The lowdown

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

‘The NHS doesn’t need any more money.’ Is the health secretary right?

Like elsewhere in the economy, surging inflation is also depleting NHS budgets. Sajid Javid recently told the Times “the NHS doesn’t need any more money”, despite widespread calls for investment in extra staffing, instead he is pushing for more efficiency savings, a policy which NHS leaders are already saying is highly unrealistic.

What is enough?

Record funding helped to meet the challenge of Covid for two years, but health spending has since fallen back to £172m in 2022/3 – still a huge figure in comparison with other government departments, but the common view amongst economists is that it is far from enough. The huge backlog added to the damage done by an 8-year squeeze on NHS funding (2010-18) prior to the pandemic means that far greater and more sustained reparation is needed.

During Covid NHS funding reached £190bn annually, which was briefly on trend with where NHS funding would have been had it not been for the prolonged period of underinvestment (2010-18).

The NHS needs around 4% annually to cover growing health costs, according to calculations by the IFS and others – although climbing inflation will push this figure up too.

Before the pandemic rise in funding averaged around 2% across the previous 8 years. Then in 2021 Spending Review the government announced that funding was set to rise by 13% between 20020/21 and 2024/25, but this has been mostly front loaded and swallowed up in the tail end of the pandemic and the resulting backlog of treatments.

Over the next two years NHS funding is set to rise by just 1.2% annually, and that is very likely to be eroded by inflation, at a time when there are key areas crying out for long-term investment.

Workforce

With a 106,000 short fall in staff, NHS leaders have named the NHS workforce crisis as their top challenge and yet there is still no fully funded workforce strategy in place. Waiting lists are rising over 6 million and health professionals are worried about declining standards of service.

An RCN survey published this year found that:

– Eight in 10 (83%) said there weren’t enough nursing staff to meet all patient needs safely and effectively on their last shift.

– Just a quarter (25%) of shifts had the planned number of registered nurses.

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Less than one in five (18%) said they had enough time to provide the level of care they would like.

In key areas like cancer, specialists are worried that recent gains in survival rates could be lost because of delays. In a bid to speed up diagnosis the government plans to introduce 100 diagnostic hubs – mobile units in car parks and shopping centres, by 2025, but according to the Society of Radiographers lack of investment in staffing means that, under the plan the 6000 extra radiographers and other staff needed to run them will have to be transferred from elsewhere within the system.

The plan?

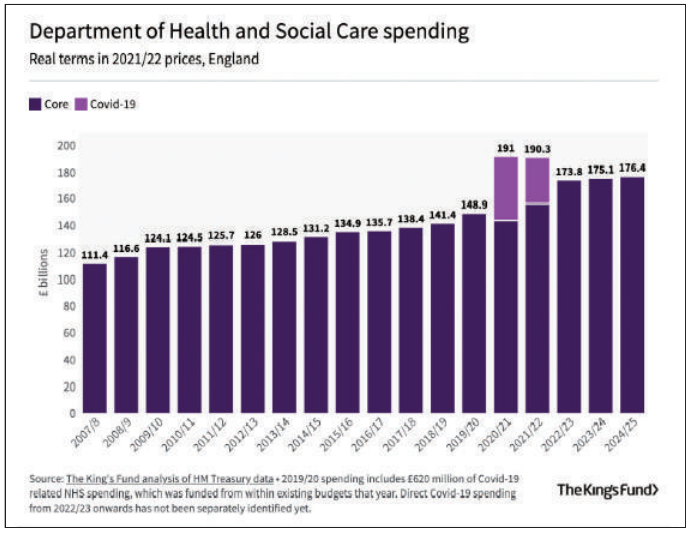
NHS England's People Plan, belatedly published back in July 2020 was full of analysis and ambition, but lacked the cash for implementation. It has since been confirmed in a speech by Sajid Javid in March that although a new long-term workforce plan is on the way any new investment to raise NHS staffing levels will need to be found from within existing NHS budgets.

The Treasury doors have been firmly closed, which limits the expansion of training places and the creation of the new roles that the service needs.

With every year of inaction the crisis gets worse. The REAL centre has revised their estimates because of the lack of progress on staffing, now saying that an extra 6,200 consultants (up from 4,400) and another 25,700 nurses (up from 18,300) will be needed, over and above existing NHS staff vacancies, in order to meet government targets for elective care by the end of the parliament.

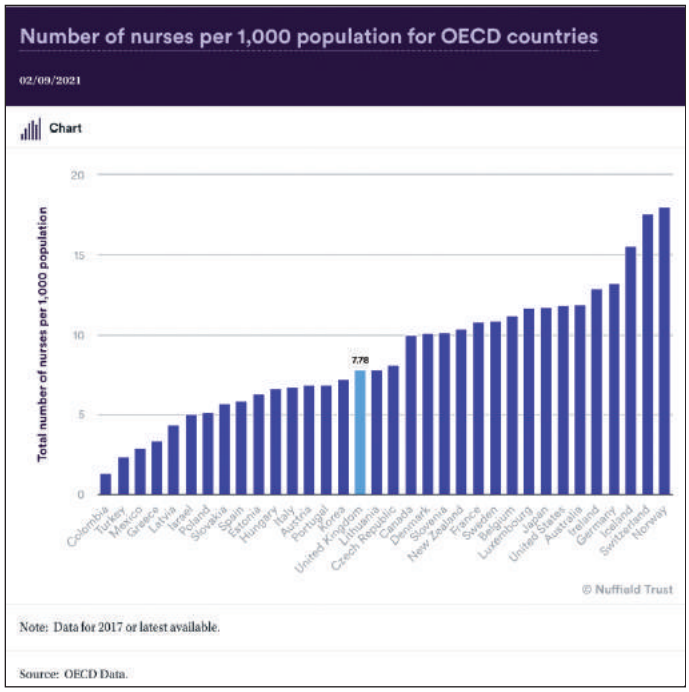
Jeremy Hunt, health secretary from 2012-18 now admits that "I was too slow to boost the NHS workforce". He can see the jeopardy the NHS is now in and from the back benches he makes a persuasive argument that it's a "false economy not too invest in staff", and has called for the reporting of staffing needs to be established in law.

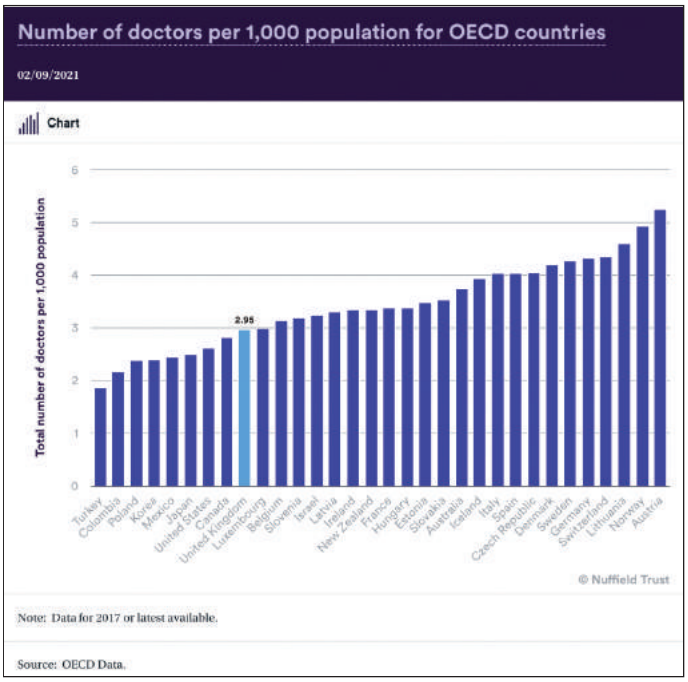
"The NHS is under huge pressure and while funding has increased, the extra funding is below what would be needed to make significant inroads into the long waiting lists, invest in primary and community services and put emergency care on a stable path" – *Anita Charlesworth, Director of the REAL Centre at the Health Foundation*



There is some good news, as during the pandemic there was a record rise in nursing students. Figures released by UCAS, the Universities and Colleges Admissions Service, show the number of nursing applicants at English universities in 2020 rose by 25.9 per cent compared with 2019, but as the Royal College of Midwives and others have previously pointed out budgets need to rise in the NHS to employ them. The number of midwives actually fell by 331 in 2021/2022

The need for a long term funded plan covering both recruitment and retention has never been greater. The government claims that it is halfway to recruiting its target of 50,000 extra nurses, but the vacancy rate remains at around 39,000 – 10% of the workforce. The number of professionals leaving the Nursing & Midwifery Council's is rising year-on-year, and 20% are aged 56 or older.





A steep challenge

Short termism must end as Health Foundation calculations point to the reality that the NHS workforce would need to grow by more than a third over the coming decade to tackle the backlog in treatment within the NHS and make good on current shortages of staff – that means a rise of 277,500 full-time equivalent staff by 2024/25

Ministers often quote rising numbers of doctors and nurses, ignoring the swathes of other crucial health professionals and NHS workers who are experiencing pressure from understaffing. Piecemeal targets tied to the Tory manifesto are too narrow a system wide strategy is what many organisations have called for.

By comparison the UK has less staff per head of population than most other comparable nations.

Pay deal

Retaining its staff will be all the more difficult amongst fears about a "growing exodus of exhausted staff", Soaring inflation is cutting into the purchasing power of wages when NHS staff have already watched their pay fall in real terms over the last decade.

The basic pay of nurses fell by 5 per cent after inflation between 2011 and 2021, even though they have done better than other public sector workers.

Unison highlights too the impact on the lower paid and the unfairness within the process of pay review. "Last year's 3% award meant a member of staff in Band 2 got an extra £580 while a member of staff in Band 8a got an extra £1,550" that widened the gap between these grades.

The trade union favours a flat rate to give everyone the same cash sum, to help mitigate the cost of living amongst the lower paid.

A dispute seems inevitable though as the government are pushing for the Pay Review Body to recommend a cap of 3% across the NHS, which mean that the average NHS salary would fall by £850 in real terms.

Unite the union has confirmed that its health sector representatives will be recommending rejection of the Scottish Government's 5 per cent NHS pay offer following a meeting in Glasgow on 16 June. The trade union will now consult its members on rejecting the offer and on a potential industrial action ballot throughout July.

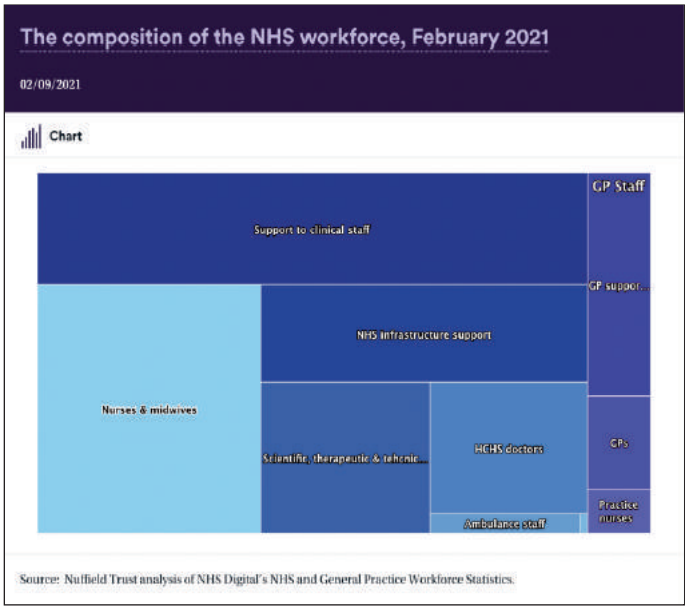
Efficiency savings?

Under the banner of reducing waste the government has doubled the efficiency savings that the NHS is required to make every year from around 1% to 2.2%, or around £4.74bn in savings. A doubling of the ambition it set in its own long-term plan back in 2019. Is this realistic?

In historical terms the NHS manages an average of 1.15 savings a year, more than the wider economy

A period harsh productivity demands has been tried before. And resulted in widespread deficits, underinvestment in workforce and buildings and cuts to services, as it was accompanied by a prolonged NHS funding squeeze.

As David Maguire, a senior analyst at the Kings Fund, points out Many of the potential productivity improvement have already been tried or are already in train such as: capping spending on agency staff, improving procurement, networking pathology and diagnostic services, improving value for money in prescription spending and reducing the number of clinically ineffective treatments. so where are these savings going to come from?



Javid pushes GP shakeup but misses priority issues

Although he has still to reveal the details five months after flagging it up in the Times, health secretary Sajid Javid is still pushing a radical proposal to transform the primary care landscape – by turning every GP partner into a salaried NHS employee by 2030.

Since The Lowdown first picked the proposal apart and analysed the possible motives behind its introduction, the momentum behind Javid's plan has picked up. The publication in March of a report from the right-leaning Policy Exchange think-tank – saying that GPs should become predominantly salaried within large-scale providers – was praised by Javid as a "pragmatic contribution to the debate on the future NHS". And just two weeks ago, he told the audience at the NHS Confederation's Expo conference that, "I will be setting out my plan shortly."

However, some aspects of Javid's salaried GP proposal may prove troublesome, judging by a statement from one commercial participant in two existing pilot programmes.

Despite the health secretary's enthusiasm for commercially developed, app-based NHS services being used to augment the capabilities of GPs directly employed by hospital trusts, access to these services looks unlikely to become widely available for some time. The CEO of Babylon Health – which already offers digital access to NHS patients in pilot programmes in London and Birmingham (via its GP at Hand service), and in Wolverhampton (in a five-year deal with the local NHS Trust) – told investors last month his company was "very cautious" about expanding further in the UK while it continued to lose money on every NHS patient it sees.

GPs blamed

Meanwhile, one or two elements of the media are still promoting the notion that GPs operating under the partnership model are the root cause of serious problems within the NHS. This month the Care Quality Commission told Pulse that the Mail on Sunday and Mail Online had each misrepresented the results of a minor survey the CQC had commissioned, jointly with just one hospital trust, to suggest that nationally almost 5 million visits to hospital A&E departments were directly attributable to "a lack of access to GPs". NHS Confederation primary care director Ruth Rankine recently outlined the impact of this type of negative coverage, saying, "Health leaders want to see an end to the constant barrage of criticism faced by GPs and those working in primary care from some parts of the media and political sphere, something which is further demoralising an exhausted workforce.

Fundamental issues

Inequitable funding and recruitment failures – rather than any perceived shortcomings of the partnership model – remain crucial factors behind poor GP access in deprived areas. At the end of

May, new analysis from the Nuffield Trust revealed a major factor in the difficulties some patients have getting an appointment to see their GP: widespread disparities in GPs' patient lists. Its research found that in some regions individual GPs were responsible for more than 2,500 patients each, while in other regions doctors only had to care for half that number. The reverse side of the coin showed that areas such as Portsmouth and Hull had around 40 GPs per 100,000 inhabitants, while the Wirral and Liverpool had double that tally of doctors.

Calls for practices in deprived areas to receive a greater share of funding are therefore growing. NHS England head of primary care Dr Nikki Kanani told the audience at the same NHS Confederation Expo conference that Javid attended, "We still have fewer members of primary care working in more deprived communities, which means [patients there] get poorer care, and those practices get less money." Currently, for every 10 per cent increase in a practice's 'multiple deprivation score', payments only go up by 0.06 per cent.

Poor workforce planning is central to the current shortages of GPs, and was one of the key points of a campaign launched in March by the BMA and the General Practitioners Defence Fund, with the backing of Health and Social Care Committee (HSCC) chair Jeremy Hunt. "I think the government has got its head in the sand when it comes to workforce pressures in the NHS," Hunt told the BMJ. "The workforce crisis is the biggest issue facing the NHS. We can forget fixing the backlog unless we urgently come up with a plan to train enough doctors for the future and, crucially, retain the ones we've got."

With the latest survey, published last month, from the RCGP showing nearly 19,000 GPs and trainees are set to leave the profession over the next five years, it's clear that the mismatch – one that existed long before the pandemic, despite claims to the contrary from the health secretary – between falling GP numbers and rising demand for patient care is set to grow.

The results of the RCGP survey prompted NHS Confederation primary care director Ruth Rankine to say, "There are now 1,600 fewer GPs in post than in 2015 and alarmingly this survey shows that those numbers could yet rise further. At the same time, according to the latest NHS performance statistics primary care staff are carrying out 50 per cent more activity than they were at the same point two years ago. In 2019 the Government pledged to increase GP numbers by 6,000, unfortunately it is now clear this target is not going to met."

The figures Rankin highlights underline the continuing governmental failures over the past 12 years to address the issue of GP numbers. Just consider the following:

– Recruitment from abroad has long been used to boost NHS numbers, and the trainee GP sector is no exception. But just last week Pulse revealed that only 124 doctors recruited via NHS England's international programme are still practising here – only 155 GPs had actually been recruited under the programme between 2018 and 2021, against a target of 2,000, and 31 had already left the programme during the same period. Brexit has perhaps justifiably been cited as one reason for these low numbers, with BMA spokesperson Dr Kieran Sharrock explaining, "You've got to remember that this all coincided with a period when the UK voted to leave the EU. The doctors who were being recruited were being recruited from across the EU and it created significant uncertainty for them."

– And adding to that sense of uncertainty must surely be the risk of deportation. Earlier this month RCGP professional development vice chair Dr Margaret Ikpoh told the HSCC inquiry into the future of general practice that new doctors are "literally going from celebrating the fact that they've become a GP to receiving letters threatening them with deportation". In April it was revealed that up to 1,000 overseas GPs were at risk despite completing their training because of complex immigration rules stopping them from extending their visas. Tellingly, the Doctors' Association UK notes that a Bill to give indefinite leave to remain to all staff working for the NHS has repeatedly been "kicked into the long grass".

The wrong focus?

However, by focusing on the salaried model for GPs, Javid appears to be dodging all the difficult questions relating to recruitment and funding, and is instead pushing a proposal within a sector that has already gone some way to embracing it – a much easier challenge. After all, a letter in the BMJ in March, reacting to Javid's proposal, floated the notion that this model would make GPs more malleable – as the correspondent explained, "The salaried model is automatically assumed to be the lowest common denominator, where GPs are dictated to by others."

In May, a Pulse survey of GPs found that 41 per cent of respondents would consider becoming a salaried GP, and that half of the GP workforce already consisted of salaried and locum GPs. And according to GPonline earlier this month, senior GPs are now warning that Javid's proposals "have already exacerbated reluctance among GPs to take on partnership roles, with interest in partnerships 'collapsing like a Jenga stack'".

So even though in May the BMA's GP committee voted to reject "NHS England's approach in replacing general practice with a one-size model all-salaried service", other elements within primary care may not be so resistant to Javid's 'nationalising' initiative. Of more concern, perhaps, is the possibility – as noted by one GP – that once practices are under the control of hospital trusts, private health providers could eventually step in to privatise them.

Martin Shelley

Low-income nations once again let down on Covid healthcare

After over a year of negotiation, the WTO (World Trade Organization) has finally agreed to a partial waiver of its TRIPS agreement covering patents. This will allow developing countries to manufacture Covid vaccines, but the deal falls far short of the demands of developing countries and non-governmental organisations (NGOs), and may well make tackling a future pandemic far harder.

The deal will let governments issue compulsory licenses to domestic manufacturers for the next five years, but it does not cover all Covid-related treatments and diagnostics, which is what South Africa, India and campaigners at NGOs were fighting for. Commenting on the deal, Max Lawson, Co-Chair of the People's Vaccine Alliance and Head of Inequality Policy at Oxfam, said:

"This is absolutely not the broad intellectual property waiver the world desperately needs to ensure access to vaccines and treatments for everyone, everywhere."

The final text that was agreed upon is just a "watered-down waiver", according to Oxfam, of one small clause of the TRIPS agreement relating to exports of vaccines, but what is worse is that there are also new obligations in the deal not present in the TRIPS rules that will actually make it harder to manufacture the vaccines.

The new rules require manufacturers to identify all related patents for the vaccines, which could prove impossible as vaccines are covered by what are known as complex "patent thickets" where patent rights overlap, and something not required under present TRIPS rules. In addition, a time limit (five years) has been put on the waived obligations, also not included in the previous TRIPS rules.

Lawson notes that these new obligations "could actually make it harder for countries to access vaccines in a pandemic."

South Africa and India have led a 20 month fight to get a full waiver to enable developing countries to manufacture and access all Covid-related vaccines, tests, and treatments, all the while opposed by the EU, USA, UK and Switzerland, and the major vaccine manufacturers, Pfizer, Moderna, and AstraZeneca.

Lawson criticised the developed nations strongly:

"The conduct of rich countries at the WTO has been utterly shameful. The EU has blocked anything that resembles a meaningful intellectual property waiver. The UK and Switzerland have used negotiations to twist the knife and make any text even worse. And the US has sat silently in negotiations with red lines designed to limit the impact of any agreement."

Many have pointed out that the negotiations have taken so long that the final deal will not have a meaningful impact on the production of Covid-19 vaccines, as there is now a global glut of vaccines.

The Indian Trade Minister, Piyush Goyal's statement on his ministry's website said "What we are getting is completely half-baked and it will not allow us to make any vaccines…..Vaccines

have already lost relevance. It's just too late; there is no demand for vaccines anymore."

There has been criticism from the other side of the table as well, the Pharmaceutical Research and Manufacturers of America (PhRMA) called the waiver a "political stunt." It called for a focus on issues like supply chain bottlenecks or border tariffs on medicines. However, the organisation has opposed any waiver, not just this one.

The lack of a waiver early on in vaccine development and manufacturer resulted in rich countries buying up all the early supplies, which became known as "vaccine apartheid" and profiteering, as companies made multi-billion-dollar profits, whilst fighting every effort to allow generic competition.

Lack of waiver stalls production of generics

Although there may be a global glut of vaccines, a waiver that covers all covid-related vaccines, diagnostics, and treatments is still very much needed and is still being called for by many WTO member states and thousands of global health researchers, as Ronald Labonte, Professor and Distinguished Research Chair, Globalization and Health Equity, L'Université d'Ottawa/University of Ottawa, notes in his article in The Conversation.

The issue with this very limited waiver, according to Labonte, is that it sets a precedent "that will restrict the ability of countries with the capacity to mass produce therapeutics, diagnostics and even personal protective equipment. This would apply to the still-with-us COVID-19 pandemic and for any new zoonotic outbreaks that are almost certainly on the near horizon."

Labonte adds that "without a meaningful waiver, new variant-ready vaccines expected later this year are likely to be gobbled up once more by high-paying rich countries, with the poorer ones left with older less-effective versions."

It is not just vaccines, the new Covid therapeutics now entering the market will also be bought up by richer countries and as the waiver does not cover treatments, cheaper generic versions can not be produced in places like South Africa and India and low income nations will once again miss out.

Pfizer, the developers of the antiviral drug, Paxlovid has said it will allow licences for generic versions to be produced for distribution to 95 developing countries, but these countries will have to wait until 2023.

Despite there being an excess of vaccine in the world, it is clear from data on vaccination rates that it is still not getting to where it is needed. Much of the world's population has not received even a single dose, whereas the developed world is on to booster doses.

As of 21 June 2022, only 17.8% of the population of low income countries has received at least one dose of a covid-19 vaccine (low income defined as having a Gross National Income (GNI) per capita below US $1,045). This compares to 79.9% in high-income states (GNI per capita above US $12,696).

In April 2020, the Covax initiative was established to ensure fair access to Covid-19 vaccines worldwide. Jointly administered by the World Health Organization (WHO), Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations, Covax planned to donate sufficient doses to vaccinate around 30% of the population of 92 low-income economies in 2021 and 2022, under its Advance Market Commitment (AMC) scheme.

Promises poured in from the developing nations and at the G7 summit hosted by the UK in June 2021, G7 leaders pledged to donate 870 million doses to Covax by June 2022. This included a commitment by the UK to donate 100 million doses.

It's now June 2022 and recipient countries have received just under 30% of the UK's promised commitment of £100 million, with a further 29% donated but not yet shipped, however that leaves 41% that has not yet materialised. The USA has shipped just over 26%, with some European countries performing better but still a long way behind on the promises, including Germany (52.6% shipped), France (51% shipped), and Italy (58% shipped).

Perhaps worse still, the UK has used its donations of Covid vaccines to reduce its Overseas Aid bill. An investigation by The Bureau and The Independent found that £100.4m was taken out of the UK aid budget to cover the cost of the surplus coronavirus vaccines sent abroad.

Donations only a short-term solution

The reluctance of rich countries to donate vaccines, despite pledges to do so, is not the only issue with the COVAX system.

In December 2021, The Lowdown reported on the challenges facing the Covax initiative. Reporting that the majority of the vaccine donations to-date had been ad hoc, provided with little notice and with short shelf lives, and as a result very difficult for countries to plan vaccination campaigns.

The African Vaccine Acquisition Trust (AVAT), the Africa Centres for Disease Control and Prevention (Africa CDC) and COVAX jointly called for the quality of donations to improve, with not just vaccine donations but other essential supplies, such as syringes. The countries need a predictable and reliable source of vaccine that can be used for a long-term sustainable vaccination programme.

It is clear from the disappointing situation with the Covax system, that relying on the generosity of the governments of rich nations was never going to solve the issue of Covid vaccination for Africa and every other poor nation. Which is why the TRIPS waiver was so important, but once again developing countries have been let down and millions of people are set to suffer..

London ICBs launch in cash crisis

With just days to go until the management structure of the NHS is thrown into a new round of confusion and obfuscation, with the establishment of just 42 new "Integrated Care Boards" to cover England, there is vanishingly little useful information in the public domain to indicate what is likely to happen.

But what Lowdown researchers have managed to quarry out of the available documents from soon to be defunct Clinical Commissioning Groups and from Trust Boards is enough to confirm that with few if any exceptions the whole system will be thrown immediately into a major financial crisis.

This is definitely the case in London, which has already been carved into five with the mergers of CCGs to pave the way for ICBs.

The most complete figures could only be found in a table tucked away at the back end of board papers for Oxleas Foundation Trust in SE London (p136).

This table shows initial plans submitted from all five ICB areas in March projected a combined deficit for 2022/23 totalling £768m (SE London £102m, NE London £100m, North Central London £283m, NW London £94m and SW London £189m).

These projections had already been squeezed downwards: according to Camden and Islington FT Board papers the original NC London deficit was a massive £359m (p55), while according to West London Trust's April Board papers "the current NW London financial gap of £94m [was a] significant improvement from the previously reported figures, which at one point was £300m." (p89)

It also reveals that under pressure from NHS England's London Regional bureaucrats the total London-wide deficit was squeezed down by another £145m to £623m by April 28 – despite the South East London projected deficit actually increasing at that time by £30m.

The reductions appear largely (if not entirely) to have been achieved by assuming increasingly large and improbable "cost efficiency" savings – and even more improbable savings have since been added in: for example the SW London system plan submitted to regulators on June 20 projects a "full year breakeven position" – on the assumption that its providers can deliver savings equivalent to an astonishing 7% of system cost base. (p208)

More extraordinary still the SW London system has assumed all of these savings can be made at the end of the year, even after notching up a £34.8m deficit in April and May (p216).

SW London CCG admits that that most significant risk is the "under-delivery of efficiency plans" – but also reveals that 52% of the efficiency savings, (adding up to £142m) are categorised either as "opportunities" or simply unidentified. In other words not even theoretical proposals.

Just 31% is covered by "Fully developed plans," and 18% by plans actually in progress.

The biggest challenges are in the acute trusts, Epsom & St Helier, Kingston and St George's, where the April Finance Committee reported concerns "on a number of fronts":

"the lateness at which the planning was taking place, albeit in line with national guidance; the size of the remaining deficit and the level of cost improvement initiatives that would be required even with the proposed deficit.

"The Committee further noted that some of the assumptions on which the Trust was being asked to base its plan, such as around the treatment of inflation, would appear to have been overtaken by events." (p99)

The SW London plan also seems to be incredibly naïve in the way it wishes away real problems and assumes that "full and frank discussions" and setting up a new "People Board" will magically open doors.

On course for a shambles

Assessing the risk of "Potential impact of workforce morale on ability to make productivity changes at pace," SW London bosses respond in the first public board paper for the first ICB meeting in July that they will sort this, through "Clear, transparent and inclusive communication with staff. As part of the SWLICB development a new People Board will be established, one of the workstreams will be belonging and inclusion." (p219)

So that's alright, then, staff are bound to be impressed with a new form of words.

The "SWL People Board" is also expected somehow to overcome the runaway inflationary crisis and "gain improved recruitment and retention." And in case anyone fears there may be inadequate communications to staff and stakeholders, leading to loss of support, we are assured: "SWL will work closely to manage a consistent and structured message to staff and stakeholders."

What could possibly go wrong? Even "unpalatable choices" that may have to be made will be made much more appealing by "full and frank discussions".

Of course it will be a shambles. New ICBs set up without public engagement or support and constrained by brutal cash limits and Rishi Sunak's tight-fisted spending review will find it extremely hard to impose impossible savings targets on trusts whose management would face the public blame for failing services.

And of course SW London is far from the only big problem.

South East London, under pressure to reduce its projected deficit, wound up increasing it by £30m, although we have not yet been told what final projection was eventually sent in to the regulators earlier this month. The process of finalising the financial plan was, like almost everything else about ICBs, done behind closed doors.

Existing deficits a major concern

And while Guy's and St Thomas's trust remains tight lipped on its financial prospects for 2022/23, we know that King's Healthcare Trust was running an underlying deficit of £23.4m a month (£281m per year) in the second half of last year, feared it was facing an extra 2% efficiency target this year, and began in April with a deficit of £6.8m, noting that its plan is "dependent of £55m cost and income improvement plans" (p18 and p38).

We also know Lewisham & Greenwich trust is concerned that "There is also continued pressure from NHSE/I for South-East London Integrated Care System (SEL ICS) to improve its current planned deficit. There are ongoing discussions across the system how this will be achieved but this could result in further improvements required to our deficit putting further pressure on internal resources and the efficiency programme." (p74).

Oxleas board is concerned that attempts to manage down the SE London deficit "currently carries a high level of risk re red rated CIP schemes, non recurrent measures and uncertainly re Elective Recovery Fund payments for 20222/23" (p121).

North of the river, there are also grounds for concern, especially North Central London, whose shambolic, scrappy and error-strewn 107-page Powerpoint document that claims to be a "System development plan" admits up front that "The underlying financial position of the NCL ICS remains unsustainable." (p69)

It also admits that this problem pre-dates the Covid pandemic:

"Pre-Covid, the NCL system had a significant gap between available funding and underlying costs, with deficits (some sizeable) in most NHS organisations, additional pressures in local authorities and challenges in primary care. This gap and these challenges will return when we exit the Covid financial regime."

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However admitting the problem does not necessarily lead to any more realistic approach to planning: the "next steps" appear to be simply more generalisations and meaningless aspirations:

"Engagement with Trust Boards, CCG GB, Heads of Finance, dedicated workshops to continue to embed financial strategy. …

"Work with wider system partners to develop a whole-system view to finances …

"Singularly define what we mean by 'need' reflecting the work on deprivation, equity of access and inequality led by the Population Health team for NCL leadership agreement." (p72)

While the waffle goes on, trusts like the Royal Free admit they are in trouble:

"The Royal Free group plan is for a significant deficit, the largest deficit in North Central London (NCL), with NCL having one of the highest deficits nationally. A £40m financial improvement programme (FIP) is being targeted but this will be extremely challenging to deliver." (p29)

Indeed the Royal Free's "Board Assurance Framework (BAF) has decided to refer explicitly to "Tighter financial constraints", since it was agreed that "reference to the 'underlying deficit' was no longer relevant in light of the new funding framework" (p71).

University College London Hospitals also updated its financial plan to NHSE/I on 28th April "with a £15.5m control total deficit for 2022/23." This position includes an increase in the Trust's efficiency target which "has been flagged as unidentified in the Trust plan, but the expectation is that this additional efficiency will be delivered through non-recurrent adjustments" (p143).

UCLH is also the only board to mention an obvious problem for NC London:

"NCL ICS is going to have one of the biggest funding reductions nationally as a result of efficiency requirements and because the ICS is over-funded based upon the new national methodology for how much NHS funding ICS's should receive based on their population." (p174)

In NE London, too there are some big underlying problems, with the finance report in the Barts Health May Board papers noting:

"The Trust is reporting a pre system top-up deficit of £173.1m… The system top-up … effectively replaces what was known as the Financial Recovery Fund (FRF) allocation pre-pandemic. System top-up funding is primarily based on NHS England's calculation of the Trust's pre-pandemic (2019/20) underlying deficit." (p78)

Further east in NE London the Barking Havering and Redbridge Trust (BHRUHT) is also many miles from any hopes of a break-even:

""The trust … was £10m adrift of the £66m planned underlying deficit.

"The underlying run rate is c£6m deficit per month with a full year underlying deficit of £76m, although it is difficult to confidently determine due to CoVID. … "The £10m distance from plan is a result of under-delivery against priority waste reduction programmes." (p116)

"… Next year the trust must reduce costs by £39m and, as part of the Elective Recovery, access an additional £10m of revenue through theatre efficiencies in order to achieve an underlying deficit of £65m. … Currently the trust risk adjusted plans amount to £23m so further work is required in order to close the gap and start the year on plan." (p120)

Unrealistic financial planning

Meanwhile in NW London commissioners and trust bosses are living in denial, blaming London Ambulance Service (£69m) and Hillingdon Hospital (£25m) for an initial forecast of £94m deficit. Then the Hillingdon trust board was badgered into reducing its projected deficit to just £9m, assuming a cost reduction target of £13.7m which "has not been fully identified and as a result Divisions will receive a negative budget to address the gap." (p40).

However two other NW London trusts, Imperial and London North West both have problems to address.

Imperial faces a need for £37m efficiency savings (3%) but had only identified schemes worth £11.9m, and the Finance Committee was concerned that hyper-inflation costs of £10m had not been properly included. (p116-117)

London North West admits its main hopes of pay cost reductions hinge on reducing bed utilisation, as well as focusing on waiting list initiative/temporary staffing cost reductions. It also aims to make savings by ceasing use of independent sector support, on which c£16m was spent in 2021/22.

But with little sign of realism from any of London's ICB areas, and finance directors apparently ready to sign off on extraordinary plans they know will be virtually impossible to achieve, it seems the rocky road starts the day the new system kicks in.

Local campaigners will need to keep eyes and ears open at all levels if they are to keep abreast of the changes and the policies as they emerge. The Lowdown welcomes any local updates from any of the 42 ICS areas and will endeavour to keep health unions, local politicians and campaigners informed of the sharpest issues as they take shape.

John Lister

ICBs offer no real place for accountability

One of the stock, unconvincing answers to those who have challenged the lack of local accountability in the new system of 42 "Integrated Care Systems" (ICSs) that will take over control of England's NHS at the start of July has been to claim that many decisions in the larger ICS areas would be taken at more localised "place" level.

This has been a key factor in winning endorsement from the Local Government Association for a system that in reality keeps the NHS firmly in charge, but makes use of local councils to give a spurious veneer of more democratic and local involvement.

Exactly how much difference, if any, place-based organisation might make – especially when the dominant pressure is the financial constraints on ICSs and requirement to eliminate deficits, and with no place-level decision-making body, no public representation, little or no public access to the executive lead, and minimal, if any, information on potentially controversial issues in local news media – has not been explained.

But we can see now it's all a sham anyway.

As the new system, which has been put in place with the barest minimum of pretence of public involvement or consultation, sits on the launch-pad, a June 23 report by the Health Service Journal, based on research in May and June, has revealed that half of the ICBs have not even appointed the bureaucrats to lead the "places," which are not expected to be functional until the autumn.

The HSJ calculates 39 of the 42 ICSs between them are set to establish 175 "places," while three single-county ICSs (Gloucestershire, Lincolnshire and Somerset) have decided not to establish any more local bodies.

Each 'place' is supposed to have a single leader, accountable to the newly-established Integrated Care Boards (ICBs). But only 16 ICBs have chosen "some or all" of these executive leads. Of those who have been appointed: "The majority are CCG/ICB executives or local council executives, with a significant minority being NHS provider chief executives."

Supporters of the changes have also argued that, in line with the letter of the Health and Care Act, ICBs which will have the full statutory powers and control of budgets will also have to "have regard to" the local strategy drawn up by broader Integrated Care Partnerships, (ICPs) which are supposed to link up the NHS with local government and other "partners".

But the HSJ reveals only 21 of the 42 ICSs have so far even appointed their ICP chair: nine of these turn out to be also the ICB chair, underlining a complete lack of any independence of the ICP. Most of the rest are councillors.

Marginal public oversight

So even before the new system creaks into gear it's already embarrassingly obvious that the ICPs, non-statutory bodies with only the most tenuous and theoretical role or influence, and created as a sop to appease local Tory councillors, are a marginal, irrelevant appendage to each ICB that nobody will take seriously.

As we have consistently warned in The Lowdown, the new system of ICSs/ICBs marks a major further erosion of local public accountability, and the challenge for campaigners will be to keep track of changes and policies as they take shape at ICB level.

Meanwhile the Health Foundation has published a useful new study highlighting the huge variation between ICBs. It shows the range of population covered – between 500,000 and 3.1m; the varying levels of deprivation; the varying levels of potentially avoidable use of emergency and hospital care; the elective care backlog; and the near 50% variation in provision of GPs – which

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US corporation Optum to acquire EMIS

Optum, a subsidiary of the US corporation United Health, is to acquire Leeds-based EMIS Group, one of the UK's largest handlers of NHS data. The deal values EMIS at approximately £1.24 million; the deal was unanimously approved by the EMIS board of directors.

The deal will be transacted via a UK-based company, Bordeaux UK Holdings II Ltd, set up by Optum, which has offered EMIS 1.925 pence per share.

EMIS supplies electronic patient record (EPR) systems and software across the NHS, but its major business is in GP practices and community pharmacy. EMIS notes that it was one of the first to develop GP record systems that permit patients access to their record and technology that allows GPs to tailor the parts of the record that patients can see. The company shares the GP practice market with TPP and its SystmOne software.

The company's technology, ProScript and ProScript Connect, are widely used in community pharmacies. Both systems enable pharmacies to manage the dispensing process and handle tasks such as labelling and endorsing, patient records, ordering and stock control.

Optum has acquired EMIS at a critical moment in the development of digital integration across the NHS. As organisations work more closely together within integrated care systems (ICS) the various IT systems and electronic patient record (EPR) systems also need to work seamlessly across the ICS. In early 2022, NHS England requested plans from ICSs on digital convergence – how they will reduce the number of EPR systems within the ICS.

HSJ reported in May 2022 that four out of five ICS are a long way off achieving a convergence of EPR systems. HSJ's analysis of trusts' EPRs revealed that just nine of the 42 ICSs have an EPR in all their provider trusts, and also have three or fewer main EPRs in their area. The analysis also found that there were 12 ICSs that use between four and six different EPRs, and 12 ICSs that use between seven and 10 different EPRs. Within many ICS there were also trusts without EPRs. The analysis did not include ambulance trusts, which use different EPRs. Digital convergence could be a long way off in many ICS.

EMIS is a dominant company in the GP and community care market, but ICS development will mean this market will have to work with systems produced by a number of other companies, including Cerner, Meditech and Intersystems, that are leaders in the secondary care market.

Too easy for public bodies to restrict access to information

One of the most contentious developments in recent years has been NHS Trusts and Foundations Trusts deciding to form subcompanies. It has been set out elsewhere that these developments (with a couple of notable exceptions) are a tax dodging device allowing VAT to be reclaimed. Proposals often also involve ways to undermine terms and conditions of staff. These subcos are one step short of the even worse outright outsourcing to dubious contractors. Those picked on are usually low paid and predominantly female.

After trade union and campaigner pressure the NHS decided to try and limit the process and produced a wonderfully named addendum to the transaction guidance. After a further couple of years it was obvious that even this was not effective and so it was promised more than 3 years ago that it would be revised – which has still not happened.

One of the worst features of this saga was how many Trusts hid what they were proposing to do. Despite the requirements for partnership working in the NHS they met and discussed things in private. Eventually they announced the decision and then after the decision was made tried to pretend they were consulting staff. Of course, all they were consulting on was the transfer of staff.

Staff were never told what problem gave rise to the solution of setting up a subco and never told what other alternatives had been looked at; probably because the whole process was dishonest.

As many will know most of the more recent attempts have been blocked by the trade unions. When proper scrutiny is applied, and negotiations are honestly undertaken the case for subcos falls apart – unless it is just a tax dodge which it is now accepted is not permissible. Such discussions allowed the trade unions to see the quite ludicrous claims being made about the benefits of subcos and demolish these with things like facts!

However one has gone ahead at the end of last year. Once again decisions made in secret, no proper consultation with staff representatives and no possibility to examine the case. It was not possible to know what other options had been considered or what claims were being made. The Trust refused to disclose relevant information.

Evasive responses to FoI requests

Under the process for authorisation by NHS Improvement (as it was) the Trust had to submit a lot of information and finally a certificate with supporting documents to show it had met a long list of requirements. It must have done so as at the end of 2021 the Trust announced it had been given the Green light, despite a Minister in response to a parliamentary question saying they had not!

I sent an FoI request to NHS I asking for all the information they held in relation to the application of the guidance around this transaction. They denied initially that they had any information then they refused to disclose anything as there was “commercial confidentiality”. This was despite the fact that for a previous application by another Trusts I had received a lot of information!

I asked for an internal review setting out why commercial confidentiality could at most only allow some redactions of information in documents that they held and could hardly cover their correspondence with the Trust. No answer. After 4 months my approach to the Information Commissioner resulted in an instruction to NHS I to respond which they failed to do. The Commissioner is to investigate them when they have some staff to do so.

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once again confirms the famous "inverse care law" highlighted in 1970 by Dr Julian Tudor Hart, noting that the areas with the greatest levels of deprivation consistently also had the fewest GPs per head of population, while the wealthier, healthier populations were far better provided. Even now NHS England is still only talking about this issue rather than taking any action.

Over 50 years on, with inequalities in health and in living standards widened by a decade and more of cynical government policy, a new "inverse rhetoric law" brings us more empty government words about "levelling up" the wider the gap becomes between richest and poorest.

Integrated Care Systems, established in a new wave of austerity, with Health Secretary Sajid Javid insisting that the NHS does not need and should not receive any more funding, will resolve none of this: nor indeed can ICSs address the parallel, hopeless privatised shambles of social care. And without functioning social care, the NHS cannot hope to free up the flow of patients through the hospital system.

As the new 'reformed' system launches as a half-arsed, chaotic, cash starved mess, under a smokescreen of unreadable and empty rhetoric, it's up to campaigners, the unions, any local politicians who really care about their constituents and any NHS managers with a shred of self-respect to fight to expose the contradictions and gaps, challenge the short-sighted cutbacks and panic measures that are likely to follow in the autumn, and try to defend the services we all depend upon.

John Lister

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Finally, after 7 months the reply came. They agreed they had misapplied the exemption. But they then claimed two new ones even less sensible than the first attempt. I have asked for a meeting and formally submitted another complaint.

This might be humorous, but it isn't.

These are public bodies supposed to be open and transparent. They are doing everything they can to withhold information not because it is commercially confidential – because it isn't, but because they know they have been caught out.

Abuse of transparency principle

They know they have not applied their own guidance properly. One requirement is a certification that the Trust "Engaged staff in decisions that affect them and the services they provide as pledged in the NHS Constitution, and has plans to comply with any consultation requirements, including staff consultations." They did not: either they submitted a false certification or NHS I just ignored it.

They also know that if they release the business case it will be shown to fail even the most basic tests of reasonable claims. It may also reveal the degree to which tax concerns were material and to what extent they are claiming benefits from reducing staff terms and conditions.

So they lie and dissemble.

It is pathetic that the FoI Act is so easily avoided and that NHS E or I or whatever they are called now allow this blatant abuse of the principles like partnership working, openness and transparency.

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If you've enjoyed reading this issue of The Lowdown please help support our campaigning journalism to protect healthcare for all.

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We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month or £50 per year for individuals, and hopefully at least £20 per month or £200 per year for organisations. If you can give us more, please do.

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