The lowdown

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

Govt policy is a greater threat to patient safety than striking nurses

While ministers play up the risks to health posed by nurses and ambulance workers striking over staffing levels and pay, the evidence over the past 12 months would suggest it's the impact of government policies that represents the real threat to patient safety.

A detailed analysis of that evidence emerged earlier this month with the launch of the National State of Patient Safety 2022 report – 'What we know about avoidable harm in England'. It identified issues linked to an under-resourced and consequently over-stretched workforce, and called for a robust workforce plan – long-promised but never delivered by the government – and improvements in the quality and breadth of patient safety data.

And a global study published in September in the British Medical Journal found that doctors suffering from burnout – a huge problem over the past 12 years among doctors working in the NHS, where sleep deprivation is widely accepted as contributing to mistakes – were more likely to compromise patient safety.

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Earlier this year a General Medical Council survey revealed that the risk of burnout among trainee doctors was "at its worst since it was first tracked", and a similar survey by the Medical Defence Union showed that 26 per cent of doctors said that tiredness had impaired their ability to provide safe care.

Under-resourcing and poor workforce planning are a key driver of problems with safety.

More than six months ago a report from the Royal College of Emergency Medicine made clear to the government that the loss of 25,000 NHS beds over the past 12 years had led to "real patient harm and a serious patient safety crisis", and pleaded for at least 13,000 extra beds to tackle "unsafe" bed occupancy levels and "grim" waiting times for emergency care. The college noted that the UK has the second lowest number of beds per 1,000 people in Europe.

The NHS is almost 10 per cent down on its planned workforce – that's more than 130,000 posts lying vacant across England. NHS Providers' interim chief executive Saffron Cordery described this statistic, released three months ago, as "further proof that the NHS simply doesn't have enough staff to deliver everything being asked of it. Royal College of Nursing general secretary Pat Cullen added, "Tens of 1000s of experienced nurses left last year at the very moment we cannot afford to lose a single professional, and patients pay a heavy price."

Earlier in the year members of the Commons health and social care select committee warned that the NHS was facing "the greatest workforce crisis" in its history, which was putting patients at serious risk of harm. The committee's report noted shortages of 12,000 hospital doctors and more than 50,000 nurses and midwives in England, and projected a shortfall of 475,000 jobs overall in the health sector by the early part of the next decade. The then committee chair (and now chancellor) Jeremy Hunt said, "Persistent understaffing in the NHS poses a serious risk to staff and patient safety, a situation compounded by the absence of a long-term plan by the government to tackle it."

The BMJ recently published the results of an Imperial College Business School study, conducted at three hospitals within a single NHS Trust in England. This showed how patient safety benefited from rostering experienced, well-qualified, permanent nursing staff, and how additional healthcare support workers and agency nurses were not effective substitutes.

Commenting on the latest data on GP-patient ratios from the Office for National Statistics earlier this month, the Royal College of General Practitioners Kamila Hawthorne noted that, since 2019, GPs' workload has increased by 18 per cent and each fully-qualified full-time-equivalent (FTE) GP now cares for an extra 120 patients, while the FTE workforce has fallen by nearly 700 – with no sign that the government is going to deliver on its manifesto promise of hiring 6,000 more GPs any time soon. In November the Observer reported that because of severe workplace shortages some GPs were treating up to three times more patients than permitted by the British Medical Association 'safe care' guideline of "not more than 25 contacts per day".

Earlier this year Healthwatch England highlighted the growing practice of DIY dentistry, following a joint BBC/British Dental Association survey which had found that more than 90 per cent of NHS dental practices were no longer accepting new adult patients. The news came barely two weeks after access to NHS dentistry was further restricted, after the government announced it was scrapping the commitment to offer six-month checkups for most adults, replacing it with a an offer of check-ups only every two years.

And more recently, the health secretary's 'in denial' default mode was clearly on display earlier this month when problems first arose over the supply of antibiotics to deal with the outbreak of strep A. On 7 December Steve Barclay suggested to the BBC that there were "good supplies" of this medication, and that any problems were down to distribution – in effect shifting responsibility from the Department of Health & Social Care onto the retail pharmacy sector. A week later pharmacists told the broadcaster that supplies of these key antibiotics had now "gone from bad to worse" over the intervening seven days, and that the government needed to act.

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So how is the government proposing to address these threats to patient safety? Technology certainly doesn't seem to be helping: last month the BMJ highlighted how failing IT infrastructure was undermining safe healthcare in the NHS – citing a ten-day IT system outage at one of the largest hospital trusts in the NHS – and noted the disconnect between this lived experience by clinicians and the government messaging promoting a bright and shiny digital, AI-infused future for healthcare.

Then there's 'self testing'. On the test launch of the Department of Health & Social Care's 'at home' NHS Health Checks programme – presumably an initiative to reduce pressure on GP surgeries, and to build on already available sexual health and blood pressure at-home testing options – the Royal College of General Practitioners chair Kamila Hawthorne expressed concern over how digital health checks could reliably link up with GP patient records and how patients might interpret their findings. She was also worried about the associated staffing implications for surgeries, and about potentially adding to GPs' already high workload.

How about advertising? More tinkering at the edges rather than addressing the main issues emerged late last month with (potentially) in excess of £28m of taxpayers' hard-earned winging its way towards M&C Saatchi. Tasked with creating a three-year strategy to ease pressures on the NHS, the ad agency's "Help Us Help You" campaign focuses on the idea of 'more suitable alternatives'. That means persuading patients to see a pharmacist before bothering their GP, consulting GPs virtually rather than in person, and phoning 111 rather than going straight to A&E.

All ultimately benefiting patient safety, no doubt, but M&C's windfall contrasts somewhat with the Department of Health & Social Care's earlier decision to allegedly slash funding – by 63 per cent, from £11m down to just £4m – to promote the uptake of NHS England's autumn covid and flu jabs.

Consistent underfunding has increased the take-up of independently provided healthcare. Record NHS waiting lists have encouraged those that can afford it to jump from public to private. But there's growing evidence that patient safety isn't all it's cracked up to be in the lightly regulated independent sector, and 1000s of patients have been transferred to NHS wards after treatment as a result. Most private hospitals lack ICU facilities, and post-operative care in the sector is often handled by unsupervised, inexperienced and overworked agency-employed junior doctors. This business model has been cited as a contributing factor in several coroner's inquests into the deaths of patients.

But the voluntary sector is being enthusiastically eyed up as a way to solve problems within the NHS, and potentially work around the threat of strike action. Last week the Guardian revealed that the Department of Health & Social Care is planning to recruit 1000s of unpaid volunteers to help ambulance crews and provide support in hospitals, building on the model offered by a £30m four-year contract the NHS signed with St John Ambulance back in August, under which the charity is to provide surge capacity to ten ambulance trusts.

The impact of this move on patient safety is unclear, but the roles being offered surely suggest some risk. The Guardian cited one ad, posted by an NHS Trust in northern England, seeking "urgent and emergency care volunteers", as well as people to volunteer on a 33-bed ward for cardiology patients and older people. The latter roles were to include "ensuring patients stay hydrated [and] ensuring hygiene needs are met".

When pressure on services is high and standards slip, management bullying has too often been the tried-and-tested way to deter whistleblowers from exposing threats to patient safety. A recent BBC investigation, for example, claimed that patients were being put at risk and doctors "punished" for raising safety concerns at the University Hospitals Birmingham NHS Foundation Trust, where some haematology patients had reportedly died without obtaining treatment. And going back three years, the Guardian revealed how the West Suffolk NHS Foundation Trust – former health secretary Matt Hancock's local hospital – felt driven to hire fingerprint experts to unmask one particularly troublesome whistleblower.

Martin Shelley

Why is the NHS pay review process not working?

Strikes in Scotland have been averted by direct negotiations between the government and the health unions enabling agreement on an improved pay offer. In England ministers are digging in their heels insisting that negotiation is unnecessary as the independent Pay Review Body has made recommendations which the government will honour in full. Trade unions claim PRB recommendations are too low, out of date and far from independent.

Is the Pay Review Body independent?

In a stream of media interviews about the strike ministers have claimed that the PRB is independent and free of government influence. They do not explain that at the start of the review process the Health Secretary defines the remit of their work in a letter sent to the PRB, making it very clear that its recommendations need to fit within the government's overall spending plans and inflation targets. The health leaders of Wales and N Ireland do the same.

Effectively this sets parameters for the PRB and a ceiling on the pay rises they can suggest. Of course the PRB could rebel, but it never has, and is unlikely to ignore the remit from the government as it would likely lead to the government rejecting their recommendations.

The government website explains that the PRB is funded and appointed by the Department of Health and Social security, and works within cabinet office rules. It also publishes a report to explain its recommendations, but its critics point to the fact that this year's recommendation of a 4.5% pay rise (on average) amounts to a real terms pay cut for NHS staff and that the pay review process has helped to hold down public sector pay over the last decade.

What is the impact of the PRB on public sector pay?

This year's offer was set in March 2022, so has not taken account of the full scale of the rise in inflation. This time lag adds to the argument for negotiation and an adjustment to the pay offer, as inflation back in March was less than 7%, raced to over 11% and now stands at 10.67%.

Average weekly earnings % growth (year-on-year) - three months to October 2022

Whole economy	6.1%
Private sector	6.8%
Public sector excluding financial services	2.9%
Construction	5.4%
Financial and business services	6.3%
Manufacturing	5.4%
Wholesale, retail, hotels and restaurants	6.4%

Next release date: 17 January 2023 Source: ONS

The private sector has been far more responsive to the economic situation, with many companies reporting that in a competitive market they have increased wages in order to hold onto their workforce. According to the Office of National Statistics average weekly earnings growth was 6.8% in the private sector in the year to October, compared to a growth rate of 2.9% in the public sector.

The number of vacancies in the NHS stands at a new record high with more than 133,000 full-time equivalent posts unfilled in September – a 29% rise in twelve months. 47,500 of the vacancies are for nurses, an average of almost one in eight posts.

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Trade unions say this is more evidence that the PRB system has consistently failed to provide big enough pay incentives to retain NHS workers within the NHS and to attract more people to work within it – which is one of its key functions.

The graphic below from a BBC newsnight report shows that historically pay in the public sector was higher by 20% in 1994, but if you take account of the higher qualifications needed in many of the public sector jobs, that difference has now totally disappeared. There is now a far greater incentive for workers to leave the public sector.

Appearing on Newsnight Jerry Cope who took part in health and prison pay review bodies said "I have chaired pay review bodies for 12-years and we fiercely guarded are independence". He acknowledged that PRBs couldn't make recommendations that were unaffordable, but asserted that it wasn't just about money; recruitment and motivation were also important factors.

In response Sian Moore, Professor of Employment Relations at the University of Greenwich said

"They (PRBs) are losing credibility and looking quite toothless at the moment. they have been complicit in holding down pay for 10 years and have offered a pay settlement which is a pay cut for NHS workers."

In reaching its recommendations, the Review Body is to have regard to the following considerations:

– the need to recruit, retain and motivate suitably able and qualified staff

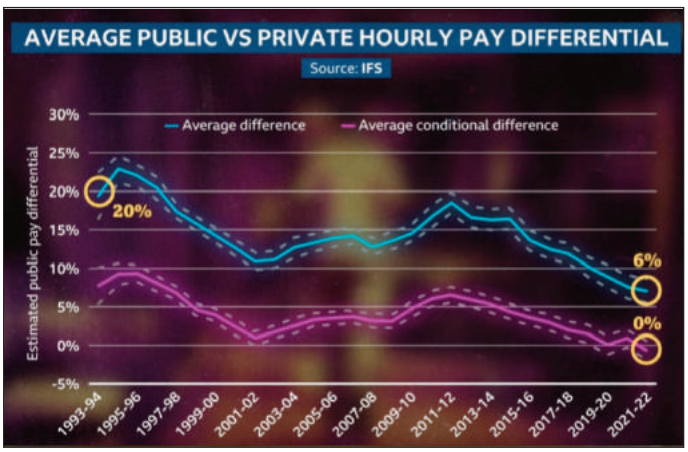
– regional/local variations in labour markets and their effects on the recruitment and retention of staff

– the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;

– the Government's inflation target

– the principle of equal pay for work of equal value in the NHS;

– the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved



Ways to raise the money the NHS needs

The government claims that to pay inflation-busting increases to public sector workers would cost an extra £28 billion: but BBC Newsnight's economics editor Ben Chu argues the cost would be £10-£15 billion.

Either way the cost is not the main obstacle: the main problem is the government refusal to fund the NHS at a sustainable level, because their priority since 2010 has been to keep taxes low for the wealthiest few and the corporations, which are coining in ever-increasing profits.

Chancellor Jeremy Hunt has said he accepts that the NHS is "on the brink of collapse" and admitted there are "massive pressures in the NHS … with doctors, nurses on the frontline frankly under unbearable pressure". But he still argues more real terms cuts in the NHS are needed to help fix the economy that has been broken by years of austerity since 2010.

His autumn statement gave the NHS just half of the additional £7bn it needed, leaving NHS England committed to £12bn of savings over 3 years and no new money for any capital investment.

But Hunt has agreed to scrap the cap on bankers' bonuses and just cut the bank surcharge from 8% to 3% while banks are making windfall profits on massive £950bn of reserves held at the Bank of England (because of increased bank rate from circa 0% to 3% and rising). Hunt has also refused to levy windfall taxes on oil and energy companies that are ripping off the wider public and reducing millions to poverty.

And while demanding NHS savings, Hunt does not appear to

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be concerned to reclaim the billions of pounds lost to fraud during the Covid pandemic: HM Revenue and Customs' Covid fraud task-force is being shut down – abandoning efforts to track the estimated £4.5 billion that was lost to fraud and error from the furlough scheme, help for the self-employed and Eat Out To Help Out.

The government is silent on up to £37 billion that was wasted on the ineffective privatised 'test and trace' system, an estimated £17bn lost on "bounce back loans", and ministers have written off £8.7 billion spent on contracts with Tory donors and cronies for PPE that can't be used or was bought at inflated prices.

Astonishingly, every year the HMRC admits to failing to collect at least £35bn due in taxes, around £15bn of which is down to fraud: but HMRC staffing has been cut, making life easier for the tax-dodgers.

Some people do very nicely from all this.

Unite the union has shown that profit margins for the UK's biggest listed companies were 73% higher in 2021 than pre-pandemic levels in 2019. Even removing energy companies from the tally, average profit margins still jumped an astonishing 52%. Across the UK company profits jumped 11.74% in the six months from October 2021 to March 2022. This increase in UK wide company profits – not Putin's war in Ukraine – is responsible for 58.7% of inflation in the last half year.

While real terms pay for nurses, NHS staff, public and private sector workers has fallen since 2010, the number of billionaires in Britain has more than trebled from 53 in 2010 to 177 at the latest count, while the number of millionaires has mushroomed more than five-fold from 508,000 to a staggering 2.85 million.

The wealth of the richest 250 people in the UK continued to grow before and during the pandemic, and has risen another 8% in the last year to £711 billion, according to the Sunday Times Rich List: and much of this wealth escapes tax altogether.

Labour MP Richard Burgon has suggested four measures that could raise an additional £40bn a year to fund public services without taxing anyone earning under £80,000 per year:

– scrap non-dom tax status (raising £3bn);
– a 1% tax on wealth over £5m (£10bn);
– a 45% tax on pay over £80k, 50% tax on pay over £125k (£6bn)
– tax dividends and capital gains at the same rates as income (£21bn)

It's hard to see why this approach should not be implemented to get the wealthiest who have gained most to pay a fairer share towards public services. It's more than enough to meet the pay demands of health workers, teachers, university staff and others fighting now, increase funding for NHS and social care – and to increase Universal Credit and other benefits to ensure more support for the poorest and lowest paid.

John Lister

Nurses' and paramedics' pay fact sheet

Since 2010...
– Nurses' real pay is down £4,300
– Paramedics' real pay is down £5,600
– Teachers' real pay is down by 20%
– MPs' pay is up by 28% – from £65,000 in 2010 to £84,000, plus £5,435 to feed each of their own children, lavish expenses and subsidised meals.

Despite inflated ministerial claims on pay rates, basic pay for nurses midwives and paramedics starts on £27,055 (Band 5), and can only progress beyond £33,000 by getting promoted to Band 6.

Shift work and overtime increases the actual earnings for many, but also adds stress, and danger of burn-out.

The Health Foundation calculates real terms basic pay for nurses has fallen by almost 10% since 2012, and even the Pay Review Body (PRB) admits "nurses' starting pay still remains below its value when Agenda for Change was introduced in 2004."

A recent survey estimated 14% of nurses (almost one in six) are relying on food banks as they struggle to pay bills and feed their families; one nurse in three regularly skips meals themselves to help pay for food for their family, and half of all nurses are having to work overtime or bank shifts to pay bills.

In last year's NHS staff survey, before the latest surge in inflation, just 31% of staff said they were satisfied with pay. The most dissatisfied groups included nursing and healthcare assistants (17% satisfied), ambulance staff (23%) and registered nurses and midwives (28%).

The 2022 PRB report in July recommended an award equiv-

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alent to "an average of 4.8%" increase in the pay bill" – way below the CPI inflation figures, and further still below the RPI figures used by the RCN. The PRB admitted "Inflation, as measured by the Consumer Prices Index (CPI), was at 9.0% in April 2022, the highest recorded rate since the series began in 1989." And it quoted a Bank of England report which at best hoped to return to "close to their 2% target" for inflation … in two years.

The rate of inflation records the pace at which prices increase: but even if that pace slows, it does not mean prices necessarily fall back to previous levels. The gap in real value continues unless and until prices actually fall.

The PRB is required to "have regard to" the need to recruit retain and motivate staff, but it has always also been constrained by having regard to "the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits" and "the Government's inflation target."

The PRB's report was published in July, but only took account of submissions between January and March 2022. It therefore ignores the additional inflation in energy and other prices from the war in Ukraine (which did not begin until the end of February).

By October the CPI annual inflation rate was the highest annual CPI inflation rate since the index began in January 1997. Energy prices in October were 89% higher those in October 2021, with gas prices doubled and electricity and liquid fuels up 65% and 70%. Food price inflation in October at 16.4% was the highest since September 1977.

However as things stand even if the PRB were to consider recommending a compensating increase next year to take account of this inflation, government spending limits mean NHS England is already warning that it can only afford an increase of around 3 per cent for staff in next year's pay deal.

ICBs six months on – the crisis deepens

Back in May The Lowdown surveyed the plans being drawn up for the launch of Integrated Care Boards (ICBs) as the new "local" bodies holding the purse strings of the NHS and charged with implementing the renewed government austerity limits on spending.

We warned that the 42 new bodies to take over from July were being created in conditions of crisis – but also that few of them appeared willing to face the grim financial realities, which have since got even worse.

We warned that despite bowing to NHS England pressure to submit largely fictional and hugely optimistic plans projecting financial balance, Integrated Care Systems face combined deficits and spending constraints that would required billion of "efficiency savings" or in the jovial NHS parlance "cost improvement programmes" (CIPs).

And we also warned that, judging from the draft plans that had been published, it was clear that a very large proportion of these "savings" would be either "non-recurrent" (one-off measures that leave the underlying problem untouched), or simply left "unidentified" – as a problem kicked down the road while management hoped against hope some more cash would turn up.

Having now surveyed the available Board papers for more than half (22 of the 42 ICBs) it's clear we were right on all counts. But since we ploughed through the chaotic array of widely different financial projections in May things have got much, much worse.

NHS England's October Board papers set out a challenging outlook, having already committed to deliver annualised savings of £12bn by 2024/25, and it is expected that inflation, still in double digits, could add a cost pressure of a further £6-7bn.

However Chancellor Jeremy Hunt's autumn statement made clear just half of this (£3.3bn) will be covered by extra funding this year and next.

In addition:

- NHS nurses and ambulance staff are striking for more pay;
- almost 7,000 hospital beds in England are filled with Covid patients (December 14) while the government's allocation of additional Covid funding is falling back towards zero;
- An average of another 13,000 front line beds are filled with patients who cannot be discharged for lack of social care or community health services to support them,
- and at the same time, NHS trusts are expected to deliver an incredibly ambitious elective recovery programme with no additional capital, hospitals needing £10 billion-plus of backlog maintenance.

But with insufficient funding and capacity, NHS England have been trying to bully their way through. They have sent out draconian orders seeking to whip reluctant ICBs in to line, threatening various bureaucratic controls over those who fail to deliver a balanced budget despite the runaway costs faced by providers, soaring pharmaceutical budgets and the rising cost in almost every

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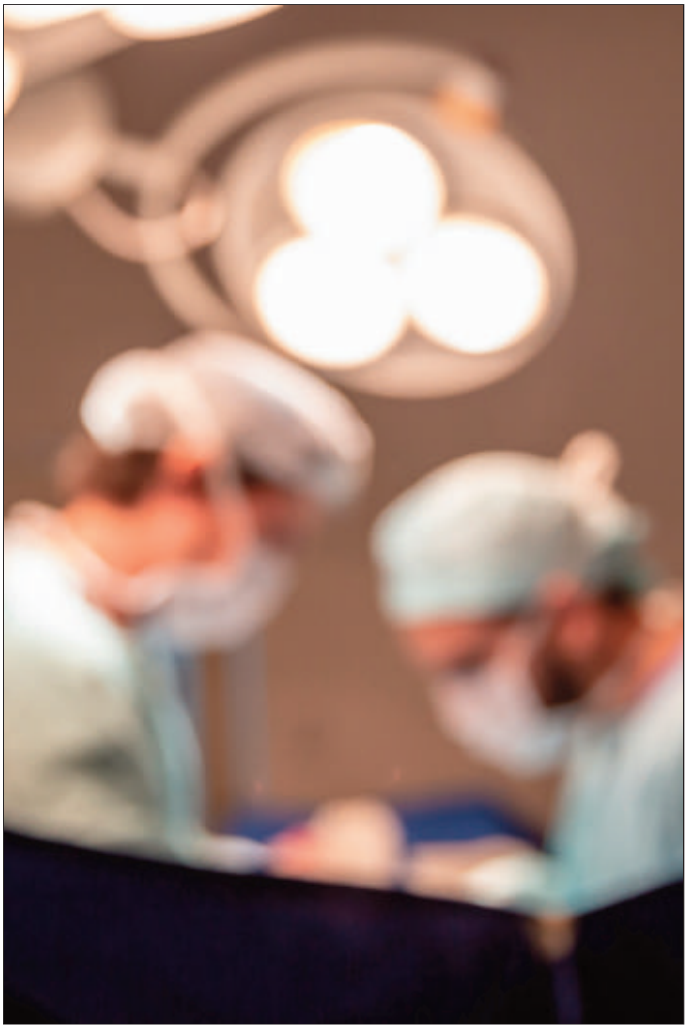

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area of employing bank and private agency staff to fill the growing numbers of unfilled posts.

However there is still little evidence that many, if any of the first 22 ICBs surveyed (in East of England, London and Midlands regions) have kept up at all with the events and decisions taking place at the top. The usual pre-Christmas letters listing impossible demands in even less likely timescales seem to have less and less impact each year as they appear even further out of step with the situation on the ground.

The aim since the formal reorganisation into Integrated Care Systems now appears to be to threaten to inundate ICBs and trusts that overspend with pointless paperwork and more meetings.

Coventry & Warwickshire ICB has revealed that on 7 November, NHSE issued to systems the "Protocol for changes to in-year revenue financial forecast" document (which has also been leaked to the HSJ, but is not published on the NHS England website).

This sets out the required actions to be taken by:

- any provider considering a deterioration in forecast but which the system can absorb, in which case the operation of the protocol will be overseen by the system
- any system forecasting for a deficit, in which case the operation of the protocol will be overseen by the region

Any NHS provider wishing even to report a forecast deterioration is expected to:

- Complete a 'variance analysis' to be presented to local system leaders
- Complete a detailed review of any uncommitted expenditure.
- Prepare a 'recovery plan' showing the steps that have been and will be taken to reduce expenditure
- Include any shortcomings identified from the Health Finance Management Association's 'financial sustainability checklist' – and how they are being addressed
- Provide evidence of sign-off of the above by the whole of the ICB's executive team
- Submit to a suitably independent review – with, for example a neighbouring provider – to confirm all possible mitigating steps are being taken
- Provide evidence of non-executive scrutiny of the above, and sign off by the board, including a board assurance statement signed by the chair, Chief executive, Chief Financial Officer and a relevant Non-Executive Director to confirm adherence to the protocol and their commitment to the delivery of the recovery plan

Any ICB and/or system wishing to report a forecast deficit position is required to go through all of the above – overseen by NHS England regional team (who apparently have nothing else to do). These obscure, bureaucrats are likely to be kept pretty busy with this nonsense as the financial wheels come off into the new year in ever more local ICBs.

The HSJ also reports that over-spending trusts must get 'sign-off' from their integrated care board for all revenue investments over £50,000, while integrated care boards and systems forecasting a deterioration face "a triple-lock sign-off process for any revenue investments above £100,000, with sign-off required by the organisation, system and NHS England regional team".

None of this of course does anything to address the underfunding and increased cost pressures that would have driven the ICB into deficit in the first place.

But it's not at all clear from ICB agendas that such correspondence even reaches the Board members who NHS England want to bully into line, and even less evidence so far of Boards other than Coventry & Warwickshire taking much notice. Even if they do, it's not at all clear how they are supposed to squeeze still more effort out of exhausted and inundated staff, crumbling hospitals, and clapped out equipment.

John Lister

See also pages 12-17 for more on ICBs

How can new diagnostics hubs cope with staff shortages?

Nineteen more locations have been announced for Community Diagnostic Centres (CDCs) by the Health and social care secretary Steve Barclay, which takes the total approved to 127, but how will they operate in the face of staff shortages, is outsourcing inevitable?

By September 2022, there were 92 CDCs up and running and the government has a target of "160 CDCs to perform up to nine million additional tests a year by 2025".

But are these centres going to have any impact on the 1.5 million people waiting for tests at the end of October 2022, 11.8% of which have been waiting 13 weeks or more from referral for one of the 15 key diagnostic tests?

Although Covid is cited by the government as a reason for the backlog, the problem is more long-standing as the 'standard' six week wait target for a diagnostic test has not been met since February 2017.

Diagnostics is a key component of many treatment pathways and any delay in tests can reduce patient survival. A lack of diagnostics is having a particularly devastating effect on cancer waiting times. In November 2022, NHS England reported the worst ever waiting times for cancer treatment.

The idea driving the CDCs is that they would reduce waiting times and clear the backlog of tests, as well as make access easier by being located at sites that are more convenient for patients, reducing visits to hospital sites.

CDCs have added much-needed physical space for diagnostics, but as with the rest of the NHS, the lack of a workforce plan means staff shortages will ultimately limit their ability to clear that backlog.

The NHS was already short of thousands of skilled staff in diagnostics even before the CDCs opened.

In July 2022, the RCR told the Health and Social Care parliamentary committee, that there was an estimated shortage of 1,939 whole-time equivalent consultant radiologists for the UK, which equates to a 33% shortage.

At the start of 2022, when the DHSC confirmed that the CDCs will need an extra 3,500 radiographers to carry out diagnostics tests and 2,000 radiologists to interpret the results, as well as 500 advanced practitioners, groups representing staff said that the staff did not currently exist for the CDCs and that recruitment by the CDCs would deplete departments elsewhere in the NHS.

Outsourcing

The shortage of staff has been ongoing for a number of years and NHS trusts are increasingly having to pay for staff to do overtime or outsource the analysis of scans to private companies. The RCR estimates that UK NHS trusts and health boards spent £122m on outsourcing radiology in 2021.

The upturn in business is clear from the accounts of the private companies involved. Two of the largest companies operating in the UK, Medica and 4Ways Healthcare, have reported big jumps in turnover in 2021. Medica, reported a £47.1m turnover in 2021 in the UK, up 33% on 2020. 4Ways Healthcare reported £34.5m turnover in the year to March 2022, up 70.5% on 2021, reportedly due to an increase in work from the NHS. The company's profits jumped to £5.1m from £1.7m in 2021.

The shortage of staff has been made worse by the refusal of the government to make changes to the pension rules in the NHS. Many consultants are reluctant to do extra sessions because of the potential impact of the extra income on their pensions, with breaches of the lifetime and annual allowances incurring penalties.

Consultants have been turning to the formation of limited liability partnerships (LLP) as a way to carry out work that otherwise would have been given to private companies. Several of these have already been set up, with HSJ reporting that in the Buckinghamshire Healthcare Trust, where there is a backlog of 8,000 to 9,000 unread scans, an LLP has been set up and the consultants are waiting for the trust to contract with it, so they can carry out extra work.

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In November 2022, HSJ reported that NHS England is assessing the viability of establishing an NHS-owned consortium to bring some of the diagnostic work currently being done for profit in the private sector back into the health service.

However, HSJ also reported that a meeting between NHSE and the private sector on joint venture arrangements was expected soon.

An investigation by The King's Fund has also found that the claim that CDCs will be located in places that are more convenient for people to visit and away from hospital sites is not holding up. The Kings Fund found that 47 of the 92 centres up and running were on existing hospital or primary care sites, not "closer to home", and not diverting people away from hospitals or more convenient as the NHSE has suggested they would be.

This trend appears to have continued – of the 19 recently announced new CDC sites, 10 appear to be at sites that are already hospitals or health centres, and it is unclear where the other nine are to be located within the city or town named.

The reason for this is that government guidance means that the CDCs have to be built within existing NHS estate and only on 'an exceptional basis' can building take place. Although some have been set up in shopping centres, unless a suitable site is available, then the CDC ends up being located with all the other NHS estate. The plan to target hard to reach populations to produce a diagnostic centre embedded in a community rather than at a distant hospital site, seems to be falling short of its goal.

In a report by The Kings Fund in October 2022, it notes that the ban on building work is also likely to have constrained the size of the centres, meaning not all tests can be carried out. It notes that although there are reports of 30,000 tests being performed weekly across the CDC, this equates to just 411 tests a week for each centre, "which suggests that not all centres are able to offer the full range or volume of tests that the Department of Health and Social Care expects the sites to meet."

The CDC programme is now over halfway through, and although 92 are up and running, it does seem that they are having little impact on the waiting list for diagnostic procedures. And without solving the workforce issue, their initial promise of ending the diagnostic waiting list crisis is likely to remain unfulfilled..

Sylvia Davidson

Streeting races up blind alley

Unlike his predecessor Jonathan Ashworth who was keen to engage and work with campaigners, Labour's current shadow health secretary Wes Streeting has kept his distance, and relied on other advisers.

They seem to be doing him no favours, since he has repeatedly made statements that are widely seen as – at best – leaning towards further use of the private sector in preference to expanding and improving the NHS.

On December 8, Streeting was again banging the drum for more use of the private sector in an Opinion piece in the Guardian, arguing:

"If Labour were in government, we would be pulling every lever available to bring down NHS waiting times, including negotiating to avert strike action. We would also be using spare capacity in the private sector to bring down waiting lists. Private providers have capacity for 130% of the procedures they were doing for the NHS before the pandemic, but the government hasn't utilised it."

This is compounded by his refusal to demand any increase in the NHS budget, despite the clear evidence that after a decade and more of real terms cuts in funding it is desperately lacking in resources and capacity: his most recent speech for

example, included his assertion that: "We cannot continue pouring money into a 20th-century model of care that delivers late diagnosis and more expensive treatment".

This was in a speech to right-wing think tank Policy Exchange (set up by Michael Gove). Again it stressed the need for "reform" that appears once again to centre on using private hospitals and contractors.

But when accused on Twitter by veteran left-wing MP Diane

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Abbott of trying to push "inch by inch" for a privatised/insurance based NHS, Streeting's reply was an indignant denial:

"I have consistently argued against an insurance-based or privatised model. It is in defence of the NHS's founding principles – publicly funded, free at point of use – that I make the case for reform."

However Streeting's proposals are as unhelpful as his ways of expressing them. A well-argued response to the call for more use of private hospitals came in a Guardian article by David Rowland of the Centre for Health and the Public Interest which begins:

"You can only assume that Wes Streeting's recent embrace of the private hospital sector as a solution to the current health crisis stems from naivety about how UK private healthcare works, or is part of the Labour leadership's attempts to turn it into a party of the centre right. It is certainly not based on evidence."

Rowland's article does an excellent job of demolishing Streeting's depiction of private hospitals as some kind of extra untapped resource that ideologically 'left wing' unions and others refuse to make use of. He exposes private hospitals' reliance on largely hidden subsidy and support from the NHS:

"… safety risks include the fact that the vast majority of private hospitals do not have any ICU facilities to look after patients if something goes wrong after an operation. Even at the height of the pandemic, 6,600 patients were transferred to NHS wards after treatment in a private hospital – a fact that suggests that far from assisting the NHS during the pandemic, the support went the other way. It is also an arrangement that costs the NHS an estimated £80m a year."

Rowland also refutes the claim there is any "extra" pool of staff in the private sector:

"… in all the private hospitals operating in the UK, the doctors are NHS doctors, working in their spare time. In commercial terms, because the private sector contributes nothing to the training of the 17,500 doctors who work in its hospitals, this amounts to a free subsidy to the private sector of about £8bn."

But Rowland does not go on to explore the economics and financial reality of increased use of private hospitals while the NHS, starved of capital to expand its own services and facing a growing £10bn-plus backlog bill even for maintenance of existing hospitals, pays for patients to get treatment in otherwise empty beds in private hospitals.

CHPI and The Lowdown have previously highlighted the costs and knock-on consequences of ill-conceived deals struck by NHS England for use of private hospitals during the peak of the pandemic, that have proved rotten value for taxpayers, but a windfall for the private sector.

The fact is that the average private hospital is so small (average size just 40 beds) and with such limited facilities they can only treat the most simple elective cases – leaving all of the most costly, complex and of course ALL emergency cases to the NHS.

So even while private hospitals can profitably treat patients on this basis at average NHS tariff costs, the reality is that this siphons vital resources out of the NHS, and perpetuates the chronic lack of front line capacity – effectively baking-in dependence upon private providers.

Streeting is too young to remember when New Labour first set out views similar to his, beginning in 2000 with Health Secretary Alan Milburn's disastrous 'Concordat' that sent NHS patients at hugely inflated costs to private hospitals in the winter peak period.

Milburn went further in the mid 2000s and squandered hundreds of millions on establishing new "Independent Sector Treatment Centres" (ISTCs) that were given preferential 5-year contracts to treat the simplest elective cases and an average of more than 11% above the NHS tariff rate.

NHS trusts and foundation trusts were banned from applying for these contracts, which made only the most marginal contribution to the reduction of waiting lists and waiting times achieved by a decade of investment.

But Streeting who has argued for a big expansion in training of new doctors should be told that the training of NHS doctors was made more difficult by the transfer of so many routine operations to these small new private units – where no training could be given. And only an increase in NHS funding can create sufficient employment opportunities for the additional new doctors.

The ISTCS were eventually recognised as an expensive irrelevance by most NHS commissioners and all but a tiny handful have since been brought back into the NHS.

But with Integrated Care Boards and hospital trusts in many areas now looking to save money by "repatriating" caseload and revenue from private sector providers as they face up to another round of brutal austerity, it's also worth noting that the failed New Labour experiment in use of the private sector took place in the context of a sustained decade of major investment in the NHS from 2000, which ended abruptly with the Cameron government in 2010.

Streeting's failure now to recognise the need for a similar sustained investment to reverse the decline since 2010 means he is picking up only the most controversial and questionable aspect of the Blair/Brown years: rather than reinventing the wheel he is reinventing the flat tyre.

If he wants to protect and restore the NHS with its core values intact he needs to start from a commitment to address today's crisis with increased resources – cash, capital and staff – rather than making more statements that raise cheers only from private hospital bosses and the Daily Telegraph.

John Lister

New NHS organisations slide quickly into deficit

A survey by John Lister of board papers and other information for ICBs in East of England, London and Midlands, available December 12-16, 2022:

Recent estimates suggest ICBs are headed for a combined deficit this year of £1.3bn (an average of around £30m per ICB): this would appear to be based more on hope than experience. The final total is likely to be much higher.

However with a very uneven approach by ICBs to reporting and response to the impact of financial pressures it is difficult even five months in to assess the actual situation on the ground in many areas or what the implications might be for patients and staff of any "savings" measures that might be taken.

In most areas most of the cost pressures seem to have landed on the acute hospital trusts. The squeeze on capacity has meant acute trusts have struggled to return even to levels of activity equal to 2019 before Covid, let alone hit the 104% target set for them by NHS England, and therefore begin to reduce the 7.2m waiting list.

This in turn raises questions over whether the trusts will receive the promised additional funding for elective recovery. In some ICBs this is being retained by commissioners where trusts have failed to deliver to target, in others it has been promised to trusts.

A common factor across almost all but the most hopelessly unrealistic of the finance reports are four key concerns which are also making it impossible to deliver savings as planned:

- Higher than expected levels of inflation affecting energy prices, drugs and other non-pay expenditure
- Over-spending on agency and temporary staff to cover vacancies and sickness absence – meaning that the 'cap' on agency spending is being exceeded.
- Continued, unfunded, pressures on beds and staff from Covid patients in a pandemic that has so far refused to die

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● Problems coping with non-elective and emergency demand, especially with so many beds filled with patients who cannot be discharged.

In this complex situation the level of engagement with the harsh reality of the financial pressures on ICBs has varied widely between regions and between ICBs.

A striking lack of detail undermines confidence in the viability of the 'savings' plans that are the basis on which any of the ICBs hope to balance the books.

And there is an even greater question mark over the 'savings' that are admitted to be non-recurrent of "one off", since they leave the underlying problem unresolved, and pose the need for even bigger savings going in to an even tougher financial regime in 2023/24.

East of England

Five of the six East of England ICBs, (including Norfolk & Waveney, chaired by former Labour Health Secretary Patricia Hewitt who is now "reviewing" the working of ICBs for Jeremy Hunt and the NHS) appear to have largely discounted the effects on their plans of double digit inflation, continued high levels of Covid and other additional cost pressures.

Bedfordshire Luton and Milton Keynes, for example, has only published a financial report based on Month 4, which notes:

"In March we submitted a deficit plan of circa £40 million, the two key drivers of the deficit were the ongoing impacts of COVID and inflation, particularly inflation as it related to energy. There was an additional £1.5 billion available to the NHS. As a system we received £22 million additional funding to cover our forecast for inflation at that point in time. … If inflation continues to rise it will present an additional risk for the system.…

But the conclusion, without additional explanation is "We are reasonably confident of a year-end break even position."

Other East of England ICBs, despite showing that deficits have occurred in the first (easiest) months of the year, also continue to assert that their local health systems will nonetheless 'break-even' at the end of March, with little or no detail or attempt to explain how this might be achieved. Many of these reports will no doubt need to be revised in the new year.

For example Cambridgeshire and Peterborough ICB identifies £54m of risks that might threaten a balanced budget (p52), but also assure us that this exact sum £54.13m is balanced by conveniently identical income (Ambulance handover funding exactly balancing extra costs of £5.65m, undefined "national support" of £14.464m; undefined "non recurrent efficiencies and slippages" adding up to £16.4m; and dipping in to Reserves for £17.619m). Without any more explanation it would seem unlikely that this is enough to answer concerns that have given a red risk-rating to the ICB's financial situation.

Only Mid and South Essex ICB bites the bullet and admits the grim situation:

"As a system, MSE continues to be financially challenged due to increased and sustained system pressures and a lack of financial efficiency delivery. The financial deficit in our acute sector makes it increasingly difficult to assert a system breakeven position for 2022/23.

"… The system continued to plan to deliver a breakeven position by the year end, with unmitigated risks of £95.4m and a need to deliver £84m efficiencies. At the end of M5, the system position was a deficit of £40.3m, £29m adverse to the £11.3m deficit expected in the profile for delivering a breakeven position by the year end."

London

Few of the five London ICBs, all currently running deficits averaging £50m (London North Central £47m; NE London £57m; NW London (most up to date figure only available from NW London Acute Providers) £38.5m; SE London £50m; SW London £59m) seem to have any convincing or tangible plans to contain or reduce them across what is widely expected to be another hugely stressful winter in the run up to the end of the financial year.

Indeed North West London ICB (chaired by prominent McKinsey director Penny Dash) has opted only to meet quarterly, and so will not even begin to engage with financial reality until its board meets up in January. Its October meeting heard an evasive financial report of the situation in September, summarised as:

"NWL financial position remains in deficit in September, although the ICS has committed to break even this year. This will be achieved through one off initiatives. The NWL underlying financial position has deteriorated in September to (£283m)."

It's not easy to see how, in the absence of any increase in NHS funding, such a large underlying deficit can be ignored by NHS England or resolved without large-scale reductions in service.

North Central London seems untroubled by the level of risk:

"The ICB reports a balanced risk position at Month 7, with £28.6m of risks (circa 1.2% of the ICB total budget). Risks are fully mitigated by use of use of nonrecurrent funding. Recurrent risks that emerge in year may adversely impact on the ICB's underlying financial position.

"NCL ICS is reporting a net unmitigated system risk of £47.6m …, mostly relating to excess inflation and Service Level Agreement risk on contract baselines from out of London ICBs."

North East London also takes a relaxed view despite obvious warning signs, and remains determinedly vague:

"The ICB has a number of underlying run rate pressures, however at month 7 it is continuing to report a forecast breakeven. … To enable this position to be achieved the ICB will need to deliver

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a number of mitigating actions in the latter part of the financial year.

"Delivery of mitigating actions will be challenging in the latter part of the year, and will need to consider non recurrent and recurrent measures. This will include; continuing to review and deliver efficiency opportunities, working with system wide partners to drive a sustainable financial position across the ICS, reviewing the delivery, profiling and impact of all investments, and analysing non-recurrent opportunities including a review of all balance sheet items and provisions."

South East London's November Board papers consisted of only 36 pages, with no financial report, so projections have not been updated from September figures.

South West London is also laid back in its report, noting:

"The year to date plan at M6 is profiled to be £59.0m deficit, with actuals of £60.6m deficit, therefore, giving a £1.6m adverse variance. The report identifies that there are significant risks attached to the delivery of the financial plan across SWL, due largely to the scale of the savings target and inflationary pressures. …

… The total system planned efficiency for the year is £280.6m and delivery remains the system's key risk.

… Efficiency delivery year to date is on plan, however, £195m will need to be delivered in the second half of the year of which £83m is currently unidentified."

Midlands

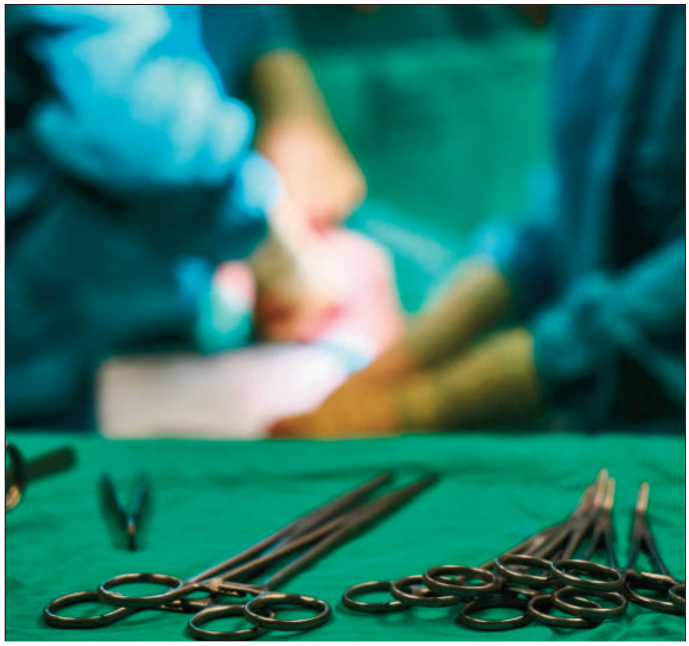
Midlands ICBs however have tried more seriously to engage with the reality of the situation, and been less ready to simply assert that break-even can be achieved in four months time.

Black Country ICB, for example, acknowledging the Year-to date financial position of a £45m (3.6%) "adverse variance to plans," admits:

"In line with NHSE's protocol on changes to in-year revenue forecasts, organisations continue to report a break-even forecast position while developing mitigation and recovery plans. However, it is becoming increasingly difficult to see a route to achieving a break-even position."

Coventry and Warwickshire ICB, admitting that £60m of the £84m target for efficiency savings is 'non-recurrent', posing serious problems for next year, is the only ICB of the 22 surveyed that discusses the October decisions and policies adopted by NHS England. It warns of the need for very significant savings or "disinvestment":

"There are operational delivery and performance pressures in many areas: Elective recovery, Urgent and Emergency Care, Cancer and diagnostics, Learning disabilities and Autism, support to the Social Care market etc which will need to be addressed within the financial plan as they have been supported non recurrently in year. Whilst transformation opportunities have been identified which could deliver up to £100m of benefit, not all of this may be cashable financial benefit and so further savings schemes or planned disinvestment will need to be found." (p117)



Derby and Derbyshire ICB also confess to a bleak outlook, in which the 'Best case' projection is a £12.9m deficit, the most likely is £39.8m and the worst case would leave the system £96.7m in the red, facing even tougher times coming next year.

The ICB also has some answers for those such as the IFS who have questioned why the increases in staff and limited increases in funding since 2019 have not yielded an increase in productivity:

"The University Hospitals Derby and Burton (UHDB) and Chesterfield Royal Hospital activity variance is driven by an increase in delayed discharges. With current months' delays being higher than historic winter delays, this has led to an inflated length of stay and occupied bed days. … Emergency Department length of stay has also increased on previous performances due to the impact of delayed discharges and the acuity of patients in attendance.

"UHDB outpatient underperformance is driven largely by new attendances resulting from reduced clinic frequency due to staffing levels and the inability to undertake waiting list initiate sessions. This is compounded by low clinic throughput through reduced physical capacity and late cancellations due to sickness of both staff and patients." (p92)

And again: "From an urgent care perspective, the key structural issue underpinning poor flow across our hospitals is exit block – with around 200 patients at any one time ready to be discharged but aren't. Excessive long stays (21 day+ or more) are of a particular concern – with two-thirds of patients waiting for discharge to

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assess support. The effect of exit block on the front-end aspects of the urgent and emergency care pathway within the hospital are significant – with the older person who needs to be admitted waiting between 8-14 hours to access a bed and around 36 hours of lost ambulance crew time per day due to handover delays." (p115)

Herefordshire and Worcestershire's Board papers sum up the 'wishful thinking' school of financial projection:

"The Integrated Care Board (ICB) plan requires a surplus of £6.6m. This was not without risk and required the ICB to stretch its financial plan around efficiency savings and use nonrecurrent opportunities/flexibilities to support the overall ICS financial position reducing the financial gap to a £14.8m deficit. [But] At Month 6 the ICB is reporting a £3.1m deficit to plan."

Leicester Leicestershire and Rutland (December Board) are among the few to have recognised the need to look beyond short term self-delusion to warn of the even worse medium term prospect:

"LLR have used underlying positions which are reported monthly by each organisation as the start-point for our plans. Using the latest figures and ensuring alignment across the system there is an underlying exit deficit as a system of £104m in 2022/23. This is that start-point used to project future deficits. …" (p162)

It goes on to itemise the pressures underlying a recurrent deficit rising from £139m in 2023/24 to £375m in 2027/28, and notes that:

"Given the scale of the challenge at the outset it is going to be extremely challenging to achieve financial balance in the earlier years, as the table below highlights to break even the system would need to generate an efficiency of over 5% in 2023/24; traditionally organisations have been able to deliver between 2-3% each year."

Lincolnshire ICB's November Board combines the initial aspiration to break even with a candid admission that this is most unlikely to happen:

"The system has a target of £2.9m deficit at month 7, and a plan to breakeven against allocations by the financial year end. The actual position is a deficit of £16.1m which is £13.2m adverse variance to plan.

"The full year forecast outturn position is unchanged from previous periods and is to break even, and this has been reported to NHS England. However, our ability to recover the shortfall that has materialized in the first half of the year over the remaining 5 months is extremely unlikely, and as reported in the risk section of this report there are further material risk in the second half of the year; the ICS is therefore preparing for an adverse forecast position.

As it stands the risk adjusted position (year to date actual plus unmitigated risk) stands at a £35.1m adverse variance to plan; …

"Communication has been sent to NHS England to enact the protocol for the system to be able to report a position adverse to plan, and we therefore expect to report a c£35.1m deficit at Month 8 reporting round."(pp 98-99)

Northamptonshire ICB Board has also chosen to come clean rather than pretend:

"The ICS has a deficit of £32.7m at the end of month 7 which is £17.1m worse than planned. The system is still forecasting that it will deliver a small surplus of £0.1m at year end but there are still a significant level of savings to be generated in the remainder of the year.

"[…] The forecast financial position for 22/23 contains £46.9m risk that is currently still unmitigated and this will therefore inevitably lead to a substantial deficit at year end unless further mitigating actions are identified.

"Each organisation within the system is currently working on an assessment of those things that would improve the financial position which may include but is not limited to:

- Non-recurrent measures, including a review of provisions and contingent liabilities
- Investments that can be further slipped
- Expenditure that can be ceased
- Controls on expenditure that would slow run-rate" (p116)

Nottingham and Nottinghamshire ICB's 2022/23 Financial Plan "was a balanced plan that required a 3.7% efficiency saving:" it has now been effectively abandoned as efforts are focused on tryin g to limit the deficit to £17m:

"at the end of month six, the NHS System reported a £36.3 million deficit position, which is £12.9 million adverse to plan. The ICB position reported a breakeven position, acute provider position reported £12.3 million adverse variance and the mental health/community trust a £0.6 million adverse to plan. The main drivers of the deficit related to Covid costs, efficiency shortfalls, Community Diagnostics Centres (CDC) funding gap, pay award shortfall and urgent care capacity above planned levels.

"… the forecast position remains breakeven against the £17 million deficit plan; however there are significant risks to delivery, particularly high risks relating to Covid, efficiency and CDC income."

Once again the Notts Board shows how unrealistic were the starting assumptions:

There are a number of risks to delivery of the plan. Highest areas of risk are:

- Covid – the 2022/23 plan was based on a low covid environment from Q2. This is not being experienced and continuing levels of covid related workforce absence is leading to high levels of overspend.
- Efficiency - £102.7m efficiency programme in place (2.9%). Plans in place to deliver with full commitment of Financial Direc-

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tors. However, delivery will include non-recurrent items, which will increase the recurrent efficiency ask in 2023/24.

● Community Diagnostic Centres - £8.5m income assumed for CDC. Available national funding has been diverted to support the 2022/23 pay award leaving this at risk. Dialogue with the national team continuing. (p297)

Shropshire Telford and Wrekin ICB was one of only five to make clear from the outset that they could not balance the books, projecting a £19m deficit. Since then Month 7 figures show things have got worse:

"The System holds a £19m deficit plan for 2022/23 and carries a significant underlying deficit. Local challenges that impact on expenditure include those associated with geography, configuration of estate and availability of substantive workforce.

"The Month 5 system financial position shows an overall £8.1m adverse variance to the plan submitted. The current forecast outturn (FOT) position shows a £4.1m adverse variance to plan …."

The ICB has received a stern letter from NHS England warning them that they now face intervention as finances threaten to get further out of hand. The letter expresses concern on four key issues, all of which are to some extent a problem facing all 42 ICBs:

● "High agency costs in YTD, at M05 the system has spent 62% of the year's expected spend

● " The costs classified as Covid appear disproportionately high

● " Efficiency delivery ambitions are heavily weighted to the second half of the year, with expectation that 78% will feature in the last six months

● "Whilst there has been a 9.5% increase in workforce, productivity has reduced by 2%."

Only Staffordshire & Stoke on Trent ICB, in their November papers, appear to have made any serious attempt to draw up a strategy to address the scale of the financial problems coming down the track– although the "strategy" itself would be laughable for its naivete if the situation was not so serious. The starting point is of course NHS England's insistence on ICBs drawing up "balanced" plans when the sums don't balance:

"We had a planned deficit of £28.6m but we were requested by NHSE to get to break even.

"To achieve this we had to make some nationally agreed assumptions e.g. no inflation impact, no Covid impact." But, of course: "There are inflation costs and costs relating to Covid in the hospitals and in Primary Care so a predicated gap of £20m is forecast and within the ICB, Continuing Healthcare (CHC) is a driver for this."

"A System efficiency target of 4.2% has been set and we are at 85% of delivery of this target."

There is a massive incentive for this ICB to attempt the impossible in order to escape a grim legacy of a decade of under-funding: "The regulator has requested a break even position and the Chief Finance Officers are working to achieve this. If break-even

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is achieved for two consecutive years then the CCGs' legacy debt of £300m will be written off."

However the ICB is faced with an underlying deficit which is currently on course to rise from £140m per year to £550m by 2027-28, so the "strategy" is faced with an impossible task. The response? Base it on some impossible hopes, not least a magical change of heart by government and the Department of Health and Social Care, to fund the NHS fully to cover inflation:

"Inflation: We have also carefully considered the impact of inflation, which is a major concern for the public sector and the economy more generally. Predictions vary, but all show costs outrunning public sector growth. This is a cost that we cannot control.

"If unfunded, it would lead to very significant service cuts. In this plan, going forward we have decided to plan on an assumption that further inflation is funded.

"This is the best case, but is what has happened in all previous years. It emphasises that as a minimum we should be living within our means before the inflationary impact."

From there the Strategy goes on to set out some goals:

- Increase the proportion of the workforce employed substantively
- Increased activity through the existing physical and clinical capacity to address backlogs – using digital and other means so that this also improves the quality of the clinician's experience
- Portfolios encouraged to 'stretch every pound' to address priorities
- Targeted system activities to make savings and get more for the SSOT pound
- Eliminate the underlying deficit over time [!!!!]
- Find non-recurrent solutions to keep the system on track in the intervening years.

But it's the explanation of how this is to be done that sums up the hopelessly unrealistic approach. Apparently all that is needed is to achieve all of the policy goals that the NHS has consistently failed to deliver since at least the 1990s, while of course giving no practical idea of how any of them might be delivered now, without capital or revenue to invest in any changes, and growing numbers of staff vacancies:

- Reducing unnecessary NEL [non-elective] attendances through interventions that keep people at home
- Better flow – more timely discharge through use of Out Of Hospital interventions / social care / etc.
- New pathways – alternatives to improve the patient journey / digital first
- Eliminate unwarranted variation
- Better value from enabling functions, for example. more efficient use of estate, reduced internal transactions. (page 80)

The Strategy – which assumes unprecedented savings of £42m-plus per year from "demand management" – adds in one more perfectly reasonable objective, but one that runs counter to the main policies announced by NHS England. That is to reduce, rather than increase, the use of private providers, to keep the resources in the NHS:

- See more patients through the existing clinical capacity – repatriate spend on IS [Independent Sector], etc.

In a way the complete lack of realism in so much of the SSOT Strategy sums up the dilemma facing NHS leaders across England. In an impossible situation, with an unworkable cash limit that ignores the key problems, only fantasy appears to offer any hope of escape.

It seems the ICB themselves have begun to recognise this, because they follow up their flight of fancy with a call to consider possible outright cuts in spending:

"Going further: This is a tough ask, but…

- The model leaves us with a gap that would have to be filled non-recurrently
- And assumes that inflation is fully funded – clearly a best case assumption
- So it is possible that we may be asked to do more
- And if so, we need to be ready to explain whether we could, and if so what shape that solution would look like.

"So we also need to consider our options for reducing some services:

- This is clearly not at all what we would want to do, but we would need to be prepared to explain the implications
- In doing this, we should ask the system to advise on any areas where this could be done, and the impact
- And maybe this could help in those services where we are short of people, so maybe concentrating workforce on a smaller number of services might have some benefits?
- The proposal is to ask each Portfolio to advise on options for making a further 1% or 2% saving in terms of service reductions. These would only be adopted in a scenario where inflation was underfunded and we felt as a system that we had no other option." (p83).

So the bottom line, when all the pretence and daydreams have been shattered by the new grip of austerity, is cuts in spending, staff and services that will further undermine the integrity and performance of the NHS.

Only a change in government policy, to reverse the decade-plus squeeze on revenue and capital, can repair the damage that has been done and is still being done to the very fabric of our most popular and universal public service.

The Lowdown will examine the plight of the remaining 20 ICBs (North East and Yorkshire, North West, South East and South West) early in the new year. Readers with any relevant information or updates on actual changes on the ground in any of the 42 ICBs should please contact John Lister at hcteditorial@gmail.com: any and all requests form confidentiality will be respected.

To help secure the future of our NHS through campaigning journalism, please support us

Dear Reader

Thank you for your support, we really appreciate it at such a difficult time. Before covid-19 the NHS was already under huge pressure, and after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help. We are researchers, journalists and campaigners and we launched The Lowdown to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved. If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today. Our supporters have already helped us to research and expose:

- unsafe staffing levels across the country, the closure of NHS units and cuts in beds
- shocking disrepair in many hospitals and a social care system that needs urgent action, not yet more delays
- privatisation – we track contracts and collect evidence about failures of private companies running NHS services

First we must escape the covid-19 crisis and help our incredible NHS staff. We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers. We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus. Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy, and we must hold our politicians to account and challenge them to do better. We rely on your support to carry out our investigations and get to the evidence.

If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you. We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes from the team at The Lowdown

EVERY DONATION COUNTS!

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.

Supporters can choose how, and how often to receive information, and are welcome to share it far and wide.

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If you have any other queries, or suggestions for stories we should be covering, please email us at contactus@lowdownnhs.info