The lowdown

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

It's going to get tougher – ICB round-up

However tough the financial regime has been for 2022/23, it is set to get even tougher in the next two years – in which the NHS is expected to deliver £12 billion in "efficiency savings", while reducing waiting times and waiting lists.

While some local issues may also play a role, our research shows all ICBs are faced with similar problems, and seeking ways to cope with inadequate resources – beds, staff, diagnostics, mental health capacity and funding.

The problems itemised in nearly every ICB include:

– assumptions of inflation at 1.8% (the official prediction of 2.9% minus an "efficiency" target of 1.1%) – while actual inflation continues in double digits, and no costs are coming down.

– large numbers of beds filled with Covid patients (for whom almost all funding has now ceased): 4,585 front-line English hospital beds were filled by Covid patients as of May 3, with 370 in East of England, and 846 in London. But while these beds are not available for routine and emergency patients, additional funding for Covid has been largely or completely ended.

– thousands more beds (throughout March over 13,000 in England, more than one in eight of England's 95,200 occupied acute beds) filled with patients who are medically fit but cannot be discharged for lack of community health and social care: on March 31 there were 992 in East of England acute hospitals and 1,451 in London – just under one in ten occupied beds. This again hampers efforts by trusts to meet tough targets to increase numbers of elective patients treated and reduce the 7.2m waiting list.

– under-funded pay awards

– staff shortages (forcing up spending on agency staff, in many cases well above the "cap" imposed on agency spending by NHSE, or in some cases expansion of the trusts' directly employed workforce to reduce spending on temporary staff.)

– failure of NHS providers to meet tough targets for "efficiency savings" in 2022/23, (or sometimes imaginary assumptions or unassigned savings) along with almost universal over-reliance on one-off "non-recurrent" measures and budgetary fiddles, which leave an underlying deficit rolling in to an even tougher 2023/24.

Last autumn NHS England warned ministers before the budget that it faced a £7bn deficit for 2023/24. Chancellor Jeremy Hunt's response in the Budget was to increase spending by less than half this amount.

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The HSJ, with the benefit of leaked information, revealed early in March that the first drafts of ICB plans for 2023/24, which projected a combined deficit of £6 billion, had been rejected by NHS England.

This has also been described by Cambridgeshire & Peterborough ICB Board papers:

"At draft plan stage the collective NHS deficit submissions were over £6 billion with 4 regions over £1 billion deficit. The East of England region had a cumulative deficit of approx. £440m with deficits ranging from £57m to £107m." (p21)

The HSJ followed up on April 12 with news that revised plans adding up to a £3bn deficit had also been rejected, with the planning for 2023/24 finances pushed back towards the summer.

The Lowdown reported how back in November NHSE set up tough new rules to deter ICB finance chiefs from giving early reports of any negative change in their financial situation – effectively encouraging ICBs to cover up reality and delay any unpleasant news (and any consequences) until the last minute.

The upshot once again is that NHSE, their heads firmly in the sand, refusing to admit the impossibility of its demands, is effectively once again telling ICBs to make up figures and submit unachievable plans, pretending that they can achieve literally incredible "efficiency savings".

John Lister

Cost-of-living crisis is a recipe for health disparity

A near-constant stream of reports about the negative impact of the cost-of-living crisis on the nation's health – and about the government's failure to address the problem – have hit the headlines in recent months.

Last week HSJ published the results of an FoI request for data from the NHS Business Service Authority relating to the NHS low-income scheme. This revealed that in 2022 there had been a 35 per cent year-on-year increase in applications under the scheme that offers help with prescription charges, dental fees and the costs of travelling to NHS treatments.

The FoI request followed on from two surveys that surfaced earlier this year. The first, conducted over the last three months of 2022 by Healthwatch, helps explain the surge in low-income scheme applications identified by HSJ.

The health watchdog found that respondents were increasingly avoiding getting prescriptions and over-the-counter (OTC) medications, and were refraining from booking NHS appointments – especially dental check-ups. This was not only because of the up-front charges, but also the incidental, associated costs relating to travel, phone and broadband usage.

More than a third of the respondents – nearly 40 per cent – said cutting back in this way, in addition to not turning on the heating and cutting back on food, had negatively affected their mental and physical health.

A month later, in February this year, the Royal Pharmaceutical Society (RPS) released the results of a survey that again showed the cost-of-living crisis was having an impact on the take-up of prescription medicines.

Around 50 per cent of pharmacists who responded said they'd seen an increase in patients not collecting their prescription, or patients asking which items on their prescription they could "do without" because of cost considerations. And around two-thirds of respondents reported an increase in being asked if there was a cheaper OTC substitute for the medicine they'd been prescribed.

Meanwhile, last month saw the release of a survey commissioned by the Joseph Rowntree Foundation (JRF) showing that more than 25 per cent of adults in Scotland have had to access the NHS because of the impact of the cost-of-living crisis on their mental or physical health.

JRF spokesman Chris Birt told the Sunday Post, "Unacceptable levels of poverty and high prices mean that it can be all but impossible for many families to live in the warm home we all need, or provide the regular, nutritious and cooked meals that keep us healthy… This cycle of health inequality is an injustice that is failing our people and turning up the pressure on the NHS."

Responding to the newspaper's coverage of the report, a DHSC spokeswoman offered a flurry of defensive statistics, but on the core issue of rising food and energy prices only suggested that, "We have a plan to halve inflation." Unsurprisingly, they made no reference to last month's increase in charges for prescriptions (up by 30p) and NHS dental fees (up 8.5 per cent).

In the same week as the JRF report was published, the Institute for Public Policy Research (IPPR) thinktank's Commission on Health and Prosperity released its first interim report – Healthy People, Prosperous Lives. This report pointed up how the Tories' approach to managing the NHS over the past 13

years has impacted on both the nation's health and its economy.

With the prevalence of cancer, diabetes, depression and hypertension all at higher levels than they were in 2010, the IPPR estimated that individuals were now losing close to £2,000 each year in lost earnings due to poor physical and mental health, thereby reducing the size of the economy by as much as £43bn

This month saw two more reports, both of which echo the findings of the Healthwatch survey published back in January. Last week MPs sitting on the cross-party House of Commons environment, food and rural affairs committee published a report claiming that poor public transport and a relative lack of digital connectivity – both essential for many patients seeking access to health services – are contributing to poor mental health outcomes across rural communities in England.

And Citizens Advice released a survey on the same day, showing that almost one million people have disconnected their broadband during the past 12 months because they can no longer afford to pay for it – with those receiving Universal Credit most severely affected and most likely to have cancelled their contract.

2022 saw the publication of major reports from the British Medical Association, the Centre for Mental Health, the Health Foundation, the House of Commons Library and the Royal College of Paediatrics and Child Health – all dispassionately showing how poverty, linked to the cost-of-living crisis, is increasingly driving health inequalities.

Those inequalities have led to charities like Dentaid having to step in to offer free dental care from its mobile clinics, to bolster provision formerly available from the now-rapidly shrinking NHS dental sector.

They have also led to many middle-income patients now reluctantly paying up to £550 an hour to see a private GP, because so many NHS surgeries are over-stretched and under-resourced.

It's perhaps best left to the JRF's Chris Birt to sum up the direction we're all heading in with this: "It's wrong that so many people in a rich country are living shorter, less healthy lives because they can't afford essentials, and it is also outrageous that we are at risk of overwhelming the NHS through a lack of action."

Martin Shelley

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Steep rise in patients seeking help with healthcare costs

There has been a 35% increase in the number of people applying for help with healthcare expenses in just one year, according to an investigation by HSJ .

Using Freedom of Information requests, HSJ obtained data from the NHS Business Service Authority on the number of applicants to the NHS low income scheme. From 2021 to 2022 applicant numbers rose 35%, from 267,248 to 361,000 and the 2021 figure is a 52% leap from the 2020 figure of 236,993.

The NHS low income scheme helps with expenses such as prescription charges, dental fees, and the cost of travelling to NHS treatments.

Patients can apply if they do not qualify for other help with healthcare costs. Many on a low income already qualify for help as they receive benefits, such as income-based jobseeker's allowance or Universal Credit. Help via the NHS low income scheme is assessed based on income and savings and is only available if income either does not cover or only just covers living requirements and you have less than £16,000 in savings.

In February this year the Royal Pharmaceutical Society, concerned at the growing numbers of people opting not to collect all of their prescribed medicines because of the cost, called on the government to review exemptions to ensure all patients with long term conditions get their drugs free of charge.

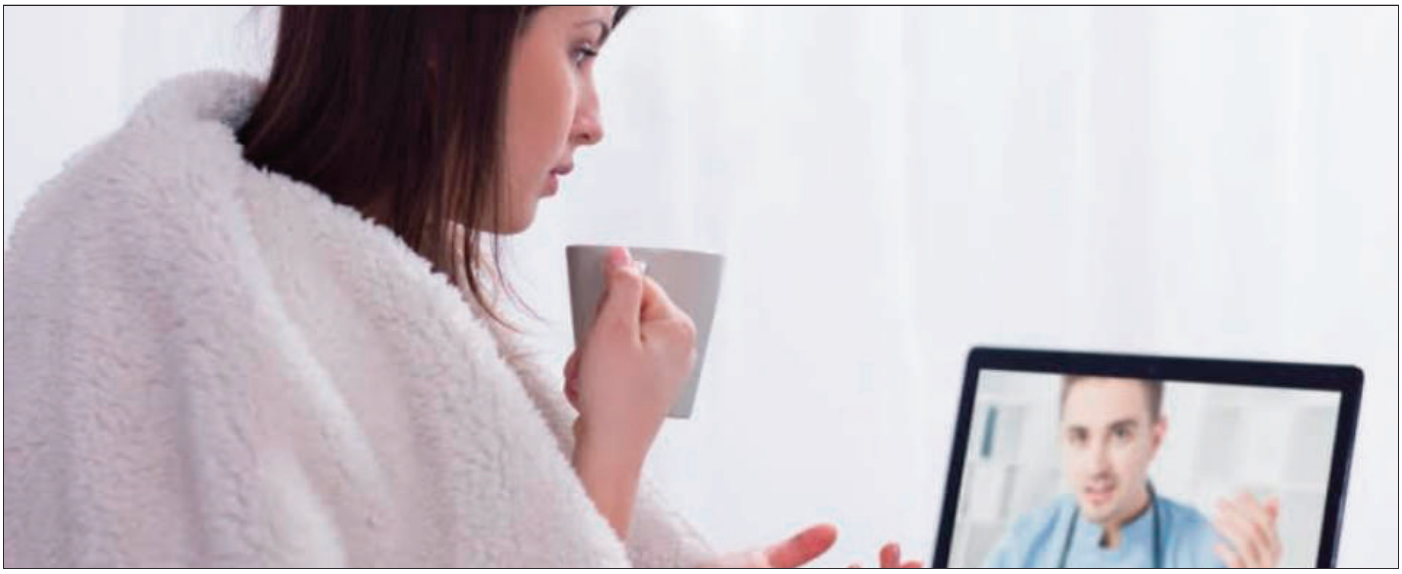
The Royal Pharmaceutical Society England board chair Thorrun Govind told HSJ: "We heard first hand from pharmacists that participated in our prescription charges survey that there was a rise in patients asking pharmacists what medications they can do without or whether they can substitute over-the-counter options they have been prescribed, for cheaper medication."

The move to impose prescription charges on 2.4 million people aged 60-66, was finally dropped by the government in March, but in April those who do have to pay prescription charges, were treated to a rise of 30 pence in April 2023 to £9.65, plus an 8.5% increase in the cost of NHS dental treatments.

Money raised via prescription charges are a tiny percentage (just 0.4%) of the £150 billion DHSC budget, while their real cost (in deterring seriously ill patients on low incomes from accessing the treatment they need) has not been calculated. Since its introduction by the Conservatives in 1952, prescription charges have never been a serious source of funding. The whole of the population of Wales, Scotland, and Northern Ireland have enjoyed free prescriptions for years.

The HSJ does note that the introduction of a trial of an on-line application process for the low income scheme, may have increased applicant numbers..

Sylvia Davidson



GP provider in financial turmoil

The digital health company Babylon Health is set to withdraw from the New York Stock Exchange and become a private company again as its leading creditor AlbaCore Capital LLP, takes over after months of financial turmoil.

Once the poster company for digital health in the UK and championed by Tory politicians, such as Matt Hancock, as a model for the way the NHS can integrate digital tech, AI and private enterprises, Babylon Health is now having to reassure patients in the UK that the deal will not adversely affect its NHS services. The company argues the financing would offer certainty after months without long-term funding.

The move by AlbaCore is billed as "a restructuring and recapitalisation" of the business, which will leave shareholders wiped out according to the FT. AlbaCore Capital LLP is based in London, but at the end of March it was reported that it is being acquired by the Japanese banking group Mitsubishi UFJ.

Shareholder approval of the deal is not needed nor will they receive any payments under the debt agreements Babylon already has with AlbaCore; the company has already loaned Babylon $300 million and will now extend $34.5 million in new funding.

Babylon has suffered significant financial turmoil since going public. Despite being based in the UK, Babylon chose to go public in New York rather than London and used a somewhat unorthodox manner of listing, via a merger with Alkuri, a special purpose acquisition company (SPAC) in October 2021. This method was popular around this time for small companies and for Babylon it resulted in an implied equity value of about $4.2 billion.

What happened next to the company's stock has been described by the company's own CEO, Dr Ali Parsa, in November 2022 as an "unbelievable, unmitigated disaster". By June 2022, Babylon's market capitalisation had fallen more than 90%, giving the company a market value of about $334 million. Its share price has fallen from around $11 in October 2021 to around $1 by June 2022.

The takeover by AlbaCore may not adversely affect the NHS but give the company financial stability, according to Babylon, but the recent months of financial troubles certainly have had an impact. Babylon had to undertake a significant restructuring of its business in the UK and with the NHS. In early 2022, the company complained about how little it was receiving for each NHS patient it saw via its GP at Hand service. In May 2022 Parsa said that the company loses money on every patient. Although the company received exactly the same amount as every other GP service in the country.

By Autumn 2022, the company had withdrawn its GP at Hand service from Birmingham, where it had only opened in 2019, leaving around 5,000 patients to find a new GP. The company also pulled out of all its deals with NHS trusts made both before and during the pandemic, including contracts with The Royal Wolverhampton Trust for digital-first integrated care and University Hospitals Birmingham Foundation Trust for its Ask A&E triage app.

The company has also attempted to sell off parts of its business. Despite these efforts net losses have continued to grow, more than doubling to $63.2mn in the three months to the end of March 2023, compared to the same period last year. The company also narrowly avoided being delisted from the New York Stock Exchange after its share price failed to maintain an average closing price of at least $1 over a consecutive 30 trading days, a rule for inclusion on the exchange.

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Can pharmacies pick up the strain on the NHS? Is it a good idea?

Patients will soon be able to get prescriptions for medicines to treat seven minor illnesses under Government proposals designed to relieve pressure on the GP sector.

It is hoped that the service, known as Pharmacy First, will be launched this winter after further discussions with industry bodies.

The conditions targeted are sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women. In addition, pharmacists will take on more work checking blood pressure and in prescribing the contraceptive pill.

Both the pharmacy sector and GP sector welcomed the additional investment and the opportunity for pharmacists to provide more patient services and divert patients away from GPs.

Thorrun Govind, chair of the Royal Pharmaceutical Society in England, called it a 'real game-changer' for patients.

Mark Lyonette, chief executive of the National Pharmacy Association (NPA) said that he hoped that the new funding 'signals a better understanding both in government and NHS England about the value pharmacies bring to the health service'.

Nuffield Trust Chief Executive Nigel Edwards said that the measures should enable pharmacists to provide more care to patients and take some pressure off general practice, but it will have 'to be implemented carefully.'

Edwards also noted, however, that the number of community pharmacies has been falling as their workload has risen and there is a possibility that if the funding is not sufficient for the plan then patients could get 'shuffled between two overloaded parts of the NHS.'

Furthermore, 'Prescribing and outcomes for patients will need to be carefully monitored to ensure antibiotics aren't overused and the right information is given about contraceptive pills.'

And Prof Kamila Hawthorne, chair of the Royal College of GPs, said:

'We're also pleased to see there will be a consultation on how giving our pharmacist colleagues greater prescribing powers for minor illnesses could be implemented safely, and in a joined-up way….However, whilst all these initiatives are positive steps, none are the silver bullet that we desperately need to address the intense workload and workforce pressures GPs and their teams are working under.'

The announcement included £645 million in new funding over two years, but this is not as generous as might seem at first sight: it will have to be split between the Pharmacy First plan, and two other services offered by pharmacists – a contraceptive service and blood-pressure monitoring, plus the updating of IT systems, to allow pharmacists to more easily access GP records and update them.

The organisation which negotiates with government on behalf of pharmacists, the Pharmaceutical Services Negotiating Committee (PSNC) is continuing to negotiate with the government over details of the plan and the allocation of funding and has said that 'the devil will be in the detail' and that its 'negotiating Team are deeply aware of and very focused on the immense and underlying challenges that pharmacies are still grappling with. It is not yet clear the extent to which this investment will be enough to help the sector through these pressures.'

There have been concerns over the level of funding received by community pharmacy, 90% of whose work is for the NHS, for some years.

In 2016, the government decided to reduce overall pharmacy funding, the justification being that there were too many pharmacies operating in the market.

Without negotiations with the PSNC, overall funding was cut from £2.8bn in 2015/16 to £2.592bn in 2017/18 (8% decrease), and the annual agreed funding has remained flat ever since. When inflation is factored in there has been a cumulative loss of almost £800m in funding for community pharmacy over the past five years.

In November 2022, Janet Morrison, CEO of the PSNC, told The Pharmacist that a Pharmacy First service would need an annual £350-£400m funding package.

So £645m split over two years would not cover the amount the PSNC estimated would be needed to fund Pharmacy First each year alone.

Dr Leyla Hannbeck, chief executive of the Association of Independent Multiple Pharmacies (AIMp) said that 'any measures to deliver patient care with a less cumbersome, less time consuming and easier bureaucratic burden will be welcomed by pharmacy teams [across] the length and breadth of the country.'

But: 'The reality remains that there is currently a shortfall of £1.1bn in pharmacy funding every year and rising, and many pharmacies are struggling to pay the ever-increasing prices of medicines, the higher general costs of doing business and managing greater workforce challenges.

Pharmacists can not pass on increased costs to patients and customers under the current contract with the NHS and so many "are operating at a loss.'

A recent survey by the National Pharmaceutical Association (NPA) found that the majority of independent pharmacy owners made a net loss dispensing medicines for the NHS during 2022, with nine in ten (92%) seeing a dispensing loss for at least one month of the year.

Lack of funding has already had an impact on the new pharmacy contraception service launched in March 2023. In late April 2023, The Pharmacist reported that just 4% of community pharmacies had signed up to the scheme within its first two days.

The board of the NPA withdrew its support for the roll-out in late April. It asked members and NHS England to pause its roll-out as with no new funding for the service, and all existing funds already allocated to other pharmacy activity, it believed that any payments to the sector for delivery of the oral contraception service would ultimately be clawed back by NHS England.

In January 2023, the Company Chemists' Association (CCA) said that community pharmacy is experiencing an annual shortfall in funding of over £750m, following the disclosure of data in parliament.

It is not just the funding that is the issue, as with other areas of healthcare, community pharmacies are struggling to stay open in the face of staff shortages. There has been a reduction in the number of students training to be pharmacists, plus workforce issues related to Brexit and pharmacists choosing to work elsewhere in primary care, rather than in the very pressured community sector, means that pharmacies are turning to locum pharmacists to fill the vacancies, but the rising demand is increasing locum fees with costs rocketing.

Even the large chains are struggling. In February 2023, Lloyds Pharmacy, the second largest community pharmacy chain, announced it will close all of its branches located within Sainsbury's supermarkets. This will affect 230 locations across the UK where the public currently access NHS services, and they will be closed with just 3-6 months' notice.

The closure came as no surprise to others in the industry, Nigel Swift, the deputy managing director of Phoenix UK, which owns the Numark and Rowlands pharmacy groups, commented to the Guardian : 'This announcement is the clearest possible sign of the dire situation facing community pharmacy in England as a result of insufficient government funding. Since the start of the pharmacy contract there has been a massive cut in real-term funding, resulting in hundreds of closures.'

The day before the Pharmacy First announcement, the BBC reported that the number of pharmacies in England has fallen by 160 over the last two years. There are now 11,026 community chemists, according to data from NHS Business Services Authority – the lowest number since 2015.

A recent survey from the NPA found that 92% of independent contractors saw a dispensing loss for at least one month of the year, while nearly half (48%) said that they had lost money through dispensing for six months or more.

Pharmacists are warning that many more businesses could close.and others are taking measures to reduce costs such as reducing open opening hours and staffing. The NPA survey found that over a third (38%) had reduced or stopped some NHS services, while over half (59%) had stopped or reduced previously free services like home deliveries or introduced charges for these services.

With less staff and shorter opening hours, patients expecting faster help from pharmacists than GPs, may well be disappointed.

Organisations, such as the NPA, have campaigned for a number of years for pharmacists to do more in the area of prescribing, and the Pharmacy First plan has been broadly welcomed, but it is clear that unless the funding is sufficient, then this plan will have little impact on the over-stretched GP services.

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The state of the ICBs – Eastern

As we reported at the end of last month, many ICBs have been unable to manoeuvre or cut their way out of deficits for last year. Our report looked at board papers for 21 ICBs in North East and Yorkshire, North West, South East and South West.

This report looks at 11 ICBs in Eastern England and London – and finds a similar tale of financial woe, denial and wishful thinking, with even ICBs that have somehow delivered a break-even for their local system (ICS) in 2022/23 warning that this has been heavily dependent on one-off "non-recurrent" savings, and that therefore the challenge is even tougher for 2023/24.

What is also common is for the ICB, as the commissioning body holding the purse strings, to be breaking even or in surplus itself, while the system (ICS) as a whole is deep in deficit, with providers carrying the pressure of delivering front line care, but unable to balance the books. The 2022 Health and Care Act, far from "integrating" the NHS has simply re-divided it, with just 42 commissioners attempting to control local trusts.

East of England

According to Cambridgeshire & Peterborough (C&P) board papers the whole of England's NHS is facing serious financial pressure:

"At draft plan stage the collective NHS deficit submissions were

over £6 billion with 4 regions over £1 billion deficit. The East of England region had a cumulative deficit of approx. £440m with deficits ranging from £57m to £107m.

"[Cambridgeshire & Peterborough] submitted a draft plan of £99.8m. Since then colleagues across the system have worked to reduce the prudence bias, manage risks through balance sheet flexibilities and manage capacity to 22/23 levels. This has resulted in a reduction of the deficit to £38m. (Cambridge University Hospitals deficit £20m and North West Anglia FT (Peterborough, Stamford and Hinchingbrooke) deficit £18m)." (p21)

While C&P has a special incentive to seek to balance the books for a further year ("there is the additional benefit of historic NHS Cambridgeshire and Peterborough CCG deficits being written off,") (p6) it's by no means certain that they can achieve it.

Indeed it seems to be a minority of ICBs in Eastern England that even claim to have come out of last year without an obvious or underlying deficit.

Bedford, Luton and Milton Keynes (BLMK) joins C&P in that position, despite a forecast £11m deficit for providers, driven by high costs of filling vacant posts with agency staff, and numbers of mental health patients being placed in out of area beds for lack of adequate local capacity.

BLMK warns that its draft plan has also been rejected by NHSE: "the System is not yet able to demonstrate a fully compliant plan", and major concerns include:

"• Bridging a funding shortfall that currently necessitates identifying efficiency cost reductions across the system;

Capacity to deliver the levels of recovery activity needed to achieve the BLMK target of 109% of 2019/20 activity (i.e., pre-COVID level);

The plans, activity and funding necessary to manage hospital flow and discharge and meet targets for urgent elective care and winter planning;" (p318)

To make matters worse BLMK's emergency services have been under pressure:

"A&E attendances in December have increased by 11.73% on the same time in 2019, with all Trusts seeing record numbers of attendances over the last two months. Hospitals have been operating with high levels of bed occupancy 95.9% (December to 10th January)." (p23).

Similar pressures in C&P led to the opening of 240 extra beds (165 general and acute, 75 community beds), and additional home care hours provided.

Herts and West Essex (H&WE) also claims to have broken even for 2022/23, with the ICB itself underspending by enough to balance the deficits in Princess Alexandra Hospital Trust (Harlow) and East and North Herts Hospitals (p68). But it admits this means that the Integrated Care System as a whole is carrying an underlying deficit forward into 2023/24.

Indeed their initial plan indicated a deficit of £107m (3.7% of income) – the largest in the region – despite assuming very substantial "efficiency savings" equivalent to 2.8% of budget (above NHS England's target of 2.2%). (p 68)

H&WE explain that the deficit is caused by:

"the underlying deficit carried by the ICS organisations in 2022/23, the non-achievement of Elective Service Recovery in 2022/23, which has resulted in productivity improvements being behind where they were expected to be and the aggregate loss of COVID funding since 2021/22 of £76m, but without being able to recurrently reduce the spend. (p87-88)

On top of this the ICB itself is showing a deficit of £16.093m for 2023/24, along with deficits in all of its main providers – East and North Herts Hospitals (deficit projected at £29m) Hertfordshire Community Trust (£4m), Hertfordshire Partnership FT (£25m); Princes Alexandra Hospital (£20m), and West Hertfordshire Hospitals (£12.4m).(p96)

The ICB emphasises the range of issues that need to be considered to generate another £100m of "savings," several of which pose the real danger of service cutbacks and delays in much-needed improvements:

Funding added to budgets for COVID needs to be identified and costs taken back out

Productivity losses since 2019/20 need to be reversed so we can deliver increased elective activity at lower cost

Greater joint working across Places and Providers to maximise utilisation of our most costly capacity or reduce the capacity required

Push for greater cash releasing efficiency savings

Slow down the pace of service developments to meet Long Term Plan requirements

Make choices and decommission services that add least value to the population (p69)

H&WE is one of a number of ICBs and trusts to be explicitly seeking to increase their workforce as a means to reduce dependence on use of more expensive agency staff – despite recent pressure from NHS England to drop such plans. The HSJ reports many trusts have been told by NHSE that they were not permitted to increased their total number of planned posts, known as staffing "establishment", for 2023-24. NHS England are clearly focused only on short term cash savings rather than any genuine integration of the NHS.

The H&WE plans propose a 12- month growth of 3.76% in the establishment, including a near 5% increase in Allied Health Professionals, "confirming the system's ongoing commitment to move staff from agency/bank to substantive," while plans for the next 5 years indicate a growth in establishment of 4.35% and an increase

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of 17.37% AHP staff-in-post. (p70)

The situation is worse at Mid & South Essex ICB (M&SE) where the March Board papers admit there is no hope of balancing the books because the major acute trust (Mid and South Essex FT, MSEFT) deficit had risen to £63.2m:

"the Month 8 deficit position made it increasingly difficult to assert breakeven by the year end. The report confirmed that regional and national escalation discussions had concluded, and the system was planning to adjust its forecast outturn position during Month 9. A negotiated stretch forecast outturn position of £46.4m deficit was reported at Month 9, (£16.8m surplus ICB, £63.2m deficit MSEFT and EPUT breakeven)" (p133)

By Month 10 MSEFT was forecasting to deliver just over half of its savings target, and declaring that the deficit was "mainly reflective of a considerable amount of escalation capacity and significant agency costs." (p186)

This was despite recruitment of additional staff: "MSEFT's total substantive workforce had increased by circa 3,000 since 2018/19, both in terms of head count and whole time equivalents, [but] circa 2,000 vacancies remained." (p208)

But MSEFT was not the only trust in trouble: the Essex Partnership Trust had a 23% vacancy rate for nursing posts, and overall the M&SE system was using twice as many bank and agency staff as allowed by the NHS England "cap" on spending. (p208-9)

Patricia Hewitt's Norfolk & Waveney ICB had been forecasting break-even back in month 8, but by month 11 was admitting that it would end up with a £20m deficit, but an even worse underlying deficit of £71m, with "no plan at present to bring to a break even position in the short term." (p343)

The Finance Committee warned that: "It should be noted that (nearly) all NHS organisations in the ICS require significant use of so-called non-recurrent measures, which show the underlying strain on the finances." (p377)

The Committee went on gloomily to discuss the coming financial year, for which the ICB's emerging financial plan "had already undergone challenge internally and by NHS England:". It warned:

"The foreseen deficit at system level for 23/24 … was £55.7m. It also assumes significant risks are absorbed by each organisation." After the first plan was thrown out by NHS England another attempt has been made to bridge the gaps, but it's all very tenuous, dependent on vague "mitigations" of substantial risk and know pressures:

"… The ICB will leave the 22/23 financial year with a forecast underlying deficit of £59m. A paper explained the reasons for that. The current 23/24 plan is a break even position but £72m of mitigations have been used to achieve that position."

Suffolk and North East Essex (SNEE) is another ICB which appears to have balanced the books but only by extensive use of one-off measures, and is sitting on a time bomb of underlying deficits. System providers had continued to forecast a barely credible £8,000 surplus for 2022/23.

But its March Board papers note:

"Unmitigated risk reported by SNEE hosted NHS organisations remains £nil, with organisations confident that … financial plans will be achieved. However, financial performance is being supported by non-recurrent resources/use of balance sheet flexibility." (p142

Worse, "All organisations are providing a narrative that the underlying position is deteriorating caused by the increasing impact of non-pay inflation and winter pressures, and the inability to discharge medically fit patients." (p148)

The chickens come home to roost in the draft plan for 2023/24, which warns of a deficit of £59m. "System partners are working towards the delivery of a challenging but credible break-even plan." (p173). This was after a £30m improvement in the ICS's finances (p394)

But an obscurely worded Financial Planning Update in the Finance Committee meeting from February 14 notes that

"The Committee was in receipt of a report," which apparently mentions an even higher deficit of £82m. The report (which we can assume is the work of management consultants, since it is not attributed to any ICB source) is not published with the Board papers, but it is said also to include much relevant information:

"information on the planning timetable, governance, work that was outstanding, allocations, national notifications re inflation and growth, risks, draft ICB position, cost improvements and next steps."

It also included news that:

"Based on feedback from NHS England, East Suffolk and North East Essex FT and West Suffolk FT there might be some pressure to increase Cost Improvement Plan percentages and develop detailed plans. (p399-400)

Committee comments on this report included a warning that the problem could be even bigger: "The £82m deficit mentioned in the report did not include risk associated to the Elective Recovery Fund and further information from the national team was awaited." (p400)

The Committee also heard warnings that the East of England Ambulance Service faced a £5-6m risk, but an even bigger looming threat of an underlying £17m deficit (p394), and the crisis-ridden Norfolk and Suffolk Foundation Trust, which delivers mental health services to the two counties, is facing a £20-£25m deficit (p399) while still in special measures since 2017.

The ICB itself faces a hefty cut in its running costs, from £18.8m to £14.2m by 2025/26, effectively a 30% cut after allowing for pay inflation. (p168).

John Lister

Survey of London ICBs: an insight into managing financial crisis

A Lowdown snapshot survey of the board papers and plans of London's ICBs reveals the depth of financial pressures and some of the impact upon services.

North Central London ICB (NCL) has published May Board papers, which nonetheless go back to a Month 9 Financial Report, with grim news that the system as a whole was £53.6m in deficit, £32m adverse to plan – all of this down to providers. There was no mystery as to why:

"The primary causes remain consistent, including system expenditure on agency staff being higher than plan and target, [inadequate] delivery of planned efficiency savings, persistent excess inflationary challenges over and above those that the system was allowed to plan for …" (p14)

There is clear evidence here of denial and delay in reporting the bad news to minimise the consequences:

"Although the system forecast position will remain as break-even at Month 10, there will be movement among providers' positions as part of this. Providers whose positions move adverse to plan will trigger the NHSE Forecast Outturn protocol but as the overall system is still forecasting break-even, the consequences of this will be limited." (p14)

Somehow despite the scale of the deficits, and the red-rated risk to long term financial stability, the ICB reports "It is likely that NCL will be able to deliver a breakeven financial position for the 2022/23 financial year. It is though crucial to note that this is underpinned by a significant level of non-recurrent benefit which will not be available in 2023/24 and that continued improvement to the underlying position of the system as whole is required." (p95)

The reality is even more alarming:

"Planning processes are underway and the plan, submitted at the end of March 2023, is likely to show a System-wide

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deficit of approximately £120 million. The main pressures arising are from excess inflation on utilities and other CPI-driven contracts, as well as from the elective recovery scheme for 2023/24, which requires NCL to deliver a stretched target in excess of almost all other ICBs but for the same share of money as other ICBs." (p95)

Indeed the whole ICB financial plan going forward is based on "an assumption on 5% efficiency savings on non-pay expenditure," for which no evidence is produced to suggest it is achievable, especially since "There is a significant gap between the revenue that NCL receives to fund elective activity and the level of activity taking place." (p15)

Despite the underlying deficit, NCL, under the red rated risk of "Failure to Deliver 2023/24 Statutory and Other Financial Requirements set by NHS England," notes:

"The 2023/24 ICB draft financial plan is reporting a break-even position for the ICB. … To achieve a balanced position the 2023/24 plan assumes c£40m of efficiencies and non-recurrent actions will be achieved. In addition, there is an estimated c£60m of risk which, if it emerges, is assumed will be fully mitigated in year." (p97)

The assumptions are far-reaching, and include:

"Requirement to identify non-recurrent funding as the ICBs recurrent cost base is higher than expected allocations – £10.8m,

Full achievement of the ICBs efficiency targets – £30.5m,

Assumption that the ICB can mitigate identified risks not included in the financial plan – £67.9m." (p82)

The ICB's chief executive warned the March meeting: "there may come a time when the ICB has to acknowledge that as a result of the operational pressures confronting it, certain targets are unattainable for the time being." (p20)

The ICB's Board Assurance Framework, assessing risks, also includes the chilling warning that gaps in the recruitment process of Continuing Health Care could

"impact on the ICB's ability to fully deliver against the NHS Long Term Plan priority of improving services for people with a learning disability and autistic people by ensuring that they have annual health checks and reduce their reliance on inpatient care." (p89)

The risk is that vulnerable patients may be left with no care at all: "Should there be a gap in resources, the delays in assessments/reviews may lead to significant concerns around patient care, given that the care is insufficient/nonexistent."

Recruitment appears to be a major weakness across the ICB: "Across permanent and fixed term contracted staff, the turnover rate in NCL is 19.3% – over 8,000 people leave our workforce every year and this is now increasing following a reduction over the past two years. The age band with the second highest turnover rate is under 35s, which poses a significant threat to our future workforce sustainability.

"… NCL's GP nursing rates remain one of the worst in the country (13 per 100,000 compared to a national average of 27 per 100,000.) …. Our Mental Health workforce is heavily reliant on temporary staffing, with 49% of the growth in the workforce over the last three years having been bank & agency rather than substantive , and the proportion of total staff who are bank/agency has increased from 12% to 15%.

"… If trends continue, our workforce gap could increase by 17,061 over the next five years." (p42)

North East London ICB (NEL) revealed in its January Board that it had given up on balancing the books and "agreed a revised deficit plan of approximately £35m which is recognised by NHS England."

It will surprise some other ICB finance directors that fessing up to a deficit they can't hide has even secured a cash handout from NHS England:

"Committing to an agreed revised plan means we will receive a small additional allocation and we also qualify for some additional capital monies for the next financial year." (p17) In fact the extra money adds up to £10.5m, "resulting in a final year-end deficit of £24.5m." (p264)

The ICB is continuing to spell out the problem, noting (p53):

"We currently have a blend of health and care provision for our population that is unaffordable, with a significant underlying deficit across health and care providers (in excess of £100m going into 23/24). If we simply do more of the same as our population grows our financial position will worsen further and we will not be able to invest in the prevention we need to support sustainability of our system."

NEL contains some of the most deprived areas in the country, and has a growing population:

"Without changes to care models we expect that over the next 5 years this translates to: A&E activity increasing by 12% (costing an extra £16m); inpatient activity increasing by 16% (costing an extra £131m); outpatient activity increasing by 15% (costing an extra £43m); and imaging activity increasing by 17% (predicted extra cost currently unavailable)." (p231)

The ICB notes "underlying deficits across the system and particularly within Barts Health and Barking Havering and Redbridge University Trust that we need to recognise and eliminate as a system … " (p234)

NEL also suffers from a huge agency bill for filling vacancies, almost double the scale of spending in the rest of London:

"we know there are opportunities for reducing unnecessary costs, such as agency spend – in NEL agency spend is 7% of

total spend vs 4% median for London ICSs." (p57)

And unlike Patricia Hewitt's report, NEL is up front in criticising inadequate, unequal and often unfair allocations from central government to the public health grant, which "significantly impacts on our ability to invest upstream in preventative services." (p57)

Allocations range from £114 per person in City and Hackney to £43 per person in Redbridge. The variation is at odds with the government's intended formula (which is based on standardised mortality rates for people under 75). Barking and Dagenham has the highest rate of any borough in London, yet receives only £71 per person. Havering has the same rate as Tower Hamlets yet Havering receives £45 per person, whereas Tower Hamlets receives £104 per person. More evidence of the hollowness of "levelling up".

NEL seems to be the only ICB flagging up a problem in relation to primary care, warning:

"Practices across NEL may be unable to deliver online consultation access to patients in 2023/24 if the expected national online consultation license funding is not made available. …

"Programme may not be sustainable due to lack of funding after 2023/24." (p131).

North West London ICB (NWL) April Board papers claim that "Subject to the audit review NWL ICS has delivered all the financial targets," but warns that "The improvement from last month's £26m deficit position is all due to non recurrent initiatives that were forecast in the previous months." (p105)

Indeed there is a problem going forward: "A break even plan for 23/24 has been agreed for the system with efficiency target at £220m. Work has started to identify 23/24 efficiency schemes however there remains a material unidentified efficiency gap that will need to be closed."

The "efficiency gap" is so wide because the NWL system is struggling to clear a massive £348m underlying deficit in just three years, reducing it to £176m in 2023/24.

This is easier said than done: "To achieve the overall financial balance, the system is required to make an overall productivity and efficiency target of 4.6% (£220m)" – well above the levels achieved elsewhere in the NHS.

It's not clear if this is possible, since "The system flagged a further £136m of risk relating to inflationary pressures, of which only £75m is mitigated." (p115)

The ICB states that sufficient potential savings "have been identified" in Continuing Health Care, Primary Care Prescribing, Estates, Primary Care and Mental Health Non NHS Contracts, and says "Plans are in development to identify the shortfall in the savings currently evident in the Non NHS Acute and Community Contract Programme areas." (p131)

Meanwhile the ICB is facing considerable problems, with significant activity increases, particularly in some of the "non-NHS acute contracts" in 22/23. It is seeking to cut spending totalling £13.4 million from "non NHS budget areas" – acute services, mental health, community health and continuing care – although no details are given of the non-NHS providers.

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One way of reining in these increasing bills is for the NHS to increase its own capacity and NW London seems set to join South Yorkshire and Bassetlaw ICB in setting up an NHS Elective Orthopaedic Centre, following the highly successful example of the South West London Orthopaedic Centre established almost 20 years ago. The NWL EOC is aimed at reducing costs of routine orthopaedic surgery by 13% (£4m per year) and keeping NHS funds within the NHS (pages 53-54).

South East London ICB (SEL) notes in its April Board papers the progressive reduction in its deficit from £60m in Month 9 (p11) top £53.9m in month 10 (p69) and £45.4m in Month 11 (p72). The system was continuing to forecast a breakeven position for year end, "with the release of non-recurrent funding across ICB partners year to date and at year end to support the position."

"The position includes the delivery of £201m savings in year, representing a combination of recurrent and non-recurrent savings, with non-recurrent savings also representing a carry forward pressures into 2023/24."

This is indicated by the projected gap in funding for 2023/24:

"a forecast gap to break even for the end of 2023/24 of just under £100m. Further work is underway to improve upon this position with a specific focus on the acute hospital sector where the gap to break even resides." (p115-6)

One key area for savings is reducing the dependence of mental health service on out of area placements, many of them to private sector facilities. (p118)

However the defiance of the law of gravity appears to be reaching its limits in 2023/24, as the Operational Plan admits, and NHS England appears to have rejected the most recent financial plan:

"Our biggest area of challenge relates to our financial position and our end March 2023 plan does not reflect a position that meets the national expectation of breakeven ICB financial plans for 2023/24. Our planning process has focussed on the application of agreed financial planning assumptions related to inflation and efficiency, put against expected income and expenditure for the year. After applying ambitious and consistent productivity and efficiency improvement assumptions of 4.5% we still have a material gap to a break even position of just under £100m at this stage, with financial pressures felt particularly in our acute hospital trusts." (p120)

A look at the biggest acute providers' Board papers also reveals the scale of the problem: Guy's & St Thomas' April Board papers note a month 9 (December) deficit of £24.6m:

"An overview was presented about how the Trust could bridge the gap between its current position and a break-even yearend position. This would require significant non-recurrent mitigations which would not improve the Trust's underlying financial position and so not alleviate the financial pressure on the Trust that was anticipated in 2023/24."

Indeed no less than 68% of the trust's identified cost cutting schemes are "non-recurrent" (p45). Another stubborn problem is spending on agency staff – 17% above the NHS England cap.

Kings College Healthcare is in an even worse position, £38.4m in deficit at Month 10, with Covid a major factor:

"The King's plan, in line with national assumptions for minimal COVID, assumed for 50 COVID beds and normalised sickness. Throughout the year, King's has had on average 150+ COVID patients, 30 additional beds out of action due to the IPC requirements relating to these patients and sickness absence which is 3% above anticipated levels. This has led to incremental costs but also hampered the Trust's ability to over perform on the Elective Recovery Fund." (p19)

King's is another Trust that has tried to recruit its way out of heavy agency bills, increasing the headcount by 650 in the year to January 2023 and continuing efforts to convert bank and agency staff onto Trust contracts. (p55)

South West London ICB (SWL) is another one that has given up the battle to deliver a break-even for 2022/23, and its March Board papers report its agreement with NHS England to move to a forecast deficit of £57.5m. It is another example of an ICS running in balance or a small surplus while all of the financial pressures are faced by the providers. (p115)

The forecast deficits are in two of the larger acute providers Epsom & St Helier trust (£35m) and St George's (£30m), while the Royal Marsden Hospital, with its extensive income from private patients and specialised caseload delivers a surplus of £7m. Significant reasons for the deficits are excessive spending on agency staff and a 24% (£66m) shortfall in the £280m plan for "efficiency savings". (p125).

Only 44% of the savings achieved are recurrent, with over £90m down to one-off non recurrent measures, implying a substantial underlying deficit going in to 2023/24. (p126)

However the ICB is vague in the extreme on its position for the new financial year, admitting only (p133):

"The operational guidance requires systems to breakeven in 2023/24 which will be challenging, given our current financial environment. Our system will need to focus on achieving productivity improvements to ensure that we make further progress in delivering against the national priorities, in particular continued recovery for elective and cancer care. We will ensure that the final plan reflects our system's ambitions whilst remaining realistic and deliverable.".

John Lister

Privatisation US-style as insurers move in on Medicare

In a shameful failure to challenge the Trump administration's cynical plan to privatise Medicare, the publicly-funded federal health insurance program for people sixty-five or older, Joe Biden's administration must now take the blame for the damage that has been done.

Official figures now show private Medicare Advantage (MA) plans now account for a majority of the entire Medicare program, with, 30.19 million of the 59.82 million people with both Medicare Part A and Part B enrolled in a private plan as of January 2023.

The long running doctors' campaign Physicians for a National Health Program (PNHP) have flagged up this grim milestone as the last remaining progressive sector of the US health system has been subordinated to the profiteering of the US medical insurance industry.

PNHP (which is celebrating 35 years of campaigning) has warned of the many problems with MA, which imposes intolerable restrictions on beneficiaries – from restricting them to narrow provider networks to requiring prior authori-

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zation prior to treatment and any high out-of-pocket costs.

They have called on the Biden administration to terminate Medicare Advantage and end this indefensible "partnership" with commercial health insurers.

Under Traditional Medicare, the federal government pays directly for the health care of seniors and adults with disabilities. Beneficiaries generally pay monthly premiums and need to have paid a 'deductible' payment before insurance cover kicks in, but patients have access to a wide range of doctors and hospitals across the country. Many patients also choose to enrol in a supplemental "Medigap" plan to limit their out-of-pocket costs.

Under (MA), the government pays a third party (often a commercial insurance company) to "manage" patients' care. While premiums tend to be lower than they are in Traditional Medicare, patients can face high out-of-pocket costs, much more restrictive networks and face the hassles of prior authorization.

By restricting care through pre-authorizations, referral requirements, and limited networks, insurers are able to keep their costs lower than the provided maximum payment from Medicare, and are allowed to keep a portion of the difference as profit.

Denying care also drives sicker beneficiaries to leave the program, which, when combined with marketing that targets healthier individuals, leads to a lower-risk patient pool – and higher overall profits.

Many MA insurers have also been accused of "upcoding" patients with a variety of illnesses and conditions that may be exaggerated or even non-existent in order to get a higher risk score and thus bigger payments from Medicare.

To make matters worse, the outgoing Trump administration established a Direct Contracting system that made it possible for Medicare Advantage subscribers to wind up enrolled with for-profit insurance companies against their will.

Far from solving this problem, Biden's team came up instead with a new, grotesquely misnamed 'ACO-REACH' program [Accountable Care Organization – Realizing Equity, Access, and Community Health]. It allows hospital-led managed care organizations to access the new Medicare privatization scheme, too – and inveigles patients to sign up, with little or no informed consent, to for-profit insurance corporations, on plans that benefit health care profiteers and create incentives to deny care.

Last year the biggest US health insurers turned over a staggering $1.25 trillion, with profits of $69.3bn. Yet they still describe every cent spent on patient care as "medical loss". Biden's team has helped boost the profits and limit the losses – at the expense of elderly patients.

PNHP has more than 20,000 members and chapters across the United States, and argues for a universal, comprehensive 'single-payer' national health program.

Next week, Sen. Bernie Sanders and Rep. Pramila Jayapal will introduce the newest versions of the Medicare for All Act in the U.S. House and Senate. PNHP are calling on 'single-payer' supporters in every state and every district to call their legislators and demand that they sign on to these important bills..

John Lister

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