www.rightcare.nhs.uk/
9 Malloy A, Martin S, Gardner T, Leatherman S. *A clear road ahead.* Health Foundation, 2016.
10 Ham C, Berwick D, Dixon J. *Improving quality in the NHS.* King's Fund, 2016.
11 Jones B, Woodhead T. *Building the foundations for improvement.* Health Foundation, 2015.
12 Quality Improvement (QI) at the RCGP. 2016. http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx
13 Health Foundation. Improvement projects, tools and resources. 2016. http://www.health.org.uk/collection/improvement-projects-tools-and-resources