Sir Mike Deegan, Dame Julie Moore, Sir Andrew Cash – written evidence (NHS0189)

We were grateful for the opportunity to present evidence to the Lords Select Committee on NHS Sustainability on 15 November 2016. At the end of the session, you kindly invited us to send additional evidence to support our arguments. We are writing, therefore, with further explanation of our views on the significant shortfall in NHS funding. We appreciate that the committee's focus is on the longer term agenda, but unless this situation is rectified in the coming years, we will not achieve long term sustainability for the NHS.

It is well known that the aggregate NHS provider deficit has grown substantially in recent years, reaching £2.45bn at the end of last year. Without non-recurrent measures, the underlying position was reckoned to be closer to a deficit of £3.7bn. That means the NHS provider sector as a whole was operating at a loss of between 3.1% and 4.7% for the year.

Whilst there are opportunities for productivity improvements, it is important to emphasise the scale of efficiency squeeze providers have absorbed already in this decade. The efficiency factor built into the tariff has been stretching to the point of unrealistic for several years, especially between 2010/11 and 2015/16 when it was between 3.5-4.0%. The cumulative efficiency in the tariff of the last nine years has been 26.5%. However, this significantly under-estimates the real cost reductions required because the tariff efficiency deflator is only one of the ways in which providers have to absorb cost pressures. Other examples are:

- reductions in Market Forces Factor top ups
- new costs and inflation for drugs and devices
- marginal rate payments for emergency activity
- loss of CQUIN funding or additional investment required to hit targets
- reductions in non-tariff prices and block contracts
- reductions in education and training funding
- regulatory costs being passed to providers by the CQC
- Better Care Funding taken out of the NHS with unclear benefit in social care

The combined impact means that our organisations now have Cost Improvement Programmes of 7-9% p.a. as the norm. That comes on the back of years of similar efficiency savings.

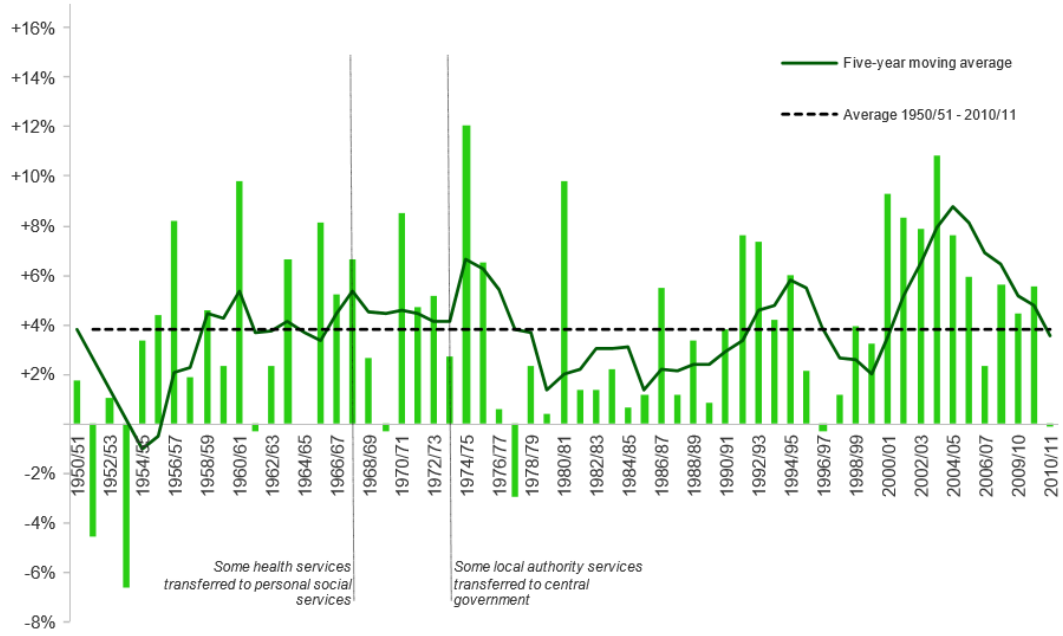
While funding has been squeezed, demand has continued to rise inexorably. We are now commonly operating at close to, and at times even above, 100% of bed capacity.

Non-elective activity has seen the most rapid growth, but is funded at the marginal rate of 70% of tariff, so is loss-making for hospitals. However, as the major A&Es in our cities, we cannot turn patients away.

The demands of a modern healthcare system are driven by ageing, chronic disease, technology and rising expectations. The history of the last six decades of the NHS shows that funding has had to grow by an average of nearly 4% in real terms to keep pace (chart below). Periods of lower growth have had to be compensated by periods of 'catch up' investment to modernise infrastructure, bring down waiting times, extend access to new drugs and

technologies and to pay staff competitively. Fluctuations from year to year have been too erratic, leading to inefficiency and hampering long term planning.

Annual change in real terms general government expenditure on the UK NHS: 1950/51 to 2010/11



Harker, R. 'NHS funding and expenditure', Social and General Statistics for the House of Commons Library, Standard Note: SN/SG/724 (3 April 2012).

We are certainly not saying that the scope for further productivity improvements has been exhausted. Nor are we saying that policy and practice cannot potentially affect the demand curve. But the operational reality is that funding levels need to be far more even and predictable, planned for the long term and much closer to the historical average of nearly 4% p.a. (with reasonable efficiency requirements), than this decade's average of 1% p.a. in real terms.

The Office of Budget Responsibility seems to believe that even growth that is more in line with the long term average for the NHS is a credible path for its financial sustainability. That will of course require tough decisions about prioritisation of public spending. That is why we are calling, along with many others, for an open and evidence-based debate with the public about the appropriate level of spending on health and social care.

23 November 2016