New rules to protect GPs from digital privateers

Private companies hoping to attract patients away from their current GP to sign on with digital GP services were dealt a blow by a change to funding rules this week.

The *HSJ* has revealed that NHS England announced that under the new GP contract, private companies providing the new ‘digital-first’ GP services will typically receive around 20% less income.

NHS England are aiming to protect GP practices from a loss of income because of the precedent set by Babylon Health, a private company that has been marketing online GP services and video appointments to NHS patients.

The private company has signed up 30,000 people who live across London or who work in the capital, to its GP at Hand service.

Patients have to de-register from their current local GP to join the digital service, which runs out of a GP surgery in Fulham in West London.

Younger, fitter patients

The company’s patients are predominantly younger and fitter than those registered at the average GP surgery and the company has been accused of destabilising the payment system in London and of “cherry-picking” and undermining the integrity of the NHS.

The decision is a reward for local campaigners such as the Tower Hamlets KONP group who have organised protests around GP at Hand practices.

Tower Hamlets LMC chair Dr Jackie Applebee, a local GP and taking part in the protest said GP at Hand “seems to be deliberately targeting healthy young people taking money from the NHS, by picking the most profitable patients’.

The changes announced in the GP contract will apply from 1 April 2019 and are being seen as a way to improve the fairness of the funding system and avoid such issues in the future.

Despite receiving the public endorsement of Health Secretary Matt Hancock, the GP At Hand service is only now being evaluated by *Ipsos Mori*.

According to *Pulse* magazine its impact on other GP practices and whether or not it destabilises primary care services are being investigated by the *Care Quality Commission*.

At present, Babylon Health is the only company that has taken advantage of a rule that allow patients to register with a GP surgery despite outside of their catchment area.

NHS England has said that a hypothetical future “digital-first” GP practice that covered all of England would receive about 20% less funding under the rule changes.

However, a further threat to Babylon Health’s business strategy would be changes to the current rules on catchment area, which allow patients to register with a GP outside of the area in which they live.

This rule has been key to Babylon’s expansion, but NHS England has announced a review.

Babylon Health has accused NHS England of “penalising providers” like them who “have invested in technology” and argues that it “sends the wrong signal.”

---

**IN THIS PILOT ISSUE**

- **WHO WE ARE**  
  – and why activists and campaigners need the Lowdown - [Back page]

- **REVEALED:**  
  Bizarre plans and assumptions in local downgrade plans 8-9

- **NEWS ANALYSIS:**  
  below the Radar - Bed cuts continue despite Long Term Plan 4-5

- **COMMENT:**  
  OUCH! time to end pain and injustice of NHS dentistry 6-7
**Angry consultants slam review of 4-hour A&E target**

*So Mr Stevens, who are these doctors with such contempt for the patient interest?*

The Royal College of Emergency Medicine (RCEM) has responded angrily to a recent media speculation that the NHS England system performance due to under-investment in acute hospital bed capacity, cuts in social care funding and undermining in EDs.

This has resulted in a significant increase in the number of crowd EDs (which scientific evidence clearly shows is linked to increased mortality and morbidity for patients).

The increase predicted by the resource departments also piles added stress on to staff, which further compromises patient care.

Dr Hassan points out that the RCEM’s concern that much of the good work that has been done could be wasted if new work is not fully supported by all sectors in meeting the needs of patients. He also points out that the target is vital for timely, high quality patient care.

The public has a right to know who these individuals are who want the target removed, not least given that in the NHS Plan with many laudable objectives, this attack on the patient interest stands out alone as the only cut in services proposed.

So Mr Stevens, who are these doctors with such contempt for the patient interest?

---

**NHS England to ban GPs from advertising private services**

GPs are to be banned from advertising private services to their NHS patients in a bid to stop the blurring between public and private treatment.

The new rules mean that GPs won’t be able to market their own services or those of any other provider if those services are available on the NHS.

The new GP contract states that:

*From 2018 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private, pay-for-GP services that fall within the scope of NHS-funded primary medical services.*

According to a report in The Guardian, it will also stop the GP surgeries from advertising patients to jump the queue by paying them to advertise.

The increase in rationing of services by Clinical Commissioning Groups (CCGs) has led to an increase in private services being offered by GPs, including vaccinations, foot care, and mole removal.

GPs will continue to charge for signing pensions, providing medical reports for insurance or other purposes, or even referring patients to other GPs. As well as not allowing GPs to advertise their own private services, they will not be able to advertise private services performed by another company.

In late 2017, Care UK was criticised for distributing a list of recommended private treatments to patients, which mentioned their own private services.

According to the Guardian, the company wanted to use spare theatre time for private patients at two treatment sites to fund its NHS care. This is despite the fact that the waiting times for NHS care at the UCH’s Genesis clinic were 60-90 weeks.

This ban will not prevent GPs working privately and having a separate list of private patients.

GP Online reported in January 2017 that a growing number of GPs were interested in setting up private practices. The new rules on practices providing private services to patients not currently on their list, however, there is a limit on how much income practices can earn from private patients.

Dr Richard Vautrey, chair of the BMA’s GP committee, said: “This ban is the wrong solution for patients about what treatment is available on the NHS and what they have the option of paying for privately.”

---

**Private midwifery firm’s collapse leaves mums-to-be in the lurch**

John Lister

The opening of the BBC report on January 31 was misleading. It simply began “Mum’s to be have been left “high and dry” after an NHS midwifery service ended with just a week’s notice.”

This clearly gives the impression that an NHS service had failed. It, as the BBC report does concede later on, the collapse was a private company, to which the private contractors had been unable enough to contract out midwifery services for the long term.

It argues that the 4-hour target is the key component, sophisticated and very successful overall marker of a hospital’s emergency care.

Doctors will come under increasing pressure to finance not only their patients’ needs but also those of relatives who may share affected genes.

---

**Genome sequencing threatens core principle of the NHS**

A plan to sell gene sequencing services performed by the NHS to healthy people has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with large-scale sequencing will lead to their DNA to be fully sequenced and a provide an insight into future potential.

The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.

The signatories expressed concern. The scheme could swamp GPs with conditions such as cancer and dementia. The Times has been condemned by experts as leading to a two-tier system and potentially overloading GPs with conditions such as cancer and dementia.
Despite the Long Term Plan, the drive to cut, downgrade and ‘centralise’ services continues

John Lister
If we believe the promises made by the NHS Long Term Plan, published last July 2018, at least it is not an end to the war of attrition on hospital bed numbers that has been going on for decades. The Plan differs from many previous plans in setting out plans for the future in a way that actually looks like a plan for the future – and that is why it has been welcome. But in practice we expect that if local areas implement the Long Term Plan effectively, it will improve performance without affecting patient care as long as there is a significant political commitment to do so.

Reducions in acute bed numbers and numbers of A&E departments were key to over 50% of published STPs in 2016; the Long Term Plan and the associated Operational Planning and Contracting guidance published before Christmas make proposals based on the STP areas, bringing these plans back into focus. They were not good or complete plans.

Derbyshire STP had the greatest level of explicit bed closures, published last October 2018, with the aim of reducing to 2,896 beds, to 2,600 in 2030. It is not clear if such reductions in capacity – with little regard for the problems of access to care – were based on the best available evidence.

In many areas to implement ill-conceived local plans of line is sharply at variance with the continued drive to improve performance without affecting patient care.

The conditions for staff, especially those who will have to cope with more distant hospitals, also are ignored, despite the evidence across the NHS that relentless pressure generates stress and burn-out for doctors, nurses and other professional staff, undermining the quality of care and leading to sickness absences, burn-out and new staff shortages.

The conditions for staff, especially those who will have to cope with more distant hospitals, are also ignored, despite the evidence across the NHS that relentless pressure generates stress and burn-out for doctors, nurses and other professional staff, undermining the quality of care and leading to sickness absences, burn-out and new staff shortages.

Plans based on this approach also almost invariably fail to address the problem of ensuring that the new care systems are properly introduced, to begin with, and to provide long-term support and appropriate training for all the key stakeholders, including the very large numbers of patients for whom the new system will be designed.

Plans are clearly needed to overcome the distance from the need to reduce the level of pressure on front line beds and staff, with many acute hospitals running close to 100% occupied for weeks and months on end.

Staff shortages have been worsened over the by the height of uncertainty over the future of the hospital that is to be downgraded, as well as the changes in local conditions and the way that local management consultants are handling the situation.

The appeal can be found here.
Cuchullin to end the pain and injustice of NHS dentistry

Paul Evans - Comment

When it comes to our teeth and oral health, getting the care you need is difficult to the rest of the NHS, but why?

Recently a friend discovered that she had an abscess in her tooth. Her dentist started root canal treatment, but after inflicting several body-arching shocks of pain, the dentist decided that the procedure needed a specialist. The wait on the NHS in her area was six months. Her choice was either to wait, risk complications and endure the discomfort, or to go for a private slot by paying €600, seeing the same specialist. There was only one NHS option in the area for difficult cases and she was hugely overbooked.

Reluctantly she chose to pay up, shocked that, effectively there was no NHS service to help her. An unusual story?

Not according to the British Dental Association who estimate that 135,000 dental patients a year go to A&E because they can’t access care for a problem. It is why a further 600,000 seek treatment from a GP, adding to the pressure on family doctor services.

Desperate measures

Some patients avoid steep charges by heading to the garden shed to have a go. It is a throwback to the Victorian age, but funding urged them to contribute a much bigger share of the cost of treatment.

According to the British Dental Association NHS patients will soon be contributing a third of NHS England’s dental budget in charges and this will rise to a half by 2032.

Patients are paying more, but the underlying services for NHS work hasn’t risen nearly as fast, causing NHS contracts to be handed back and a decline in the number of NHS dentists that can make their businesses viable. Austerity has been felt.

In the last five years government funding for dental services has fallen 35%.

Dentists are also getting harder to recruit. A recent survey found that 68% of practices experience difficulty in filling vacancies in the last year. Numbers have dropped to 2010 levels.

Brexit factor

While NHS professionals are not all lagering to come, Brexit deters like heartburn. Of those already working in the UK a third consider leaving and one in five blame Brexit.

Many who can’t pay will be put off going to the dentist. Enduring pain, popping painkillers and hoping the problem goes away. According to official statistics, almost one in five have delayed treatment due to its cost.

If only more of us listened to the official advice and got our teeth checked regularly, before the rot sets in. Actually, many of us are trying to do the right thing, but space on NHS dental lists is very hard to find. Figures show that one million patients were unable to register with a NHS dentist last year.

The root cause?

NHS charges are going up, but the number of new NHS dentists is falling back. People are being driven towards the private dental market, but many can’t pay.

The NHS charging structure is a backhander to patients, perhaps meant to distract us from the fact that it is a tax on health. Patients are being asked to contribute a much bigger share of the cost of treatment.

According to the British Dental Association NHS patients will soon be contributing a third of NHS England’s dental budget in charges and this will rise to a half by 2032.

Patients are paying more, but the underlying services for NHS work hasn’t risen nearly as fast, causing NHS contracts to be handed back and a decline in the number of NHS dentists that can make their businesses viable. Austerity has been felt.

In the last five years government funding for dental services has fallen 35%.

Dentists are also getting harder to recruit. A recent survey found that 68% of practices experience difficulty in filling vacancies in the last year. Numbers have dropped to 2010 levels.

Matt Hancock was recently endorsing a private company that makes money from the lack of NHS capacity.

The obvious move is to invest heavily in a new body of NHS community dentists – that have no tie to the private sector, so all their time goes on NHS patients. Funding more urgent care dentistry would help to reduce the pressure on our overworked GPs and A&E services.

Mr Hancock’s Solution

At first glance such a move would appear to be in tune with the new NHS long term plan. In it we are promised more community services, better primary care and more prevention – all cornerstones of improving oral health services. And yet there is virtually no mention of dentistry in the NHS plans.

Is this a sign? Many governments have neglected their NHS dentistry. Unlike the endless shuffles elsewhere in the NHS, dentistry policy has remained largely untouched.

But is the government going further, driving down the NHS service and effectively reducing it to a safety net? Dentistry is a mixed market, although most practices still provide NHS and private care, but the huge pressure on NHS funding has shifted the market towards private provision.

According to market analysts Laing and Buisson the NHS number of private-only practices has dropped from 15% to 4% of the overall total.

Unsurprisingly demand for private work has risen by around 10% in just the last three years.

So far no reassurances over the future of NHS dentistry have come from health secretary, Matt Hancock. In the reverse case he had previously been keenly seen endorsing a private company that makes money from the lack of NHS capacity.

MyDentist targets areas with shortages of NHS practices and offers prices that are slightly higher than the NHS for basic work, but much higher for anything more complicated.

The health secretary was warm in his praise: “Companies like MyDentist play a really important role in delivering a good service to keep our nation’s teeth strong.”

The fate of NHS dentistry offers an allegory for the NHS as a whole. Charges open the door for reduced funding, less public funding leads to private provision, a two-tier system quickly emerges and before you know it access to care then depends on your spending power, which is the very opposite of the NHS.

Charges

Charges for dentistry first appeared at 1961, a tax to curb demand. They have now become deeply set in the system and dominate people’s decisions about when and if to access dental care. Over the last 60 years our view of oral health has changed. It is now very much a field of healthcare.

Dentists treat our decay, but they also monitor our health watching out for mouth and neck cancers and taking action against conditions like gum disease - which has recently been linked to Alzheimers.

Some of their work is cosmetic, but most should be housed within the NHS as a crucial part of our healthcare and connected with our other health services.

Today a quarter of children start school with some tooth decay, record numbers of children are having teeth removed each year.

A million of us cannot access to NHS dentistry. This is the time to invest in public health and NHS dentistry provision.

We must change the focus, to look at solutions that can improve the health of everyone in our society.

Matt Hancock (UHB) said that, despite NHS stockpiling, shortages would likely occur due to “unprecedented” demand and Covid-19 restrictions.

Guy’s and St Thomas’ Foundation Trust has a group coordinating which patients will be at the front of the queue for treatment, as “largely untouched” private dentistry could be significant. The police are planning for between three and six months of disruption to NHS dentists.

End of the line?

The plans include staff sleeping at hospitals, nursing homes of Lon.

The Evening Standard reported that Professor Marcel Levi, of University College London and Guy’s and St Thomas’ said that, despite NHS stockpiling, shortages would likely occur due to “unprecedented” demand and Covid-19 restrictions.

The plans include staff sleeping at hospitals, nursing homes of London, meeting that communications from NHS England were now “almost daily”. The plans are to be put in place if a no-deal Brexit causes dentists to run short.

The doctor’s union the BMA, has been very concerned about the impact of Brexit on the NHS for some time and has produced a series of briefing papers. These outline the many positives of EU membership and the problems that may arise after Brexit.

The BMA notes “Any form of Brexit could have widespread, and long-lasting consequences for health services across the UK and Europe, including patient care, access to services, access to medicines, workforce statistics and immigration, Northern Ireland, access to medicines, reciprocal health care provision, qualifications and patient safety, access to medical radioisotopes and medical research and rare diseases.”
Mysterious notes and a US company create confusion in Weston plan

John Lister

The controversial plans to reconfigure services at Weston General Hospital in north Somerset are gearing onwards, with new documents nodded through a February meeting of Bristol, North Somerset and South Gloucestershire CCG. But the proposals are less than clearly explained in the documents that have now appeared.

The plans centre on three basic proposals:

* To make permanent the long-running “temporary” night time inpatient ward at Weston's A&E – with patients diverted to Bristol or Taunton (each 28 miles away).
* A reduced level of care from Weston's high dependency unit.
* And reduced coverage of emergency surgery to “any time” hours in place of 24/7.

However some of the accompanying data, with minimal if any explanation, appears to be contradictory.

For anyone with the energy to wade through the 133 pages of “Case for Change” data, there are some intriguing, if confusing revelations.

Private hospitals

For example, on page 25 a note on a graph reveals an astonishingly high level of NHS referrals to private hospitals: the orthopaedic caseload figure “Do not include independent sector commissioning of orthopaedics from CCG – up to £40m in 2016/17.”

However the Business Case commissioned by US company Chen Med, a company offering “VIP treatment” for older patients – at a price. Their sales blurt boasts that they offer:

> A personal physician who comes with an entire team dedicated to the patient to help promote and coordinate their care.

> “Head-to-toe executive physicals” and ongoing preventive care to detect and treat disease early.

> “Access to the patient’s doctor and phone service” are encouraged to simply walk in without an appointment.

> Comprehensive care in one location, including prescription pick-up and refill, blood testing, a- and b- selected specialists.

These proposals are less than clearly explained in the documents that have now appeared.

One document which Shropshire and Telford & Wrekin CCGs have chosen not to publish as part of the discussion, is the report expensive compiled by US and multinational consultancy Optimity Advisors.

The CCGs confine themselves to quoting a few confusing extracts in the Business Case.

The first Optimity document, published in March 2017 (but for some reason based on 2013/14 figures), makes the unsurprising point that patients sent over 800 accounted for 41% of emergency care load and 45% of elective admissions, and that:

> “Health care costs increase with patients’ age [...] average cost per head significantly rises over the age of 60.”

Hypothetical

Optimity go on to discuss the hypothetical advantages and cash savings that might result from improving out of hospital services. These were proposed up at the February 2016 Shropshire CCG commissioning body meeting with the CCG's\[...]

But with Weston’s A&E already closed overnight, it’s clear that the implementation of the cutbacks is already underway.

Many more questions remain to be answered from the hundreds of pages of documentation. The Lowdown will be following with interest.

Shropshire appendices removed

At the end of January, in a venue seemingly selected to be as remote and inaccessible as possible from the community in Telford and Wrekin, whose hospital services were to be downsized and cut back, a joint meeting of Shropshire and Telford & Wrekin CCGs took just one hour, with no significant debate, before rubber stamping their controversial “Future Fit” plan.

The decision, which had been expected, was immediately challenged by the “Future Fit” campaigners invoking their scrutiny powers to refer the plan to the Secretary of State.

The curious footnote: “According to a yellow page publication, Weston hospital has by far the highest proportion of patients aged over 65, which is only slightly higher than the non-elective inpatients stay while 71% of Weston hospital revenue (each 28 miles away) to Bristol or Taunton, or the NEL trust average LOS for NEL orthopaedics from CCG – up to £40m in 2016/17.”

The fact that Weston has by far the highest proportion of patients aged 65 might be a factor – but Weston also has by far the lowest level of delayed transfers of care compared with other hospitals, North Bristol and Taunton.

Weston’s bed occupancy levels are also consistently the highest in the area, being promoted as “clinically led”.

On page 120 another note on a graph sets out a hypothetical argument:

> “According to a yellow paper commissioned by the Bristol and Weston CCG, over 650M could be saved across the region by reducing mental health patients use of the acute care system to a level closer to that of their peers.”

The data does not offer any explanation for these variations, or any proposals to address them.

For anyone with the energy to plough through the 318 pages of “commissioning body meeting with the CCG’s” documentation? Who are the campaigner Gill George’s “One Health” initiative is designed to meet the concern that the CCGs have wisely archived their collection of documents available on a “One Health” initiative is designed to meet the concern that the CCGs have wisely archived their collection of documents with no explanation for these.

Aspirational

This assumption was based at most aspirational (the next sentence pointed out “These are gross figures only and do not include the investment that will be needed to deliver a new model of out of hospital care.”)

Few people other than the “Future Fit” leaders would regard such tenuous assumptions as a basis to plan for a reduction in bed numbers and emergency services.

Now the plan has been referred to the Health Secretary, it will be interesting to see whether they stand up to any external scrutiny.
Clerical support

While trusts and NHS England keep up the pressure to cut so-called “bureaucratic” jobs in the name of efficiency savings, a very interesting research paper from Australia, published on open access in the BMJ has shown the increased efficiency that can be achieved by increased clerical support for doctors.

The article is catchy titled “Impact of scribes on emergency medicine doctors’ productivity and patient throughput: a multicentre, randomised trial”; but don’t let that put you off. The term “medicalscribe” is simply explained at the start of the article: “A medical scribe helps the physician by doing clerical tasks. The scribe stands with the physician at patients’ bedsides, completing electronic medical record tasks, finding information and people, booking beds, printing discharge paperwork, and doing clerical tasks.

They deliver a computer-on-wheels connected to the hospital’s electronic medical record system. The aim of the role is for scribes to do clerical tasks otherwise done by the physician, enabling the physician to manage more patients in the same amount of time.”

The study compared the results between thousands of physician-to-scribe pairs: who had the scribe and who did not. The results were significant:

- Increased the number of patients that physicians saw
- Increased the number of patients seen in emergency units
- Decreased emergency units bed occupancy
- Increased patient satisfaction
- Reduced physician patient completion times
- Reduced the need for nursing and clerical staff

Integration no panacea

A Nuffield Trust report at the end of January investigated whether Age UK’s Personalised Integrated Care Programme (PICP) had been able to reduce cost pressures on health and care systems and whether there had been any impact on the levels of hospital use.

The scheme set out to improve the lives of older people who are deemed to be at risk of a future emergency admission, through practical support. On average of almost 2,000 older people, the Nuffield researchers concluded that it had “almost certainly not been able” to reduce either costs or emergency admissions.

Indeed there was no sign of a reduction in use of hospital beds.

While this might appear to suggest that the project had delivered the very opposite of its objectives, the reality is not so negative. “The scheme may be identifying unmet need in the population, which manifests in greater use of hospital care. This might be the ultimate benefit of these people in the longer term.”

So as campaigns and unions have argued for some time, integrating and enhancing patient care can deliver benefits: but they are not likely to reduce costs.
Who we are — and why we are launching The Lowdown

The Lowdown is launching in February 2019 with this pilot issue and a searchable website.

We aim to develop in the next few months into a weekly source of evidence-based journalism and research on the NHS — something that isn’t currently available to NHS supporters. We are seeking your support to help establish it as an important new resource that will help to create enduring protection for the NHS and its staff.

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Information is power, and we aim to provide people with the information tools they need to negotiate, communicate, campaign and lobby in defence of the NHS.

We will summarise news from across the media and health journals, provide critical analysis, and where necessary highlight news that might otherwise be missed, and make complex proposals understandable through a range of briefings. We will bring stories and insights you won’t find anywhere else.

And we are keen to follow up YOUR stories and ideas. We welcome your input and feedback to help shape what we do.

Paul Evans of the NHS Support Federation and Dr John Lister (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) have almost 60 years combined experience between them as researchers and campaigners. They are now leading this work to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

This package is therefore something quite new, and a genuine step-up in the resources that are currently available.

As we go we will build an online archive of briefings and articles, and use the experiences and comments of NHS staff and users to support and guide our work. In time we believe this will become a resource that will establish credibility with academics and journalists and which they will use to support inform and improve their own work.

The project aims to be self-sustaining, enabling it also to recruit and train new journalists, undertake investigations and research that other organisations aren’t undertaking.

By donating and backing the mission of the project, our supporters will help develop this new resource, ensuring it is freely available to campaigners and activists, get first sight of each issue, and be able to choose more personalised content.

Why is it needed?

Public support for the NHS is high: but understanding about the issues that it faces is too low, and there is too much misinformation on social media.

The mainstream news media focuses on fast-moving stories and has less time for analysis or to put health stories into context.

NHS supporters do not have a regular source of health news analysis tailored to their needs, that is professionally-produced and which can speak to a wide audience.

In our first year we will:

- establish a weekly one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally

Help us make this information available to all

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We are therefore planning to fund the publication through donations from supporting organisations and individuals — and we are very grateful for those individuals and organisations who have already given or promised generous donations to enable us to start the project going.

Our business plan for the longer term includes promotion of The Lowdown on social media and through partner organisations, and to develop a longer-term network of supporters who pay smaller amounts each month or each year to sustain the publication as a resource.

But we still need funding up front to get under way and recruit additional journalists, so right now we are asking those who can to as much as you can afford to help us ensure we can launch it strongly and develop a wider base of support to keep it going.

We would suggest £5 per month/£50 per year for individuals, and at least £10 per month/£100 per year for organisations.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it.

On the website and in the bulletin from Number 1 we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info