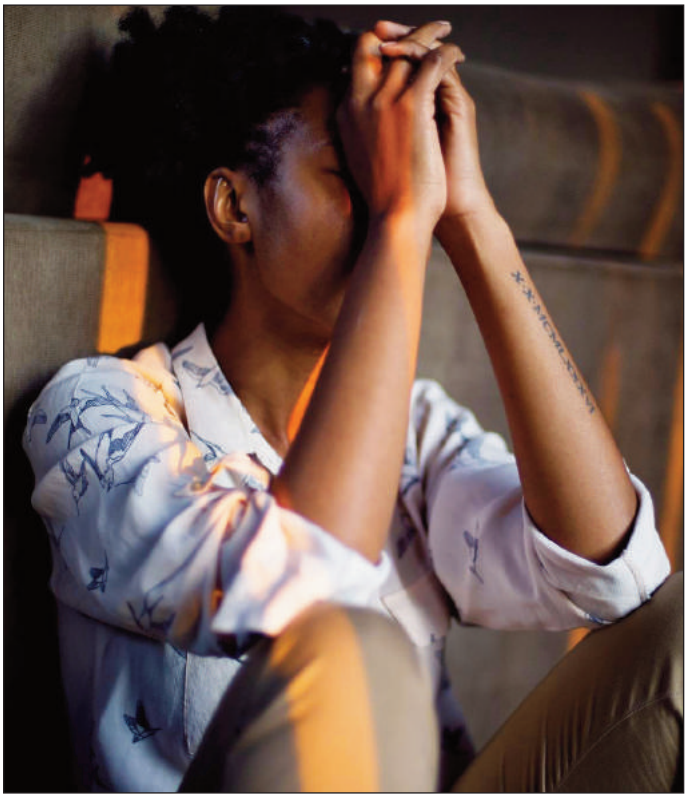
The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

Pressures on mental health services being felt by GPs on frontline



A new survey from Pulse has revealed how the pressure on mental health services has led to GPs having to provide specialist mental health support that they say is beyond their competence.

The survey of 569 GPs, which looked at the effect of the Covid-19 pandemic on mental health services at the GP level, found that 70% were providing mental health support outside of their competence to children, and 63% for adults.

Pulse reported that GPs were also having to provide:

- Dealing with suicidal ideation in adults (86%)
- Dealing with mental health crises in adult patients (81%)
- Monitoring patients who should be monitored by a specialist team (70%)
- Diagnosing children and adolescents with mental health issues (69%)
- Dealing with suicidal ideation in children (66%).

GPs are seeing a massive increase in mental health problems in consultations: pre-covid only 25% of consultations had a mental health element, now the level is at 38%.

However, when the GP needs to refer a patient to specialist services, they are finding it increasingly difficult to get patients the specialist help they need, as local trusts have raised the thresholds for both adult and CAMHS referrals.

Referrals are continually rejected, noted many GPs, even when they state clearly that they can progress no further and there are no other options. Waiting times for some specialist services – such as ADHD and autism assessments for adults and children – are now exceeding 18 months.

GPs are having to tell patients to go private, but for many patients this is not an option.

Dr Richard Van Mellaerts, a GP in Kingston upon Thames and BMA GPC executive officer, told Pulse that: 'The wait time for CAMHS is so long now that it becomes almost useless for all but the most significant and serious of mental ill health. And if patients lack the resources to go private, they are left in limbo.'

NHS England is working on changes to mental health

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services, including the introduction of mental health waiting-time standards, which include a 24-hour target for urgent mental health care. However, any introduction of such targets will be subject to Government approval.

And HSJ has seen a report on child and adolescent mental health services by Getting it Right First Time, an NHS England national programme, which contains 21 recommendations for changes to CAMHS services. This includes a recommendation for a major change in funding - moving to a system of funding by outcome or "therapeutic models" rather than the current 'payment per bed day' model. Other recommendations include a clear strategy to reduce the number of young people remaining in inpatient units for more than 60 days, and the implementation of new models of community care for young people on crisis pathways.

CAMHS is one of the most under-resourced areas of mental health and has relied for years on the private sector for capacity, despite regular damning CQC reports on services and hospitals.

All these changes, however, revolve around having adequate numbers of the right staff in the right place at the right time, and there is a heavy emphasis on community care. So despite all the good intentions of these recommendations and the introduction of waiting time targets - nothing will change for the better unless the lack of capacity and staff is addressed.

As The Lowdown has written about time and time again, the increase in mental health need in the population was clear prior to the pandemic and the escalation in need driven by the pandemic was widely predicted and is now fact, so there is no excuse for funding not to have been put in place well over a year ago.

Just for the area of eating disorders, which has seen an 'explosion' in demand in the past two years, the NHS Confederation has recently called for £12 million in extra funding over the next two years to ensure that children and young people's eating disorder services are back on track.

The government needs to address children and young adults' mental health needs with the same level of attention and extra funding, as it does elective care waiting times, say NHS mental health leaders, and this needs to run alongside a further commitment to roll out mental health support teams in schools and colleges nationwide. The Government's target is 25% access to mental health support teams and this needs to be increased to 100% blanket coverage so that every school and college has a support team in place.

Care worker shortages resulted in 170,000 hours of homecare not being delivered

Almost 170,000 hours a week of homecare could not be delivered in the first three months of 2022 due to a shortage of care workers, according to the latest Waiting for Care and Support report from the Association of Directors of Adult Social Services (ADASS), and the number of people waiting for assessments, reviews or care to begin is now at over half a million.

The first three months of the year saw a 671% increase in unmet hours compared to spring 2021, according to the survey, which also found a 16% increase in the number of hours of homecare that have been delivered compared to spring 2021.

The number of people waiting for assessments, reviews, and/or care support to begin as of February 2022 was 506,131, a significant increase from the 294,353 people reported as waiting in September 2021. The burden of care is increasingly being passed to friends and relatives.

As the report notes: "This means that people will be waiting without support and relying on unpaid/family carers….. Others will not be living a decent life and are likely to be deteriorating (becoming dehydrated or malnourished or falling for example). A proportion will need admission to hospital or will see their health and wellbeing deteriorate significantly."

More than six in 10 councils that responded (61%) to the survey said that due to a lack of care workers they were having to prioritise assessments and were only able to respond to certain cases, such as where abuse or neglect had been highlighted, those due to be discharged from hospital or from a temporary period of residential care to support recovery and reablement.

ADASS received 94 responses to its Waiting for Care and Support survey, a 62% response rate and the results have been extrapolated to represent figures for 152 local authorities.

Sarah McClinton, ADASS president said: 'We have not seen

the bounce back in services after the pandemic in the way we had hoped. In fact, the situation is getting worse rather than better.'

The latest data from Skills for Care show that home care companies and local authorities are struggling to recruit staff, with the vacancy rate continuing to rise over the last year, with a new high of 13.5% for domiciliary care in April 2022 (8.3% in April 2021).

This is not a new situation, nor one created by the pandemic, care workers have suffered poor pay, terms and conditions for many years as a result of over a decade of cuts to local authority funding by the Conservative central government.

But now the lack of care workers has been made very much worse by the triple whammy of - immigration issues that are part of Brexit, the Covid-19 pandemic, and the cost of living crisis. The Independent reports figures from the Care Workers Charity that show a record number of care workers are facing homelessness as they struggle with low pay and rocketing costs for food and energy. Despite working full time many have to switch off heating in their homes, rely on Universal Credit or handouts from family.

It is no surprise that care workers are now leaving for better paid work outside the sector, including in the NHS, cleaning, and retail, where they can command higher hourly rates. With advice from government ministers on national TV (Rachel Maclean talking to Kay Burley on Sky News) being to find a better paid job if you are struggling or work more hours, there will soon be no care workers left.

As well as the high level of unmet need for many in the community, the problems in home care have a knock-on effect - NHS hospitals struggle to discharge patients back home, which in turn reduces beds available for patients from A&E and for elective care, which contributes to ambulance waits, cancelled clinics and cancelled operations, and makes it more difficult for hospital trusts to reduce waiting lists and respond to emergencies. Furthermore, prolonged stays in hospital can increase the risk of infection for the patient and a deterioration in physical and mental health.

HSJ has reported that nearly 600 patients waited 10 hours or more in the back of an ambulance to be transferred into emergency departments in April 2022, with one wait of 24 hours recorded. At the end of March 2022, the waiting list for NHS hospital care in England reached another record high at almost 6.4 million. The data also reported that an average of 12,589 beds were filled with patients who were medically fit to be discharged during March, and this was a limit on hospitals' ability to admit patients and perform planned surgery.

Inadequate provision of social care is one of the reasons why the NHS is struggling, noted Chris Hopson, the chief executive of hospitals body NHS Providers, along with a 10-year budget squeeze, lack of capacity in hospitals to treat the number of patients turning up, and major staff shortages.

Despite reforms to social care announced back in December 2021, which had a lukewarm reception, and promises of money from the health and social care levy (£5.4bn over the next three years) as part of the government's reform plans, things are getting worse, not better.

Dr Jane Townson, the Homecare Association chief executive, said: 'Far from fixing social care, the government's policies are steadily weakening it. We continue to call on the government to invest properly in homecare so we can build capacity and reduce unmet need, take pressure off the NHS and help people live well at home and flourish in their communities.'

And Cathie Williams, ADASS Chief Executive, said: "We need a funded plan so that we can ensure that everyone gets the care and support they need, with more of the Health and Social Care Levy being used to fund care and support in people's homes and communities over the next two years. People cannot wait for funding trickle into adult social care and wider community services".

Overhaul of commissioning could hit specialised services delivery

The introduction of integrated care systems (ICSs) this summer, triggering a major overhaul of commissioning responsibilities, could have a negative impact on the delivery of specialised services – which range from chemotherapy, radiotherapy and kidney dialysis to treatment trials such as mitochondrial donation – across England, according to a group of major hospital trusts.

In a letter, leaked last week to HSJ, the Shelford Group of teaching and research trusts warned NHS England (NHSE) two months ago that the provision and quality of these services risked being diluted by "the wholesale [transfer] of commissioning of 80-90 per cent of specialised services to an ICS footprint".

The group – which includes University College London, Imperial College Healthcare and Guy's and St Thomas' Trusts among its membership – suggested the changes could lead to a post-code lottery in provision. It highlighted the risk that ICSs will now "focus on high-volume services for their local population, leading to de-prioritisation of [such] services, and/or an inclination to support development of services within that ICS' footprint, as opposed to at the optimal level for ensuring clinical quality".

Seemingly of less concern to the group, however, was the spiraling cost of specialised services provision. That cost reached £19.3bn in 2020-21 (equivalent to 17 per cent of the NHS' entire budget), and is predicted to rise to £25bn by 2025.

This level of funding has up until now allowed NHSE to directly commission all 149 'prescribed' specialised services. But according to a recent government policy paper outlining the implications of the recently passed 2022 Health and Care Act, NHSE will now gradually transfer direct commissioning responsibilities to "other NHS bodies, individually or jointly", and instead assume an "assurance" role, overseeing the commissioning activity of those bodies, while continuing "to have responsibility for developing and setting standards nationally, which local healthcare providers will be expected to follow".

The national body will, however, retain direct responsibility for 'highly specialised services' – services such as liver transplants, and enzyme replacement and proton beam therapies, rarely made available to more than 500 patients each year – which are currently delivered nationally through "centres of excellence".

In a follow-up policy paper, the government dodged the funding implications of the changes to how specialised services are commissioned, and instead positioned the Health and Care Act

as an essentially positive outcome for patients as well as clinicians, by allowing NHSE to introduce 'integration measures' that will "ensure services are designed (and investment is made) with the whole patient pathway in mind".

This argument is tentatively supported by the Nuffield Trust, which recently argued that putting some specialised services into ICSs could help align incentives and lead to better service integration or investment decisions – suggesting, for example, that combining the commissioning of both transplantation and dialysis would align the incentives to increase the former in order to control the costs of the latter.

The Trust adds, however, that the theoretical advantages of joining up one set of services could potentially be outweighed by the risk of creating new fragmentation with others.

Historically, specialised services have been prey to the same structural and financial constraints and reorganisations as the rest of the NHS over the decades.

National level planning was formalised in 1983, when the Supra regional services advisory group was set up. Responsibilities were later devolved, first to primary care trusts in 2002, and then to national and regional specialist commissioning groups in 2006. Six years later commissioning was further fragmented following the 2012 Lansley reforms, which led to the creation of clinical commissioning groups.

How the latest changes, ushered in by the 2022 Health and Care Act, pan out only time will tell. The Shelford Group told HSJ it was generally supportive of the ICS reforms despite its misgivings over commissioning but, given the size of the NHS budget allocated to specialised services, the sector is bound to remain the focus of Tory ire. With the ink barely dry on the new legislation, only last week the Telegraph decided to run a story on what it called "an explosive report" from Policy Exchange. The right-leaning thinktank's publication called for particular scrutiny of how specialised services were commissioned, suggesting the sector had "largely evaded political scrutiny"..

Martin Shelley

New NHS organisations launched but are already in deficit

As the July lift-off day for so-called Integrated Care Systems (ICSs) draws closer there is little sign anywhere in the NHS that the new system will offer any significant change or benefit.

They will not herald either the demise of the NHS, which has so often been prematurely and unhelpfully pronounced by some campaigners, or the smooth coordination and integration of services claimed by deluded advocates of this second complete reorganisation of the NHS since David Cameron's Con-Dem coalition took power in 2010.

The first part of this survey warned that almost all of the ICS areas for which figures are available are already projecting substantial deficits in their first year in charge. Having now sought information on the remainder, we know that some – deliberately, or by omission – have published no information at all, but all those for which we have any data are facing deficits and outright cuts in spending this year, with no relief in sight.

Rumours that these deficits – which result from the abrupt withdrawal of "non-recurring" funding streams that helped to keep most trusts and CCGs out of the red during the pandemic years of 2020 and 2021 – could add up to as much as £4 billion have been published in board minutes.

In some cases regional totals giving credence to this level of problem have also been divulged. The initial deficits of four of the five London ICSs alone add up to over £1bn (South West London £256m; North West London £300m before being squeezed down to the current £94m; North Central London £359m; NE London £100m). Outside London several board papers refer to a South East Region total of £693m; and available ICS figures in North East and Yorkshire add up to £577m.

The Lowdown has been sounding the alarm over the grossly inadequate funding settlement in Rishi Sunak's spending review last autumn: of course ministers have toured newsrooms to assure gullible interviewers that the NHS was going to be given plenty of money.

But now more and more finance chiefs are echoing the HSJ's recent warning that "Every health system to face real-terms funding cut in 2022-23" which calculated the real terms inflation-driven cuts ranging from 2.1% in North Central and South East London down to 0.2% in Buckinghamshire Oxfordshire and Berkshire West.

These may seem relatively small changes, but the percentages relate to very large sums of money, and every cutback comes after years of relentless efforts at cost-saving. These reductions in purchasing power run alongside actual cuts in

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many ICS budgets as part of a "convergence" process to make funding more equal by spending down for most and increase it by a fraction for a few.

This real-terms cut also links up with actual reductions in budget – from the ending of funding streams for Covid patients (cut by 58%) and complete cessation of funding for the Hospital Discharge Programme. This second change is set not only to pull tens of millions from many trusts' budgets, but also to rapidly worsen the problem of finding suitable support to enable the discharge of patients from front line beds.

The cut of HDP funding appears to be resulting in every instance in trusts and commissioners agreeing to axe the services that were provided from 2020, since even though most seem to argue that the policy was a success, they can't face making cuts elsewhere big enough to keep it going.

This is already beginning to take its toll as hospitals fill up, lacking beds for elective patients and emergencies – as waiting lists rise to 6.4 million and A&E performance bumps along way below performance targets, apparently concealing tens of thousands of 12 hour delays to admission.

Salisbury Hospital alone reports already having up to a third of its 396 beds filled with patients medically fit for discharge. The continued unresolved crisis in social care and the axing of NHS support mechanisms mean this can only get worse, no matter what the happy clappy rhetoric about integration.

And with hospitals running at or close to 100% capacity, for many, like Frimley, the current year means that "All contracts will be block with no new money coming into the system centrally unless elective activity exceeds the 104% target." And with no spare capacity, there is no scope even to reach 104%, let alone exceed it.

The scale and universality of the cuts imposed as core funding suddenly reverts to pre-Covid (2019/20) levels means that some Board papers are once again actually using the word "under-funding" to describe why, having worked staff so hard for so long, they are now in this predicament. Mental health budgets, too, are being squeezed, with some systems deciding not even to pretend and simply stating that there is not enough money to implement targets, for example for expanding IAPT talking therapy services.Others state outright that they have taken on more staff to improve community services during the pandemic – and now have to decide whether to get rid of them again or find ways to cut other services to pay for them.

As CCG and trust committees are informed of the state of play, some, to their credit, express dismay at how late in the

day information has been revealed, meetings convened and decisions have been taken.

What I find astounding is the number of CCGs and even Trusts that are meeting in April and even May, weeks in to the new financial year, with meeting agendas and papers focused exclusively on their performance in the last year gone by, with no hint of awareness or concern about the immediate situation and the future. We know from their neighbours that no regions are immune from the pressures to come – and ostrich tactics can only delay the recognition of the problem.

We can assume that, for at least some finance chiefs this reticence is because they are reluctant to share the information, or allow the bad news to leak out. Some trusts have opted to discuss their financial plight only in the private sessions of board meetings, or issued evasive financial reports – promising reports that don't materialise – or resorting to publishing meaningless lists of aspirations and NHS England targets without any discussion of the financial implications, affordability or availability of staff.

As we reported in the previous survey, many of the most substantial forecasts of deficits have been cosmetically dealt with by promising ever-more ambitious and unlikely targets for CIPs ("cost improvement programmes"). Some plans aim to save as much as 6.2% of their budgets. Cambridgeshire and Peterborough ICS promises to deliver 4.8% savings for three successive years: but we all know targets above 2% per year have seldom been achieved or sustained.

Resigned to deficits

But this raises another crucial issue. NHS finance wonks have for decades managed to primp figures and fiddle away deficits, or (as they did with Sustainability and Transformation Plans) use and even inflate deficits to improbable and unmanageable levels, to make the argument for changes that would otherwise be dismissed as unacceptable – only to ignore the figures later.

So if trusts across the country are this time really going to be forced by the new ICSs to cut substantial services, staff numbers, or quality of care – as the HSJ warned back in the spring would be the case – the consequences could be serious.

Fortunately it seems, at least from the current evidence, that the ICSs are more or less resigned to commissioners and providers running up deficits, although keen to keep them as small as possible.

Numerous trusts report having been persuaded to find (effectively invent) more "efficiencies" to reduce their initial deficits, but none have reported any likelihood of action by ICSs to force trusts into line.

Indeed it appears that Regional chiefs within the NHS England structure are more likely to be trying to crack the whip (notably in the South West of England) than the partially-established and still powerless Integrated Care Boards, which will be left with an effective fait accompli when they take over in July.

It's also worth remembering that for the eight smallest ICSs, with fewer than 1 million population and in most instances already run by merged CCGs covering one or at most two counties, and for a number of the others covering a single county, the trappings of "Integrated Care Systems" has always been a bit of a bluff and a fraud. They are just basically revamped CCGs – but less democratically accountable, and now since the Health and Care Act, more vulnerable to central intervention.

A time to challenge

As the new system cranks up for July the same constraints will apply to ICB/ICSs as applied to CCGs – and perhaps even a bit more.

Cutbacks that damage patient care, even if forced through in private, will eventually emerge as a great, stinking embarrassment to local politicians: and with the formal establishment of ICBs and grudging acceptance that places on them could be taken by elected councillors rather than servile chief executives, this could now cause more ructions than before.

But to maximise the chance of ructions campaigners and the public need to get digging now through published papers of every ICB and local trust to ensure that every significant erosion of the NHS is publicised and challenged.

There are only 42 ICS to keep track of, compared with over 200 CCGs when they were first set up. There are campaigners in many areas with the skills needed to follow every move they make. And with local government taking responsibility for decisions, council leaders must also be challenged and held to account.

It's not what the Tories planned to come out of the Bill, but their latest "reform" could have actually made it harder at local level to continue the austerity regime and the erosion of the NHS that they thought would be centrally driven through ICBs.

As the ICBs prepare to take over, let's not pronounce the 'death of the NHS', organise wakes or funerals, or in any way give up on defence of the valuable services that only the NHS provides: let's step up the fight to keep it alive and kicking through its 75th anniversary next year, and beyond!

● *For space reasons the third, and final, part of this survey, focused on London's five ICSs, will appear in our next issue.*

● *Author John Lister is joint author with Jacky Davis of the new book NHS Under Siege: the fight to save it in the age of Covid, published May 19 by Merlin. It is reviewed by Roy Lilley here. You can purchase it online here.*

	Population	Allocation £bn	Spend per head £	Financial position 2022/23
North East and Yorkshire				
Humber & North Yorkshire:	1.77m	2.778	1,563	£140m deficit: CIP target 4%
North East and North Cumbria:	3.13m	5.488	1,742	£240m deficit
South Yorkshire and Bassetlaw Integrated Care System:	1.48m	2.396	1,610	£76.5m deficit (reduced from £140m draft plan)
West Yorkshire and Harrogate Health and Care Partnership	2.6m	4.018	1,529	£121m financial gap in initial plan
North West				
Cheshire and Merseyside Health and Care Partnership	2.7m	4.018	1,769	£219m deficit in initial draft plan
Greater Manchester Health and Social Care Partnership	3.13m	4.810	1,628	Not known.
Lancashire and South Cumbria	1.8m	3.191	1,758	£370m "system gap" reduced to £90-£100m – requires 5% CIPs from each organisation
Midlands				
Coventry and Warwickshire	1.04m	1.530	1,449	£37.9m deficit
Herefordshire and Worcestershire	812,712	1.277	1,556	Deficit: CCG & both acute trusts in the red
Joined up care Derbyshire	1.05m	1.812	1,626	In-year planned deficit of £196.8m. After efficiencies £89.9m deficit.
Leicester, Leicestershire and Rutland	1.17m	1.620	1,363	System plan showing a deficit of £27m plus £77m of "risk that is not mitigated"
Lincolnshire	801,457	1.287	1,592	System in national recovery support programme, discussions with NHSE on deficit plan
Live Healthy Live Happy Birmingham and Solihull	1.57m	2.381	1,503	System deficit of £48m
Northamptonshire Health and Care Partnership	1.23m	1.173	1,436	£49.7m deficit, reduced from initial £118m and £75.7m
Nottingham and Nottinghamshire:	1.23	1.895	1,522	£96.7m system deficit forecast (£59.7m attributed to NUH)
Shropshire and Telford and Wrekin		0.827	1,582	£13m deficit
The Black Country:	1.27m	2.051	1,600	£48m deficit
Together we're better – Staffordshire and Stoke-on-Trent	516,452	1.876	1,596	System plan submitted with £48.2m deficit, reduced from £78.4m. Underlying deficit £133.4m
East of England				
Bedfordshire, Luton and Milton Keynes	1.06m	1.492	1,390	Anticipated efficiency ask across BLMK system of £56m
Cambridgeshire and Peterborough	1.0m	1.424	1,408	System Partnership Board March 30 projected break-even (assuming **4.8% efficiencies, £52m** from Elective Recovery Fund, and only **2.8% inflation**) Total **unmitigated risks £77m.**
Hertfordshire and West Essex	1.61m	2.349	1,450	No clear information. West Herts and East & North Herts trusts have deficits of **£15.3m** and **£54m**.
Mid and South Essex Health and Care Partnership	1.25m	1.912	1,518	Initial expectations of need for £65-£70m of efficiencies to balance books increased to £85m.
Norfolk & Waveney	1.08m	1.757	1,613	System draft plan shows £51.2m deficit
Suffolk and North East Essex	1.04m	1.614	1,536	No clear information
South West				
Bath and North East Somerset, Swindon and Wiltshire	980,516	1.37	1,403	Plan submitted for £58.6m deficit
Healthier Together Bristol, North Somerset and South Gloucestershire	1.06	1.54	1,462	No clear information with CCG and trusts all focused on last year's performance.
Cornwall and the Isles of Scilly Health and Care Partnership	596,230	0.987	1,641	No system figure but Royal Cornwall Hospital Trust forecasting **£28.8m deficit** (with CIPs of 6.2%) "within the context of a system deficit".

Devon	1.27	2.06	1,622	"Deficit is second highest (proportional to allocation) in the region at 5.5%: **it has reduced by £27m to £104m**."
Our Dorset	819,184	1.33	1,627	March CCG Board papers: "Work is ongoing to identify and reduce the **underlying CCG and system gap for 2022/23.**
One Gloucestershire	676,860	0.963	1,423	No figures published. **Gloucestershire Hospitals FT** in April expected its Operational Plan "would reflect a **system deficit** which was in line with most other systems in the South West".
Somerset	596,836	0.956	1,603	System plan **deficit of £20.3m** for 2022/23
South East				
Buckinghamshire, Oxfordshire and Berkshire West	1.93	2.5	1,291	No useful information on finances published by BOB ICS or CCG. Oxford University Hospitals FT reveals "The ICS has made a 'flat cash' proposal to its providers...."
Frimley Health and Care	808,083	1.11	1,380	ICB **deficit £36m** (Frimley Health FT May Board)
Hampshire and the Isle of Wight	1.92	2.9	1,514	**Deficit across provider and commissioner of £105.6m,** improved by **£60.8m** from initial draft submission (HIOW CCG May).
Kent and Medway	1.95	3	1,526	"System plan **£85m deficit** and **South East Region £693m**" "... all acute trusts in Kent currently showing **deficits,**" (Dartford & Gravesham April Trust Board)
Surrey Heartlands Health and Care Partnership	1.22	1.65	1,471	"The ICS submitted second iteration of financial plan for 2022/23 which predicted a **deficit of £143.27m** (Ashford & St Peters May Trust Board)
Sussex Health and Care Partnership	1.82	2.92	1,604	**No ICS/CCG figures published** but major Trust (Uni Hospitals Sussex) has **core gap of £57m**, and aiming for **£44m CIPs**. ICS document Sussex 2025 is 24 pages of uncosted aspirations despite admitting **"We are currently spending more money than is available..."**
London				
North Central London Partners in health and care	1.73	2.6	1,503	NCL position **"currently showing very significant deficit"**. **Cumulative deficit of £359m** (Camden & Islington FT, March). NCL **"faces one of the biggest funding reductions"** – deemed to be "over-funded".
North East London Health and Care Partnership	2.32	3.34	1,424	Initial draft financial plan indicated **£100m deficit** (Homerton Trust Board April)
North West London	2.72	3.71	1,363	Draft ICS financial plan showed a **deficit of £94m** (£69m London Ambulance Service, £25m Hillingdon Hospital). £94m figure an improvement on earlier reported figure of **£300m**. (West London Trust.)
Our Healthier South East London	2.04	3.28	1,600	No details on draft or other plans for 2022/23: **system is in "financial recovery" requiring 3% efficiency savings** (South London & Maudsley May Board) £46.5m "convergence" reduction to ICS budget (Oxleas March board)
South West London Health and Care Partnership	1.73	2.41	1,395	SW London CCG meets only 3 times/year – last met in February. **£256m "challenge"** across SW London system in 22/23 (One Croydon H&C Board, May).
England Totals	**61.5**	**94.6**	**1,538**	

ICB sitrep, regional round-up pt 2

East of England

Bedfordshire, Luton & Milton Keynes

The merged CCG Governing Body meeting in March revealed that they were depending upon costly consultants from Deloitte to develop their plans for up to £56m of "efficiency savings), which involve triangles and envelopes:

"Between the submissions, more triangulation is needed across workforce, activity and finance information. Each organisation across the system has been asked to focus on this internally, and Deloitte will be supporting this work through the NHSE triangulation tool. As mentioned above, we will need to do more triangulation with our non-acute partners, and put in place a system transformation and system efficiency programme to ensure we can live within the envelope provided."

"Taken together, with the current financial plan gap and already identified mitigations – the CCG has a risk adjusted financial gap of c£14m [up to £18m]."

Cambridgeshire and Peterborough

The System Partnership Board meeting on March 30 projected a 'break even' for all partner organisations … but only on the most tenuous basis:

"The Board is asked to note that the plan contains a significant level of risk, including:

• Delivery of c4.8% efficiencies, including a significant reduction in covid-related expenditure

• The … assumes a significant level of ERF [Elective Recovery Fund] contribution can be achieved

in-year (net £52m) as well as a reduction in covid costs.

• … our plan assumes c2.8% inflation but we know that economic pressures will be a challenge to this, as well as ongoing challenges on Continuing Healthcare and GP Prescribing." (p4)

Despite ministers' constant claims of extra funding, the finance paper warns:

"Effectively, this will require total system expenditure to remain at or marginally below planned inflation (flat real)," and this is far from certain: "the plan articulates total unmitigated risks of c£77m."

North West Anglia FT (Peterborough & Stamford) Board in April noted "Virtual Wards feature heavily in the Operating Framework for 2022/23. There is an expectation that we build at pace Virtual Wards to accommodate 15% of patients across the C&P system who otherwise would be delayed in hospital or admitted into the Trust. But the Trust is less than galvanised into action:

"We would be required for our population to supply 250 'virtual' beds. … In line with this we implemented two virtual wards at NWAFT offering up to 30 beds." (p76)

Hertfordshire and West Essex

No clear information on the state of play in this ICS. The Trusts are all predicting deficits. West Hertfordshire Teaching Hospitals Trust May Board meeting was told "The [22/23] plan at this stage results in a £15.3m deficit of income over expenditure. … Other allocations may need to be re-directed if deficits are to be avoided." (p409)

East & North Hertfordshire Hospitals' May Board meeting shows an underlying deficit for every month of 2021-22, resulting in an above forecast deficit of £54m that was covered by non-recurring income (p92). Its Elective Recovery Board Update avoids any mention at all of the cost and affordability of delivering the proposed increases in elective care. (p144 ff)

Princess Alexandra Hospital Trust's April Board papers show: "The financial plan was discussed and members were partially assured [sic] as further work is required to reduce the planning gap of £14.8m." (p132)

Mid and South Essex Health and Care Partnership

March meeting in common of Basildon & Brentwood CCG, Castle Point & Rochford CCG, Mid Essex CCG, Southend CCG and Thurrock CCG notes repeatedly that the system faces an underlying deficit, and the need to:

"Achieve key statutory financial duties including delivery

of the system financial control total, value for money and reduction of the underlying system deficit.".

"Initial expectations were for a system expectation of c. £65m-£70m of efficiencies during the year, both cash-releasing savings and productivity improvements. As the financial plans have developed over the past month this challenge has risen to c.£85m…" (p87)

However Mid and South Essex had seen hospital waiting lists size increased by around 39,000 patients since start of financial year to 128,605 – with 4,571 patients waiting over 52 weeks and 889 over 78weeks (18 months).

Mid and South Essex Foundation Trust has been concentrating its efforts on encouraging more patients to travel to private hospitals (ISPs) for treatment.

"397 patients have been identified from the admitted waiting list for transfer to ISP from the digital patient questionnaire.

"… Sharing waiting times with patients is resulting in increased patient appetite to travel to ISPs" (p4)

Norfolk and Waveney

The CCG's 2022/23 Draft Financial Plan explains:
"The pre-mitigation deficit of £49.4m driven by the following major items:

- [Community Health Care] CHC and other package cost pressures – £28.7m (this is driven by historic cost inflation and growth pressures above the levels funded.)
- Hospital Discharge Funding - £11.0m
- Other growth and inflationary cost pressures – £13.5m" (p112)

Norfolk & Norwich Hospitals FT April Board papers reveal and underlying deficit (2021/22 Normalised Outturn) of £39.2m (p122)

Queen Elizabeth Hospital Kings Lynn has a chronic problem of a collapsing hospital building with a roof constructed from Reinforced Autoclaved Aerated Concrete (RAAC), is and constantly having to fight for the resources to keep it moderately safe: The Trust's April meeting heard:

"QEH will receive £80m for RAAC 2022/23-2024/25 (3 year) RAAC capital programme, which is £70m less than the quantum of funding required to ensure the current hospital is fully safe and compliant. We continue to lobby for further national capital to close this gap." (Corporate Strategy page 8)

Suffolk and North East Essex

No sign of forward planning or any detail of financial prospects in board papers of West Suffolk, Ipswich or North Essex CCGs, or East Suffolk and North Essex FT. Could this be the ICS that manages to avoid any discussion of deficits in 2022/23?

South West

Bath and North East Somerset, Swindon and Wiltshire

Like many areas, BaNESSW faces real problems with the scrapping of funding to assist with more rapid discharge of patients after treatment. The CCG Governing Body in March noted funding for this had totalled £30m in 2021/22:

"Funding for this additional capacity was currently funded through the national Hospital Discharge Programme (HDP) fund and those monies that had been made available at year end to support the Omicron surge. This was to discontinue on 31 March 2022, detailed work was underway to look at discharge and capacity plans for 2022-23 to understand the recurring requirements. Difficult conversations were to be held with system partners to consider the choice of investments against the limited allocation." (p6)

HDP funding is just one of the streams of non-recurrent funding boosts that have been withdrawn or cut back in 2022/23: the CCG CEO's report states:"This has manifested itself for BSW in a baseline reduction in funding of £48m particularly in areas such as the Hospital Discharge Programme where we have seen complete cessation of support schemes ceased and with covid where support has halved."

Despite a "minimal upside" of an extra £3m from convergence measures to get systems closer to their fair shares target, based on the needs of their population, the area is still £18m below target funding. As a result "The system has struggled to respond to this size of reduction and submitted an unbalanced financial plan with a deficit of £58.6m."

But while nationally these are "deemed to be 'acceptable' deviations from plan," from excess inflation and non-recurrent covid costs which account for £40.2m of the gap, Regional chiefs are taking a tougher line:

"Feedback from the Region is that they are expecting systems to break even and will be requiring us to take steps towards closing the gap – the challenge for us is how much further can we go towards break even." (p31)

Swindon's Great Western Hospital April Board papers

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note that the problems are widespread:

"An in-depth discussion of the Draft Plan for 2022/23, focusing on the high level numbers. The draft Plan for 2022/23 shows a deficit of £26.7m at this stage, largely due to the withdrawal of non-recurrent Covid and associated funding. Other Acutes in BSW and elsewhere are facing similar pressures."

Salisbury Hospital FT May Board papers show concerns which are affecting many trusts, not least with around a third of its 396 beds filled with patients who have completed their treatment and care episode within Salisbury Hospital and are deemed able to be discharged, but can't be. "As a consequence of this the hospital [which is running at 100% capacity] has significantly reduced patient flow and cannot properly function as clinically intended."

The need to reduce numbers of these NC2R [No Criteria to Reside] patients is just one of the "significant risks to be managed" as well as covid-19 staffing absence reducing, inflation not exceeding current assumptions, elective productivity increasing as planned, additional staff being recruited and £4m of unidentified cost improvement plans being achieved.

The Trust is one that cannot sign up to the NHS target of recovering elective capacity up to 104% of pre-pandemic levels: "instead a "targeted" approach has been adopted, based on what is felt to be achievable given the Trusts current operational constraints."

It is forecasting a £18m deficit, which will lead to pressure on cash management towards the end of the financial year." (p31)

There are problems in mental health, too: **Avon and Wiltshire Mental Health Partnership NHS Trust** has a predicted £34m underlying deficit exiting 2021/22.

"This includes the cost contribution that is currently being made on Out of Area beds (where the internal bed base is being exceeded) and the significant cost premium associated with a high use of agency staff to cover vacancies and high rates of absence."

The Trust has been told it will receive £24m of system funding support in 2022/23 to contribute towards this underlying deficit and continued expenditure related to COVID. This leaves a total efficiency requirement of £8.4m," (p110) but so far the Trust has only identified recurrent savings of £2.3m leaving a current savings gap of £6.1m. (p117)

Healthier Together Bristol, North Somerset and South Gloucestershire

Even in May this CCG's Governing Body papers focus exclusively on 2021/22 year gone by, giving no sign of serious discussion of financial pressures in 2022/23 or NHS England demands for increased productivity.

The picture is of worsening waiting list performance, with numbers increasing of patients waiting over 52 weeks and numbers waiting over 104 weeks.

62 day referral to treatment time for BNSSG cancer patients also worsened in January to 61.43%: the 85% national standard has not been achieved at population level since April 2019.

Cornwall and Isles of Scilly Health and Care Partnership

Interestingly this ICS quite openly reveals its concern to identify itself as a 'brand'. It has commissioned management consultants KPMG to provide support for the ICS and ICB, and will also be led by Price Waterhouse Coopers (PWC) who have been appointed by NHS England and NHS Improvement as the partner for the south-west region.

However it's not so clear that they have been any help on one of the main concerns of Kernow CCG – the lack of adequate support for patients discharges from hospital:

"There were approximately 100 patients medically fit for discharge in Treliske Hospital and a similar number in community hospitals. In addition, there were 75 COVID-19 patients, so a total of 275 occupied beds more than needed if there were no pandemic."

Royal Cornwall Hospital Trust has been at the sharp end of this, and its May Board papers reveal how it is under combined pressure:

"With the revised arrangements for the 2022/23 financial year just started and significant changes to both income available to the Trust (and wider Cornwall system) and our recurrent cost base the Trust is now facing a significant financial and operational challenge in the financial year just started.This change in income includes for example a 58% reduction in covid funding for the Cornwall system. The Trust's 2022/23 financial planning submission was approved by the Trust Board at an extraordinary meeting on 26th April in advance of the submission to national timescales on 28th April 22. The financial plan currently forecasts a significant deficit position for the Trust by March 23 within the context of a system deficit also."

"… For the Cornwall system and RCHT both the March draft plan and this updated submission remain non-compliant with this requirement. It is expected therefore that the Trust and system will be asked to consider further options to improve this deficit plan position." CEO report, p36

" … the Board have approved this submission on the basis of a £28.8m deficit, this represents a £4m improvement on the draft submission of £32.8m." (p302)

Devon

This county has a hefty projected deficit despite one of the highest per-capita levels of funding.

Devon CCG's April Governing Body was told:

"The Devon system has submitted its draft System 2022/23 Operating Plan which includes plans to work towards delivery of key elective care targets and address underlying issues that restrict ability to deliver elective activity. Operationally the ICS remains under extreme pressure with services competing for resources." (p37)

The 2022/23 Operating Plan admits that the deficit "is second highest (proportionate to allocation) in the region, at 5.5%. Work is continuing to improve the position and 12 April it has reduced by £27m to £104m. An expenditure review process is in place in early April to further impact." (p40) To make matters worse 50% of financial risks have no mitigating measures in place.

Torbay & South Devon FT April Board papers reveal the scale of the financial disarray in what was once a flagship modernising trust:

"The Trust submitted a draft operational plan to NHSEI for year end 2022/23 which showed a full year adjusted deficit of £32.71m. The plan was unlikely to be accepted by the regulators." (p24)

"The Trust currently has a planned adjusted deficit of £29.9m for FY 2022/23. The final plan will be submitted on 28 April to NHSE/I. The following areas are worth noting:

• The plan is unlikely to be accepted by regulators and further improvement would be required.

• The planned deficit of £29.9m is after the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives." (p56)

As with other trusts, it is running at full stretch – with negative consequences:

"In March, the overall bed occupancy at 95% continued to be above required levels to support patient flow to avoid emergency care delays and required the continued stepping down of routine elective capacity. Plans to reduce length of stay and reduce overall bed occupancy continued to be constrained by the levels of delayed transfers of care that averaged 60 patients per day who were classified as medically fit for discharge." (p103)

'Our Dorset'

CCG Governing Body's March Finance report discussed the loss of additional discharge funding, but also identifies a specific concern that is not widely discussed: personal health budgets.

"Personal Health Commissioning (PHC) budgets are showing an increased pressure of £5.0m against its annual budget. This is due to a rise in numbers of the more complex packages which incur higher costs, alongside inflationary pressures in excess of those rated in national guidance…. Continuing Healthcare (CHC) cost pressures are expected to be mitigated by nonrecurrent efficiency savings, but this represents a significant recurrent cost pressure into 2022/23." (p2 & p6)

University Hospitals Dorset March Board papers reveal the problems of failing to deliver promised cost savings:

"Cost savings of £3.8 million have been achieved to date against a target of £8.706 million, representing an under achievement of £4.9 million. The Trust is forecasting to deliver … a recurrent shortfall of £7.3 million against the £10.1 million full year target. This places a considerable pressure on future years budgets." (p56)

To make matters worse the hospital is running well above recommended levels of occupancy, "now consistently over 97% on both sites, which impacts significantly on both emergency and elective flow." (p15)

This lack of capacity is likely to prevent this and other trusts delivering the minimum 104% of baseline 2019/20 activity – and therefore limit the opportunity to draw on Elective Recovery Funding.

One Gloucestershire

Here, too almost no useful information about the state of play of CCG or trust seems to be published looking forward to 2022/23. CCG March papers suggest commissioners are quite happy to look for answers outside the NHS:

"Independent Sector elective activity is above originally planned levels, this additional activity has been agreed with the CCG as part of the overall System plans to improve elective waiting times and the continuation of activity at these levels, and beyond if possible, is planned for 2022/23 to help progress elective recovery within Gloucestershire." (p85)

Gloucestershire Hospitals FT April papers also duck the issue of the size of the deficit::

"A draft Operational Plan 2022-23 was due to be submitted by 17 March, with final submissions due by 28 April. It was expected that the first submission would reflect a system deficit which was in line with most other systems in the South West." (p6)

Somerset

While the CCG's March Governing Body finance paper gloated over breaking even in 2021-22 on the strength of one-off funding, the Chief Exec's report pointed to strains on still underfunded services:

"As at 22 March 2022, the escalation level for the whole of Somerset was OPEL Level 4, described as: "Four-hour perform-

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ance is not being delivered and patients are being cared for in overcrowded and congested department(s). Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised.

"… The key question to be answered is how the safety of the patients in corridors is being addressed, and actions are being taken to enable flow to reduce overcrowding.

"The expectation is that the situation within the hospital will be being managed by the hospital CEO or appropriate Board Director, and they will be on site. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered."

Somerset FT May Board Papers give a red rating to the risk of being unable to reduce demand for services to allow the system savings required to be delivered to meet the overall control total. (p95)

The Yeovil District Hospital group is working towards a planned deficit of £2.858m, "which forms part of the overall system plan deficit of £20.330m." (p411)

Somerset FT aims to limit the deficit to £8.176m, (p422) based on a Trust savings programme of £14.181m for 2022/23, (p423) of which "… As at the current date, just over 56% of the target has schemes either fully developed, in progress or being scoped." (p424)

South East

Buckinghamshire, Oxfordshire & Berkshire West (BOB)

Neither the CCG nor BOB ICS publish any useful information to gauge the financial situation for 2022/23. However two of the three major acute trusts are more forthcoming.

Oxford University Hospitals FT: March papers

"The Board is asked to comment on the draft finance plan which indicates that the £47m underlying deficit can be covered by underlying income. However, there is no clear source of funds for investment (other than in elective recovery) and agreed business cases may need to be delayed to achieve breakeven." (p2)

"7.1. The Trust ended 2019/20 with an underlying deficit of £45m. We estimate, after removing one-off items, the equivalent figure at the end of 2021/22 is £47m. (p11)

"7.8. The ICS has made a "flat cash" proposal to its providers which incorporates all the variable elements of the ICS funding into a single cash offer. (p12)

Buckinghamshire Healthcare Trust March Board Papers:

"The Draft financial plan for 22/23 … currently shows a deficit of £29m. There are additional downside scenario risks outside of the plan in the range of £8m-£10m, which would increase the deficit to £38m if downside risks materialised. In the best case scenario, if additional funding becomes available in line with a genuine "flat cash" offer, this would result in a deficit of £9m. There are two key drivers for the £29m deficit. Total income has fallen by £20m compared to 2021/22 and an additional £9m of investments have been funded." (p111)

However the Trust has a "Normalised" (underlying) deficit of £67m, so exactly how this is reduced to £29m is left more and a little hazy. (p149)

Frimley Health and Care

Frimley CCG May Board Papers report:

"… the Frimley system's elective plan was being supported with demand and capacity modelling commissioned by NHS England in the South East and provided by McKinsey and Company." (p8) Whether this has resulted in any benefit is not clear.

Frimley Health FT however knows it is up against it, and says so in May Board papers:

"The number of vacant hospital beds is probably at the lowest level we've ever seen, elective waiting lists continue to grow, and despite the opening of the new Heatherwood Hospital our total elective capacity is severely impacted by patients requiring urgent care and staying with us for longer.

… 2022/23 is probably going to be the most financially challenging year the Trust has ever faced. The Trust is planning for a deficit of £35.4m. This is particularly driven by the ongoing costs of Covid, operational pressures, and inflation which is far outstripping the assumptions made when the NHS funding settlement was agreed last autumn. The deficit of £35.4m is after taking account of a £28.1m (3%) efficiency programme, and an additional £15m of funding from the Integrated Care Board (which it currently hasn't identified the money for)." (p116)

"… The ICB deficit is £36m which includes the FHFT posi-

tion. The ICB position will carry a significant £27.9m risk which is the value of the deficit reduced from the draft submission and represents the system gap …" (p119)

Even hitting this target is dependent on non-NHS income:

• …this assumes private patients, car parking (staff and patients) and catering can return to 2019/20 levels …

• Heatherwood: the business case relies on £10m increase in PPU income at a margin of 28%. PPU income is 33% of the overall Heatherwood income value." (p125)

And the capacity of the Trust to claim a share of the Elective Recovery Fund is limited by the need to repair another dodgy roof, as the HSJ has noted:

"A well-regarded foundation trust expects to lose £9m for missing elective recovery targets in 2022-23, £2m of which is because it needs to close theatres to fix a dangerous roof.

"Frimley Health Foundation Trust expects to carry out 99 per cent of the amount of elective activity it did in 2019-20, short of the 104 per cent target set by NHS England and government in their elective recovery plan. As a result of this, the FT says, it will lose £9m in funding."

Hampshire and Isle of Wight

The CCG's May Board Papers don't beat about the bush: this ICS faces a substantial deficit:

"The financial plan position across the system represents a deficit across both provider and commissioner totalling £105.6m (3.2% of overall allocation). This is an overall improvement since our draft financial plan submission of £60.8m, but this not where the ICS wants to be, and our expectation is to further improve this position." (p2)

£86.2m of this is down to local providers, £19.2m to the CCG itself.

This deficit is after hugely ambitious efficiency savings amounting to £159.2m (4.6%), of which "we ascertain that at this stage c£66m of this is high risk."

The CCG estimates "uncontrollable costs" add up to c£65m – such as "inflation; energy/fuel; NICE approval for drugs; cleaning standards; capital charges on investments (basically understood pressures) and some COVID costs which will require difficult choices on spending". (p25)

Hampshire Hospitals FT in April initially projected a deficit of £25m, but is now proposing submitting a plan leading to a financial deficit of £18.7m, which "is higher than ideally required and certainly contains substantial risks of unidentified saving plans." (p251)

University Hospital Southampton March Board papers report: "The underlying financial position excluding ERF remains at c£4m deficit per month once ERF income is excluded." (p120)

"The trust has submitted its draft financial plan for 2022/23 indicating a £24.7m deficit. A separate paper provides more detail on the content of this." (p121)

Portsmouth University Hospitals Trust March board meeting heard the CEO warn: ""During the last few months we have operated consistently at OPEL 4 level. The number of patients we are seeing in the hospital has reached maximum occupancy levels of around 100% on several occasions with an average of 97.3% in February." (p22)

Isle of Wight May Board meeting heard that the Trust's deficit is projected as £22.5m (p92) after a reduction in Trust income of £20m compared with 2021/22. (p158)

Kent and Medway

Dartford & Gravesham NHS Trust April Board, hearing the Trust plan for a £5.4m deficit, heard: "Currently the draft plan does not achieve financial balance or all of the Trust operational and constitutional targets.

"The Trust is not alone in its financial and activity position with all acute Trusts in Kent currently showing deficits, (the Trust is the lowest proportionately to turnover) and struggling to achieve the operational targets. The system draft plan is for a £85m deficit and the South East region at a £693m. Nationally many regions also have planning deficits." (p226)

East Kent Uni Hospitals May Board papers report a "Draft plan for 2022/23 with a £22m deficit position, a challenging financial year ahead impacted by reduced Covid-19 funding and inflation and energy increased costs, including a £30m efficiency target." (p13)

Maidstone & Tunbridge Wells NHS Trust April Board was told "A breakeven position was unable to be included in the initial submissions, so a deficit of £9.7m had been submitted." (p11)

Surrey Heartlands

According to the HSJ "all five providers within Surrey Heartlands ICS have submitted plans for deficits – totalling £143.5m in 2022-23, according to board papers."

Ashford St Peters May Trust Board CEO report warns:

"The financial risks facing the Trust in 2022/23 are significant. The risks are interconnected and have potential to affect many areas including savings delivery, increased costs or income loss;

"… The ICS recently submitted its second iteration of the financial plan for 2022/23, which predicted a deficit of £143.27m. The Trust's predicted deficit within this, accounts for £24.45m.

It is worth noting that all five NHS providers in the ICS are in deficit. The system deficit position is likely to drive a third set of

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financial submissions from each component part of the system, including us. Other providers and the system itself will be required to find further efficiencies and opportunities to reduce costs. Overall, the challenge facing both the Trust and the system to achieve a much greater degree of efficiencies is unprecedented." (p3)

Surrey and Sussex Healthcare Trust March papers predict a deficit of £39.7m due to "a reduction in income that does not allow time to lose costs within the year and underfunding of pay and prices."

"The budget includes waste reduction plans that see Divisions and Departments returning to spend within their recurrent budgets from 2019/20 … (altogether this will total £17.8m, a 4.9% saving based on 2022/23 income)."

Royal Surrey FT March Board papers also carry the same message: "The draft plan is deficit -£20.0m compared to a current year [2021/22] surplus of £3.6m."

Sussex Health and Care Partnership

The ICS document Sussex 2025 – Our Vision for the future is 24 pages of non-stop aspirations, not one of which is costed, and with no plan for workforce, leaving many major questions unanswered, especially given the need to cut spending:

"We are currently spending more money than is available to run services and this means we are unable to invest in new innovation and ways of working that would bring real benefits to our populations. We need to change how we run services to ensure we get more value for the money that we spend."

University Hospitals Sussex Trust May Board meeting reports: "The Trust has submitted a plan of £12.55m deficit, which solely relates to excess inflation. Consideration of further support for this is being sought by the Trust and Sussex ICS, from NHSE/I.

"… To deliver the £12.5m deficit plan requires the Trust to deliver £44m efficiency savings (3.7% of Trust income)" (p55)

East Sussex Healthcare Trust April 12 Board paper notes that the Trust is effectively being penalised for having increased staffing:

"… changes to the way the Trust was funded for 2022/23 would present a significant challenge to the organisation. The funding would be based on a pre-covid 2019/20 staffing establishment baseline; since then, the Trust had appointed 532 more whole time equivalent (WTE) employees. Many of these additional staff were brought in to improve community services and help manage during the pandemic." (p16)

The Trust has also just bought up its own private hospital:

"The Trust was due to take ownership of the private Spire Hospital from 1st April, which would be renamed Sussex Premier Health. It was planned that all private patient services, as well as some NHS work, would be brought through the facility. Acquisition of the unit would bolster efforts to recruit and retain clinical staff and would offer patients greater choice. Any profits made by the venture would be reinvested into the Trust's clinical services." (p8)

Still to come... London's five ICSs

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