The lowdown

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

Surprise privatisation of NHS staff at London urgent care centre

NHS staff at an urgent treatment centre in Denmark Hill have been told by their employer King's College Hospital Foundation Trust that they will be transferred to the private company Greenbrook Healthcare who are taking over the running of the centre on 4th October after winning a three year contract worth £10million.

Staff are dismayed and upset according to trade union sources who say there has been "no proper consultation" or information with many staff finding out by text message.

In a letter sent to trust bosses and seen by HSJ, emergency nurse practitioners at the UTC criticised the planned takeover and described the apparent lack of communication as "dumbfounding", prompting an apology from managers but the trust confirmed that it is "consulting appropriately with staff"

The staff will be transferred under the TUPE regulations but representing staff interests will be difficult. Jamie Brown, Unison head of health for London, told the HSJ "Staff employed in the unit don't want to work for a private company, and many are leaving as a result." Whilst the RCN confirmed that Greenbrook does not have a recognition agreement with any trade union and this transfer will "erode years of constructive joint working between management and trade unions."

Greenbrook Healthcare runs nine urgent care centres and four walk-in centres in London/home counties, an Ealing GP practice, Greenwich GP Out of Hours Service and Hounslow Intermediate Community Response Service, but itself was acquired by the rapidly expanding health care company Totally plc

Totally plc reported revenues of £133m in their most recent accounts, and provides a range of healthcare services in community settings, GP surgeries, and prisons. Its out-of-hospital services include physiotherapy, podiatry, dermatology, referral management services, clinical health coaching, and since October 2017, urgent care centres, out-of-hours GP services and 111 services. The company's contracts are with both the NHS and private sector organisations.

The move could destabilize local services at a high pressure time. London continues to have the worse nursing gaps in its workforce, with 8,938 nurse vacancies (June 2021) a rise of 8% from 8,270 in March 2021.

Paul Evans

Also in this issue...

No private firms to sit on Integrated Care Boards

Health Minister Edward Argar has agreed to table a government amendment to the Health and Care Bill that would prevent private interests from being on any Integrated Care Board. This has now been confirmed in the published report of the First Sitting of the Bill Committee on September 7.

Responding to opposition amendments seeking to exclude private companies, Argar said:

"We recognise that the involvement of the private sector, in all its forms, in ICBs is a matter of significant concern to Members in the House, and we are keen to put the point beyond doubt.

"However, having taken appropriate advice, I am afraid that that these amendments would not cover a number of scenarios—for example, lobbyists for private providers, or those with a strong ideological commitment to the private sector—and they would therefore not be watertight.

"As it stands, these amendments may well not offer the robust assurance that perhaps hon. Members intended. Therefore—this is where I may surprise the hon. Member for Ellesmere Port and Neston—to put this matter beyond doubt, we propose to bring forward a Government amendment on Report to protect the independence of ICBs by preventing individuals with significant interests in private healthcare from sitting on them." (p143)

This is an important step forward for the MPs fighting for amendments to limit the damage the Bill could do.

The Bill would establish ICBs as the main 'local' decision-making bodies of the NHS, and its ambiguous wording appeared to be opening the door, at least in some areas, to extended private sector influence over decision-making.

Many of the greatest fears over the implications of the Bill have been based on the assumption that private corporations and management consultants might play a leading role in shaping and deciding policies within the ICBs.

More concessions on the way?

Ministers had given verbal assurances that this was not their intention, but their decision now to include an explicit amendment along these lines will encourage the opposition team seeking to amend the many other controversial sections of the Bill.

Widening participation in ICBs to include patient and public representation, and ensure involvement of mental health, community health and public health professionals also requires amendments, but may well draw in support from some Tory MPs – or result in concessions by ministers to minimise delays in progressing the Bill.

However the promised new amendment applies only to ICBs: the Bill still explicitly provides for private sector participation in the advisory Integrated Care Partnerships – which are not, under the Bill's provisions, required to meet in public or publish their minutes and papers. Argar's response to proposals to exclude private sector involvement on ICPs emphasises their entirely peripheral and advisory role, with no powers to spend money or make policy.

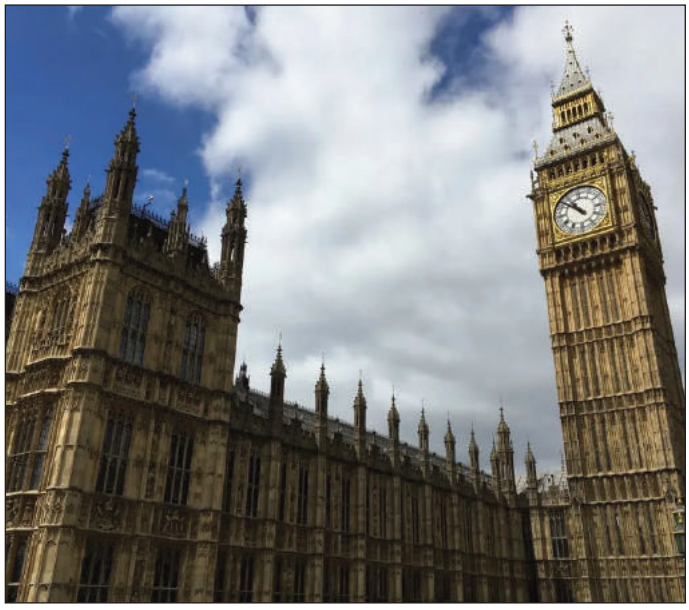
As the Bill stands, however, continued or increased penetration of the private sector into the NHS will also continue on other fronts. The Committee discussions in the Commons have not yet got to the question of regulations governing procurement, or opposition amendments proposing that the NHS should become the default provider whenever contracts come to an end, with a rigorous process required to justify seeking to outsource to a private provider.

The Bill repeals parts of Section 75 of Andrew Lansley's 2012 Health and Social Care Act, which requires Clinical Commissioning Groups to put clinical services out to competitive tender: but campaigners and unions are also keen to see amendments that would extend the repeal to cover non-clinical support services.

They also want an amendment to ban trusts or ICBs from creating subsidiary companies, whether this be to dodge taxes, evade scrutiny or undermine terms and conditions of staff.

With the clock still ticking on the timescale to force through the legislation in time to establish Integrated Care Boards by next April, who knows what more may yet be won against the odds?

John Lister



Rise in waiting times for surgery leads to increase in opioid use for pain relief

The dramatic increase in NHS waiting times for hospital treatment means patients are suffering excruciating and debilitating pain for much longer than previously and a consequence of this is a significant increase in the use of opioid drugs for pain relief, according to researchers from the University of Aberdeen.

A study from The University of Aberdeen found a 40% increase in the use of opioid analgesics, such as morphine, to ease the severe pain from osteoarthritis suffered by patients now waiting much longer than in pre-pandemic times for hip and knee replacements.

The study, published in the BMJ Quality & Safety, looked at data collected from 452 NHS patients from the north east of Scotland who were on the waiting list for hip and knee replacement surgery. The number of patients who had been prescribed opioids while waiting for surgery pre-pandemic was compared with those waiting during the pandemic in 2020.

In March 2020 when the pandemic struck hospitals across the UK cancelled elective surgery moving to acute use only, leading to a backlog in surgery.

The increase in use of opioid analgesia, such as morphine or tramadol, was associated with an increase in waiting times; patients in the study waited on average 90 days longer for surgery during the period of the pandemic in 2020 than pre-pandemic.

Limited benefit, increased risk

These opioid drugs are viewed as drugs of last resort, and the researchers note there is growing evidence for their limited benefit and even the long-term detriment to health, especially in older adults. Long-term opioid use pre-surgery has also been associated with "increased risk of complications related to the operation, poorer outcomes, and ongoing opioid dependence."

Luke Farrow, Clinical Research Fellow at the University of Aberdeen's Institute of Applied Health Sciences, who led the research, notes that the work is evidence of "an emerging opioid problem associated with the influence of Covid-19 on elective orthopaedic services" and that there is an urgent need to find "better alternative methods for managing severe arthritis pain for those awaiting this type of surgery and work to recover the backlog of associated operative cancellations during Covid-19 to prevent more widespread opioid use."

This study looked at the time period during the pandemic when hospitals cancelled elective procedures wholesale; although hospitals restarted elective procedures later in 2020, the backlog has not gone away and waiting lists have risen to record levels. This means that the number of patients potentially being prescribed opioid analgesia is substantial.

Earlier in September, NHS England announced the latest waiting list figures: the number of people waiting for hospital treatment in England was 5.61 million, an increase of 1.4 million more patients than when the pandemic struck in March 2020. There have been warnings that the waiting list could reach 10 million this year and 13 million soon after that.

The amount of time people are waiting is also increasing; 1.8 million of the 5.6 million people who were waiting for care in July had already waited at least 18 months - more than double the 860,309 people who were in that situation in March 2020. There were 1,732 people waiting over two years for joint replacement surgery - primarily hip and knee replacements. This is potentially leading to an increase in opioid use and its associated problems.

Sylvia Davidson

Major mental health provider told “patients deserve better”

Mental health services are very unlikely to see any of the £15 billion in funding announced by the government in the first week of September, according to sources reported in the HSJ, despite NHS England’s estimates of around 10 million people who would benefit from these services. The money is earmarked for reducing the backlog in elective surgery, so once again mental health services takes second place to physical health.

Not only do mental health services lag behind in funding, it is probably the area most reliant on private companies to provide services. As the NHS’s capacity to deal with demand for mental health services, particularly inpatient services, fell over the years, private companies have been given substantial contracts to provide much of the inpatient care needed. So any money mental health services receive is in part paid to private companies in the business of making a profit out of caring for some of the NHS’s most vulnerable patients.

Yet the standard of care provided by some of these providers has been the subject of repeated criticism by the Care Quality Commission (CQC). Two of the leading companies are Cygnet Healthcare and The Priory, both of which receive millions from the NHS and local authorities each year.

Let’s look at Cygnet Healthcare, which in 2020 received almost all of its £456.3 million in revenue from public organisations - the NHS, clinical commissioning groups, and local authorities.

The company, which is owned by the giant US corporation Universal Health Services Inc (revenue $11.6 bn in 2020), has around 140 facilities in the UK (primarily in England) providing a range of inpatient care and outpatient services, including acute care, mental health rehabilitation and recovery; personality disorder; CAMHS; eating disorders; learning disabilities; autism spectrum disorder; supported living; and nursing homes.

Cygnet Health Care has 15 provider companies registered with the CQC, but there is a single executive board and senior leadership team for all the 15 registered providers. As a whole the company provides approximately 734 beds across their social care services and approximately 2,130 beds across their health care services.

The company deals with thousands of vulnerable patients across the country each year, however several of its facilities

have been rated either 'requires improvement' or 'inadequate' by the CQC over recent years and reports from the CQC have been damning, particularly of Cygnet's management.

In June 2021, the CQC published a review of how Cygnet Healthcare was performing in terms of management - also known as a 'well-led assessment'. The review followed-up on a 2019 review triggered by the Whorlton Hall scandal (although Cygnet did not own this hospital at the time of the scandal).

Leadership failings

In the 2019 review published in January 2020, the CQC told Cygnet to take "immediate action" to improve its management following an investigation of the company and its hospitals. The CQC found that Cygnet-run hospitals were more likely to use seclusion and physical restraint on patients than other NHS providers of mental health care. The incidents of self-harm and assaults by other patients were also much higher. The CQC report also found that checks to ensure directors and members of the executive board were "fit and proper" were not carried out. The full-scale review was triggered by a BBC Panorama report in May 2019 into Whorlton Hall, a centre for people with learning disabilities. As a result of the programme ten people were arrested for abusing patients.

The new 2021 review revisited the 2019 concerns and also considered additional concerns that had been raised at 13 Cygnet services during inspections at services since 2019, including ongoing serious incidents, whistleblowing contact and safeguarding concerns.

Some of the most damning conclusions to come from the 2021 review once again concerned the management within the company. The CQC found that the company did "not have a longer term strategic plan" and "members of the senior leadership team were not able to articulate which groups of service users they were planning to support in the future and how they would ensure they had the appropriate estate and skilled staff to meet their needs. " A consequence of this management approach, noted the report, was that "Cygnet had continued to close and 'repurpose' services and at times this took place with short notice and in response to serious concerns," which had an adverse impact on the care of service users and caused distress to patients.

From October 2018 to January 2020, 10 of Cygnet Healthcare's hospitals were rated "inadequate". However, in 2021 alone the CQC has rated seven of Cygnet's facilities as 'requires improvement' and three as 'inadequate', plus Cygnet Appletree Hospital in Durham, which has not received a rating but was given an urgent enforcement notice and restricted patient admissions.

The Appletree Hospital provides services to female patients needing inpatient mental health care. The hospital was found to have "ineffective leadership" and there were concerns over bullying and "inappropriate" restraint. The CQC had also been told of concerns of under-reporting of safety incidents and safeguarding issues, high use of intramuscular medication on patients, and incidents where medication was administered at higher levels than prescribed.

In September 2021 the CQC rated Cygnet Views, the company's hospital in Matlock as 'inadequate'. The hospital cares for up to 10 women with learning disabilities and complex mental health needs. The CQC report is damning of the hospital, noting that patients did not always receive safe care, good practice was not followed, and staff were not trained adequately. The report also criticised the hospital management. Earlier in the year in July 2021, Cygnet Hospital Hexham was rated 'inadequate' and in August 2021, Cygnet Wast Hills was rated 'inadequate'.

Over 2020 alone, numerous CQC inspections led to ratings of 'inadequate' or 'requires improvement'. The inspection reports often mentioned an issue with management.

An unannounced inspection by the CQC at the company's CAMHS at the Godden Green hospital in Kent in October 2020 identified serious concerns about environmental risks and staff's ability to keep patients safe from harm and injury. The inspectors found that the staff had no experience of working with young people and lacked training. They did not always treat patients and young people with compassion and kindness, nor always respect patients' privacy and dignity. The CQC had received complaints from other professionals and relatives.

Staffing problems

Inspectors found a culture of negativity had developed among some staff, with patients referred to as 'difficult' and 'troublemakers' in records. As a result of the report, Cygnet decided to close the CAMHS service and focus on adult patients at this hospital. A follow-up inspection, however, found that there were still problems and rated the hospital 'requires improvement'.

An inspection of Cygnet's hospital in Colchester in October 2020, led to the CQC telling the hospital it must remain in special measures as improvements were still needed. The inspection followed reports relating to the safeguarding of patients and the reporting, investigation and management of incidents. A more recent inspection has now rated the hospital as 'good'.

In September 2020 the CQC carried out an unannounced inspection of Cygnet Yew Trees, a 10 bed facility for women with learning disability. The CQC reviewed 21 episodes of closed-circuit television footage and found nine that showed staff "abusing patients, acting inappropriately or delivering a poor standard of

continued on page 11...

Care Quality Commission – an impossible job?

The Care Quality Commission (CQC) was set up by the last Labour administration, under the terms of the 2008 Health and Social Care Act, and began operating under the umbrella of the Department of Health & Social Care the following year.

It replaced three existing organisations – the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission – and was tasked with the registration and monitoring of all health and social care facilities in England and Wales.

The CQC currently defines its role as ensuring, through regular inspections, that these facilities are safe, effective, caring, responsive to people's needs, and well-led

If a facility fails on any of these scores, the commission suggests it has a range of sanctions it can impose. These include: using requirement notices or warning notices to set out what improvements the care provider must take, and by when; making changes to a care provider's registration; placing a provider in special measures; issuing cautions or fines; and prosecuting when patients are harmed or risk being harmed.

Problems from the start

However, confusion over its role, inadequate resourcing, poor monitoring and an apparent reluctance to impose sanctions effectively, led to criticisms of the CQC's performance from the very start. A damning report from the Commons Public Accounts Committee in 2012 – echoing concerns raised in earlier reports from the Commons Select Committee and the National Audit Office – noted the following: the CQC's focus was on activity levels rather than the quality of inspectors' work; inspectors had insufficient training or support; no provider had ever been prosecuted; the CQC only assessed compliance, not quality of care; the commission had scrapped its whistleblower helpline; inspectors had no clinical expertise; the CQC had taken no follow-up action following a whistleblower alert on patient abuse at Winterbourne View, later exposed in a BBC Panorama exposé.

The predilection of Tory-led administrations since 2010 for the private provision of care – particularly in the mental health sector, where there are now almost 6,000 fewer beds (a drop of 25 per cent) in the NHS than there were a decade ago, despite the number of detentions under the Mental Health Act rising by 50 per cent over the same period – has inevitably impacted the commission's performance ever since, as commercial operators appear to undermine the regulatory framework.

Between 2010-15 around 25 per cent of mental health contracts were awarded to private providers, yet the CQC struggled to successfully monitor these new entrants to the sector. Private Eye reported in 2015 that most of the residential establishments closed down after failing a CQC inspection simply re-opened under a new name or new ownership, losing their negative ratings in the process. And in 2017 Which? found that more than 25 per cent of care homes were failing to display their CQC ratings online, which is a legal requirement.

Three years ago, in 2018, delegates at the Royal College of GPs annual conference argued that CQC-style inspections were ineffective in raising standards or ensuring patient safety. The following year the Commons Joint Committee on Human Rights recommended that the CQC make more unannounced inspections at night or over weekends, and use covert surveillance, in order to better inform inspection judgments.

Continuing failures

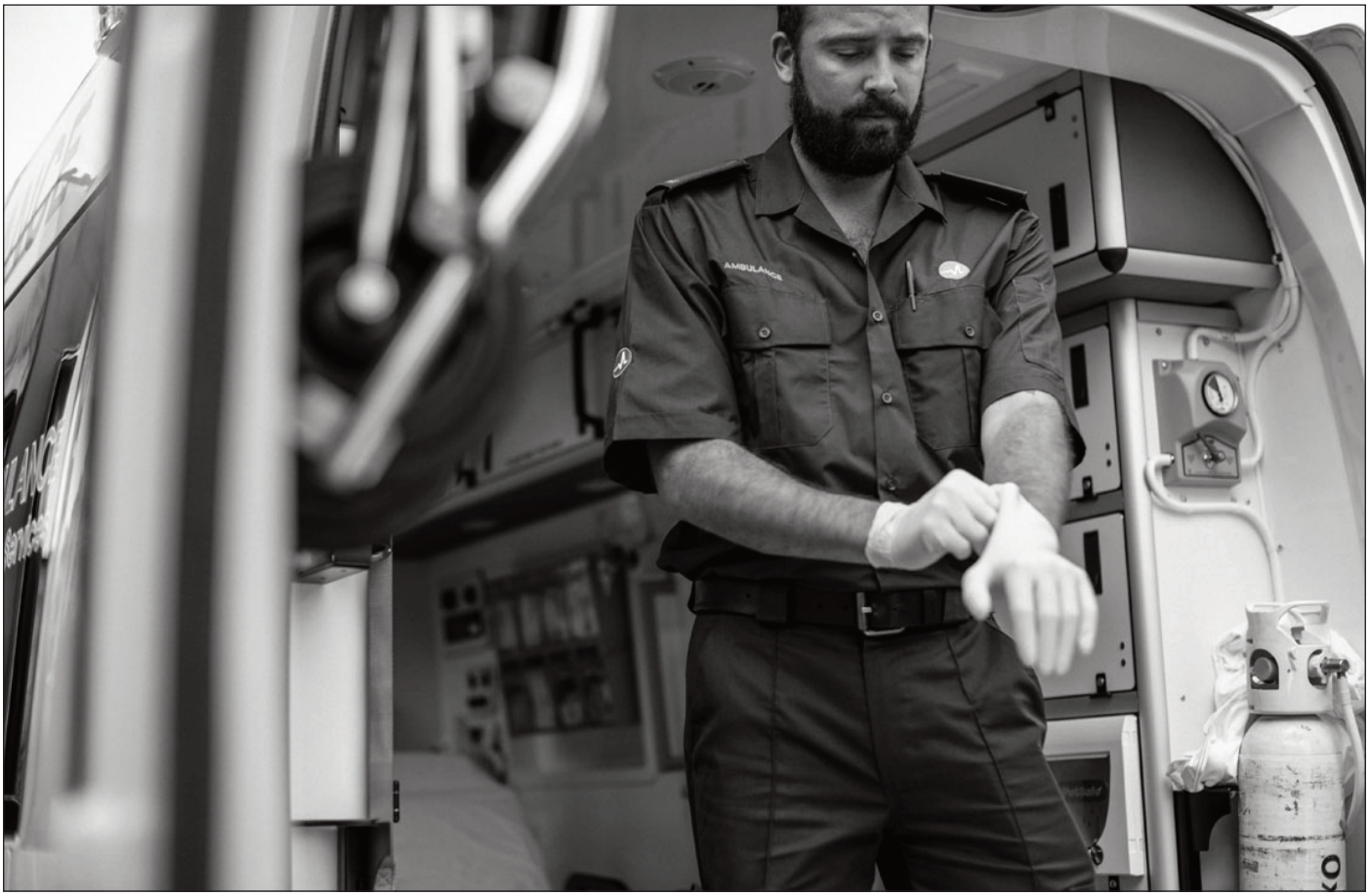
But the failings persist. During this month's investigation into the deaths of three vulnerable people at the private Cawston Park hospital – which was closed down in May this year by owner the Jeesal Group, after the CQC had put the facility into 'special measures' – the Norfolk Safeguarding Adults' Board suggested that the commission could have removed the hospital's registration sooner.

The Lowdown's sister website www.nhsforsale has previously documented a litany of care failures – including patient deaths – reported by the CQC at facilities owned and run by the Priory group, the UK's leading provider of mental health services and recipient of huge sums from NHS and local councils' social services budgets.

Despite this – and despite one of its facilities, Barnt Green, having just been rated by the commission as 'overall inadequate' – the group's website proudly proclaims, "Because of the hard work and commitment of all our staff teams across all our 84 CQC-registered hospitals, 87 per cent of our sites are rated as 'Good' or 'Outstanding', compared to 78 per cent in the NHS or other independent providers."

So never mind their clinical value, CQC ratings now clearly have considerable marketing value too. Perhaps it's no surprise then that several companies have taken to offering 'boost your cqc rating' software packages – possibly much cheaper for service providers than actually investing in staff and patient care.

Martin Shelley



Urgent support for ambulance staff needed

UNISON has written to ambulance service chiefs calling for urgent support for staff as services face unprecedented 999 call volumes and unsustainable demand from the public.

The letter says employers must act now to limit the impact on the wellbeing and morale of staff, especially those working in control rooms.

In the letter, UNISON says 'missed meal breaks, late finishes, queuing outside hospitals and increasing levels of sickness absence have become widespread'. The letter continues: "This is all having a terrible impact on morale, as well on the health and wellbeing of ambulance staff.

"Ambulance staff have been at the forefront of the Covid response, working under levels of pressure never seen before."

Ill thought-out trust systems and working patterns – and growing delays as ambulances queue to hand over patients at over-stretched hospitals lacking sufficient staff and front line beds make matters worse.

"In London, July was the second busiest month only to March 2020, when paramedics worked through the first peak of the coronavirus pandemic"

In June UNISON, Unite and GMB got together in the North West to call on bosses at the North West Ambulance Service (NWAS) NHS Trust to change the system that can see ambulance workers called anywhere across the region with up to 40 minutes driving time.

The three unions accused the NWAS management of 'failing both patients and staff,' and held a consultative ballot of ambulance members in July to see if they wished to have a full-scale industrial action ballot, including the option to strike.

In June NWAS was receiving an estimated 4,500-5,000 999 calls each day – more than 50 per cent of which were identified as category 2. These calls are classed as an emergency for a potentially

continued on page 8...

...continued from page 7

serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport.

The London Ambulance Service (LAS) has also faced "significant pressure" this summer as it tackles "unprecedented" demand, with June, July and August this year making up three of the top five busiest months ever for 999 call operators. July was second busiest only to March 2020 when paramedics worked through the first peak of the coronavirus pandemic.

West Midlands Ambulance Service also reports that 19 of the 20 busiest days they have ever experienced have come in June, July, August and September this year. However the increased call volume has run alongside unprecedented abuse and even death threats against hard-pressed call handlers, and ambulance crews have faced violence when they arrive to treat patients.

Nationally more than 1 million 999 calls were handled by ambulance staff in the month of July, the highest total on record.

Major issues that are being reported to UNISON by staff across the country include:

An ambulance service employee having to attend jobs for an extra five hours and travel over 100 miles after their shift officially ended.

"One service had 400 calls outstanding and had worried people ringing back asking when an ambulance would arrive"

Timewasting 999 calls from the public including requests for crews to attend a property where someone couldn't reach their TV remote control and another where the person was too hot because they couldn't turn their heating off.

Staff at ambulance stations crying at the end of their shifts because of stress, low morale and lack of breaks. Some are spending hours queuing in A&E department corridors waiting to hand over patients on stretchers to hospital staff.

Significant delays in responding to patients because of the overwhelming number of emergency calls. One service had 400 calls outstanding and had worried people ringing back asking when an ambulance would arrive.

Emergency call handlers starting shifts with ambulances needed at over 100 incidents. In some cases, there's been a 24-hour wait for ambulances to arrive.

Ambulance services regularly reaching the highest possible alert level (REAP 4) because they're under such extreme pressure.

UNISON is urging employers to ensure employees get their legal entitlement of rest periods, minimise missed meal breaks and shift overruns, and check staff are not working excessive hours because of overtime or extra shifts.

John Lister

Gaps in Health and Care Bill question level of local control

A major gap in the government's controversial Health and Care Bill is the lack of any guarantee of much more local "place based" decision-making and planning of services to meet the needs of local communities within much wider "Integrated Care Systems" (ICSs).

The Bill would put just 42 ICSs in control of the NHS across England – several of them covering populations of over 2 million.

The largest, with over 3.2m population is the most northern ICS (North East and North Cumbria) will cover from coast to coast – Carlisle to Newcastle, and from Whitby in the south to the Scottish border – an area and population so large and unwieldy that the ICS website manages to avoid displaying a map, listing the 17 councils covered, or any mention of the size of the ICS population.

Four more ICSs have populations of 2 million or more – Greater Manchester, West Yorkshire, Cheshire & Merseyside and North West London.

By contrast 16 of the 42 ICSs have populations of less than 1 million, and three have just 500,000 – Somerset, Cornwall and Shropshire and Telford & Wrekin. But even in the smaller ICSs there are distinct differences between more local "places" within the ICS area. Putting such large and remote bodies in charge, NHS England has made much of the idea that more local "place-based" arrangements would be able to decide for specific areas and communities.

Indeed even while they were forcing the mergers of Clinical Commissioning Groups into ever fewer local bodies and planning to reduce to just 42, the NHS England website has also been singing a different song to avoid complaints of lack of local voice, more or less claiming that ICSs will act as bodies to support place-based 'partnerships,' rather than the new decision-makers:

"An important part of our vision is that decisions about how services are arranged should be made as closely as possible to those who use them. For most people their day-to-day health and care needs will be met locally in the town or district where they live or work. Partnership in these 'places' is therefore an

continued on page 10...

...continued from page 9

important building block of integration, often in line with long-established local authority boundaries.

… We are recommending that these place-based partnerships be supported by a statutory NHS ICS body to oversee NHS functions across the whole system…."

A new NHS England guidance document entitled 'Thriving Places,' again bigging up the idea that "place-based" decision-making will be part of the new system, admits that:

"We expect the allocation of decision-making functions between system and place will vary across the country and should be shaped through collaborative discussions."

No guarantees

So there is no guarantee of any real local control: the ICSs will be calling the shots. However 'Thriving Places' goes on to assert that: "The considerations of what is undertaken at system or place should be guided by the principle of subsidiarity, with decisions taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value." (p21)

This seems to have been enough to convince the Liverpool Health and Wellbeing Board, which has produced its own paper on Establishing Liverpool Health and Care Partnership, noting "the plans to establish a strong place-based health and care partnership – the One Liverpool Partnership" within Cheshire & Merseyside ICS.

This cites recent misleading NHS England guidance documents, and asserts, wrongly that:

"The Health and Care Bill sets out two key components to enable ICSs to deliver their core purpose, including:

· strong place-based partnerships between the NHS, local councils and voluntary organisations, local residents, people who access services, leading the detailed design and delivery of integrated services within specific localities (Liverpool), incorporating a number of neighbourhoods.

· provider collaboratives, bringing NHS providers together, working with clinical networks and alliances and other partners, to secure the benefits of working at scale." (page 74).

In fact neither place-based partnerships nor provider collaboratives are mentioned in the Bill, which makes no reference at all to "place." Instead it makes clear that each ICS will be able to establish its own constitution – opening up the probability of wide variation in the extent to which ICSs opt to devolve decision-making down to more local level.

There is also the danger that place based partnerships could be used to take the blame for failures to make savings or balance the books at ICS level: Thriving Places states ominously that they "will need to play a major role in the delivery of national expectations attached to NHS funding" (p22).

The Bill as tabled (which may well be substantially amended by the government) would give an additional 138 powers to the Secretary of State – but says nothing about more local structures.

So even if Cheshire & Merseyside does decide to establish the One Liverpool Partnership as a subsidiary body this does not guarantee equivalent arrangements, even elsewhere in Cheshire & Merseyside.

Amendments are needed to ensure that the "principle of subsidiarity" is written in to the Bill and that all ICS constitutions are required to spell out clearly how they will devolve decisions to 'place' level wherever possible.

Many of the decisions taken on these issues will be steered by the ICS chairs, 25 of whom have already been appointed, with the remainder to be appointed by NHS England in conjunction with the Secretary of State – and can only be removed by the Secretary of State. They will pick up salaries of £55,000-£80,000 for the part-time posts.

With this line of accountability directed only upwards to national level, and not at all downwards to more local place level, the actual level of local control within each ICS will be strictly limited.

Adverts have gone out for applications to become ICS Chief Executives, on salaries from £197,000 to £270,000, incurring predictable ill-informed rage from the Daily Telegraph, which headlined: "NHS spends millions hiring an army of £200,000 bureaucrats."

The Telegraph quotes 'senior' Tory MPs, who had presumably voted in July for the Bill establishing ICSs without realising the new bodies would need to be managed. But while Tories are "appalled" at the new salaries on offer, they appear unaware that with even the smaller ICSs controlling budgets of billions, the CEO salaries on offer are minute compared with private sector equivalents.

Elections a possibility?

Indeed with ICS budgets higher than those controlled by most elected Mayors and much higher than Police and Crime Commissioners, the argument for ICS chairs to be elected, to give some actual control back to the people whose health care is being decided, is a strong one.

While it falls short of long standing demands for health authorities to be elected, it could be pushed forward as an amendment to the Bill that would – for the first time ever – give new power over NHS decisions to people rather than central government and their appointees.

John Lister

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care". Managers suspended eight permanent members of staff from working at the hospital. Referrals have also been made to the police. However, once again, the CQC criticised Cygnet's management for allowing a culture to develop at this hospital which led to people suffering abuse.

And there are numerous other reports by the CQC into Cygnet's facilities in earlier years.

After each inspection report and rating of 'inadequate' or 'requires improvement' Cygnet is issued with a comprehensive outline of where it has gone wrong and what it needs to do to improve. In some cases admissions are restricted, further visits are made, more reports produced. Yet, the failures keep happening. Whatever the CQC does appears to be having little effect on Cygnet's management style and its hospital culture and on the failures of care.

Such was the level of failures that in April 2021, a letter was sent to Cygnet management by Claire Murdoch, the national mental health director, and John Stewart, national commissioning director, which HSJ reported warned Cygnet that "patients deserve better" and they will "not hesitate to take further action" if improvements are not made. The letter noted their concern and disappointment with regard to the repeated service failures and that they are not decreasing in number. The letter also noted that NHS England had been meeting with senior management in Cygnet since February 2020 to address the issues. Cygnet's CEO is Tony Romero and the company has an advisory board that includes former Royal College of GPs chair, Clare Gerada, and Lord Patel of Bradford, who chairs England's social work regulator.

Whether things will change following the letter, only time will tell as there is a several month lag between inspection and report publication. If things do not improve, what can NHS England and the CQC do? The CQC has issued warnings and restricted admissions, but with capacity so low for inpatient mental health services and demand escalating due in part to the Covid-19 pandemic, closing facilities could make things very difficult for the commissioners of services. Closures could mean more patients being sent miles away from home for treatment, something that services have been working very hard to reduce in recent years.

Sylvia Davidson

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.

Please send your donation by BACS (54006610 / 60-83-01), or by cheque made out to NHS Support Federation and posted to us at Community Base, 113 Queens Road, Brighton BN1 3XG

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