CCGs’ cash crisis leaves Shropshire plan in chaos

Shropshire’s already troubled NHS faces an escalating financial problem, combined with runaway growth in emergency admissions, even as health chiefs try to push through the closure of A&E services at Telford’s busy Princess Royal Hospital – a move being challenged by Telford & Wrekin council.

Many other CCGs across the country will also be nervously grappling with the pressures of the coming financial year.

The situation facing Shropshire is revealed by a Medium Term Financial Plan published by Telford & Wrekin CCG in advance of their March Governing Body meeting. It shows the area facing a financial gap next year of £50m.

Previously the CCG has always been getting by financially (unlike Shropshire, which is facing an £18.3m deficit for 2018/19 and will carry more than £60m cumulative deficit into 2019/20).

There is also a huge increase in emergency/non-elective activity, which will not have been helped by axing the out of hours primary care services provided until last September by Shropdoc.

Emergency admissions

The T&W CCG paper shows A&E attendances are 9% above plan, ambulance conveyances 10% above plan, and emergency admissions a massive 16% above plan (and above 2017/18 activity levels). Shropshire’s emergency admissions are also 5% above plan.

This means actual demand is already far greater than provided for under the highly controversial “Future Fit” proposals to scale down acute hospital services and “centralise” emergency services in Shrewsbury for the large rural county.

T&W CCG warns that the scale of the financial problem is so great it is beyond the scope of the CCGs to deal with it.

The target of £9.6m for ‘QIPP’ savings in the coming year is “higher than any QIPP that has been delivered in any previous year.” It may well not be achieved: £4.2m of the £9.6m cuts have not yet been identified.

A third of the “savings” have to be made from acute sector, the Shrewsbury & Telford Hospitals Trust, which itself was already facing a projected £24m deficit this year, £5m above its control total.

The Future Fit plan hoped to deliver a marginal surplus of only £2.6m for the Trust, but this is one that has been wiped out by the additional cuts from T&W CCG. Shropshire CCG also has to aim for cash savings from acute services, posing the Trust with even deeper financial problems.

It’s now clear to all that the Future Fit plans don’t add up either financially or in terms of demand and capacity.

Cllr Andy Burford, co-chair of the Joint Health Overview and Scrutiny Committee of Shropshire and Telford & Wrekin councils told The Lowdown:

“On the face of it these new CCG figures are very worrying. “We have a JHOSC meeting coming up soon, and we will be asking some searching questions to establish what the real financial position is for health care in our area.”
UNISON mounts campaign against hike in professional fees

The Health and Care Professions Council (HCPC) is increasing its annual fees by 18% for members for 15 health professions.

The increase has been met with dismay by UNISON, the union representing many of the health care professionals affected, and by professional organisations, including the Chartered Society of Physiotherapy and the UK Association of Dietitians (BDA), that represent professions regulated by the HCPC.

UNISON has launched a campaign against the fee increase and is urging people to contact their MPs and ask them to sign the ‘Low Down’ petition, which asks the HCPC to reconsider the increase.

UNISON notes that this rise means that the fees have increased by 40% since 2014. As well as the fee hike, the HCPC has also decided to cut discounts for new graduates.

The HCPC argues that the increase in fees is needed to make up for losses of fees that will take place as social workers will no longer be registered by the HCPC from later this year.

As social workers under went the highest number of fitness and ethics tests, then the HCPC will also lose money from this aspect of its work.

Registration with the HCPC is essential for members of 15 health professions, including physiotherapists, psychological therapists, occupational therapists, radiographers, dietitians, and paramedics. Subject to parliamentary money from this aspect of its work.

Staff have had to endure over the last few real term wage freezes that many health care professionals affected, and by dismay by UNISON, the union

The letter points out that the increase is “disproportionate to the current rate of inflation and fails to take account of the real terms wage freezes that many health staff have had to endure over the last few years.”

In addition, it is likely to deter staff staying in their roles and new staff joining, in particular part-time workers.

The MPs called upon the HCPC to look at the way it works and improving its processes and procedures to save money, rather than increasing fees.

Labour party motion seeks to stop back door NHS changes

A ‘prayer motion’ sponsored by Jeremy Corbyn and six other Labour MPs has been tabled in the House of Commons in an attempt to prevent major changes being made to the current legislation on providing GP services without full Parliamentary scrutiny.

The changes are being introduced by the Department of Health and Social Care using Statutory Instrument 2019 No. 249 – The Amendments Relating to the Provision of Integrated Care Systems 2019.

Changing legislation in this way means that MPs do not get the chance to debate or vote on the legislation.

The changes will be introduced by the statutory instrument will be part of the new integrated care provider contracts that NHS England is due to introduce in 2019 as part of its drive to convert all areas of primary care to integrated care

The amendments will allow whichever organisation holds one of NHS England’s new integrated care provider contracts to take control over the provision of primary care and directly employ GPs. This means that a single organisation can hold a contract for all health care in an area - hospital, community and primary care.

The contract leaves open the chance for private companies to take on the lead role in integrated care. Although a report by the Health Select committee judges that this looks impractical in practice.

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Prescription charges kill

The shocking story of the death of 19-year-old William Hague. He may be gone, but his battle against prescription charges continues.

Prescription charges in England are clearly raised more to make an ideological point than to fund the NHS. They are, at 0.16%, visibly small, at an irrational cost.

Charges have been added up to just less than £1600, just half of one percent of the budget of the Department of Health and Social Care. There are significant grounds to oppose the charge, major Objection to the working of the poor.

Catherine Hale, leader of the CQC, which found the service was “underperforming in seven out of nine key performance indicators as of April 2020.”

Vehicles checked were “unclean”, with unsecured stretchers, “unsecured clinical waste on vehicles and a dirty, stained patient blanket behind a folded chair.”

Vehicle cleanliness was “not audited by local managers,” and on some training levels were below 50%, and the service did not have a structured plan with set actions to achieve compliance. “Staff morale was poor in areas; the culture of the service was one of fear to speak up. Staff team meetings were rare.”

In 2014, an investigation of their service in Dorset brought a damning report from local communities, “whilst the county’s Sustainability and Transformation Partnership, with no evidence to claim they have dealt with a total year’s deficit of £50m.”

While NHS England tries to convince the public that closures are inevitable, the reality is that patients with rare diseases are facing endless cuts, particularly cancer services, hip and knee replacements, at the county’s four CCGs to make more and deeper cuts as part of the conditions for merging into a single CCG.

According to the comparative figures drawn up by NHS Improvement’s “Right Care” initiative, Derbyshire is “overspending” against comparable areas by almost £84m, with the greatest variation in Musculoskeletal (£14m), followed by Respiratory (£7.5m), Cirrhosis (0.4m) and Cancer (0.41m) – even though local cancer services are working at 101% of their performance targets.

Main victims

So why are NHS England’s chief executives desperately seek savings at any price, it seems the main victims will be users of these services, three of which are potentially life-threatening and one of which can leave patients denied treatment immobilised by chronic disease.

There is no hint of any compassion in the Medium Term Financial Plan rubber stamped by the “meeting in confidence” of the Governing Bodies of the 4 CCGs. It stipulated a four dear of repeated hiring and deepening of cuts in services. Despite apparent increases in funding things seem to get worse if anything in the year from April 2020, since the demonstrable new money is largely Illusory:

“Of the 201718 allocation set to be carried out, just 1 m of £69.5m of cuts needed to be carried out without immediate and disastrous consequences. “Less than half” of £5.4m of cuts needed next year to hit the “control total” has been identified. Finance chiefs apparently agree: “we can no longer afford to wait to commission all current services at the same level” – so tough luck if you need care or a joint replaced."

No, clear what the implications are for staff, although a governing body member from North Derbyshire told the Derby Telegraph he feared they would “struggle,” while the chair of Erewash CCG was hopeful to be able to alter staff roles, saying that “We need a bit more flex to help our patients this differently.”

The Turnaround Director for the 4 CCGs, Sandy Hogg said: “The system is not the one seen by the CQC. Not the one seen by the CQC.

"The culture of the service was one of fear to speak up. Staff team meetings were rare.”

The CQC’s net real term growth in 2019/20 is therefore tied together with the scale of the underlying deficit means that 2018/19 remains a very challenging year for the CCG.

Deficits

It charts an unbroken series of in-year deficits in 2017/18 (€80m); 2018/19 (€35m); 2019/20 (€36.5m); 2020/21 (€76.1m); 2021/22 ($50.4m) and 2022/23 (€34.1m). It notes that QIPP “efficiency” savings will generate enough in 2022/23 to stave off “a small surplus.” For this year just ending the cuts target for 2018/19 was £51m, the magic figure set by the “Commissioner Sustainability Fund”, and now they have to claim they have dealt with a total year’s deficit of £50m.

Mr Hogg said that the new Derby and Derbyshire CCG begins life next month with a £1m of deficits carried forward.

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John Lister

Debate over a short enabling Bill in Parliament to give ministers legal powers to fund and implement healthcare deals after Brexit has highlighted a number of major concerns.

And with every optimistic estimate of a possible influx of at least 100,000 British migrants looking to the NHS for their treatment in the event of a no deal Brexit, the stakes are high.

The official line is that the NHS, Health and Social Care argues the Bill “will establish the legal basis to fund and implement reciprocal healthcare arrangements and share necessary data after we leave the EU”.

But questions have been raised by Labour on the actual numbers of people involved: according to Shadow Health Minister Justin Madders, WKI statistics show more than twice as many – up to 469,000 UK pensioners – might be living in the other 27 EU countries. In debate on the second reading he said:

“Some of the figures in the Government’s Bill may be underestimated completely to understand the complexity and cost of implementing what might end up being a diverse array of agreements.

“When they gave evidence to the House of Lords European Union Committee, the British Medical Association and the Royal College of Paediatrics and Child Health were clear that should no EU-wide reciprocal agreement be achieved, the costs of implementing what might end up being a diverse array of agreements would help do this.

“However, in the absence of any agreement, it is the assumption that member states will apply the same rules to UK nationals that they apply to EU citizens.

“The report flags up the uninspiring assumption that should be spent on UK patients and should be by no means universal and enforcement of entitlements is likely to be problematic.

“It goes on: “The UK hope that member states will be willing to support UK nationals to access healthcare and the Bill will support us to implement bilateral agreements that would help do this.

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The situation with reciprocal healthcare arrangements with EU and EEA countries would fall on the NHS.”

The Library Briefing Paper on it produced by the House of Commons Library the Bill does not propose any specific healthcare arrangements, it simply gives the Government the power to bring in new reciprocal arrangements or make payments.

Parliamentary debates on the Bill have centred on ministers’ use of “statutory instruments” to introduce new pressure to charge visitors for NHS care

New pressure to charge visitors for NHS care

Unfortunately the debate on the Bill has also highlighted a worrying apparent parliamentary consensus in favour of NHS trusts being more aggressive in levying charges for treatment on people from overseas. Labor’s Justin Madders is quoted in the Commons Library Briefing Paper on the Bill that “irrespective of Brexit, it is deeply concerning that millions of pounds that should be spent on UK patients by the NHS is going to waste because people are not able to get a grip on cost recovery”. As a result of Tony legislation in 2010 and 2011, accompanying the “hostile environment” for migrants and linked with hugely inflated claims on the scale of so-called ‘health tourism,” a new legal duty was put in place on NHS staff charged people not resident in Britain for other services, but sometimes it fails to do so.

“I am not sure there is a magic bullet. It probably requires drilling lots of people in 442 and down on the land to focus on whether people should be paying or getting free treatment.”

By Poole MP Robert Syms. He is eager to compel hard-pressed and dedicated staff in A&E to focus more on recouping money for patient care: “We need to emphasise to trusts the requirement to recoup money, because that means more money for British people using the service and for other services, but sometimes it falls down the priority list.

“The Secretary of State to report back to Parliament, even in the event that a reciprocal deal cannot be reached.

He went on: “Where are the checks and balances if the NHS ends up having to police 27-plus different sets of arrangements? What if the deals reached end up costing far more? “What if our cost recovery continues to lag well behind what it should be? There needs to be greater parliamentary oversight of all these issues.”
The NHS is still trapped in Tory no-man’s land

Paul Evans

Nearly seven years ago the coalition government introduced the biggest ever set of changes to the NHS. Now NHS England wants to undo large parts of that legislation.

The Health and Social Care Act was driven through Parliament despite opposition. This week plans were published calling on the present government to introduce fresh legislation.

However, this major shift in policy could be mired because the government lacks the necessary Parliamentary majority, leaving the NHS in a dangerous hinterland.

NHS England already have skin in the game. At the start of the year they published a plan – an ambitious 10-year vision to bring councils, hospitals, GPs and non-NHS providers together, to organise healthcare in new local systems, breaking down all the old barriers. It was all launched with bold promises to save 50,000 lives and transform our NHS. NHS England CEO Simon Stevens knows that success rests on some critical elements that are not directly within his control.

Solving the workforce crisis needs further funding and a more open immigration policy.

A solution on social care has been ducked by governments for decades. A third crucial piece is the need to reorganise the NHS.

It won’t be called a reorganisation, as part of the fallout from the last NHS shake up is that the service has an understandable aversion to more change. But NHS England has already started the process, by merging existing areas to form one of 42 integrated care systems (ICS) – new partnership boards made up of key organisations and providers.

Yesterday’s ideas

The once radical ideas behind the Health and Social Care Act are being overwritten. They are at odds with NHS England’s new era of integration.

NHS leaders are now trying to pull health bodies out of their competing silos, confronting the fragmentation that has predictably emerged from forced competition, but there is a problem. The laws and structures behind the market mayhem are still in place.

NHS England is trying to make changes without Parliament, but they are clear about their preference for primary legislation and believe that “legislative change could make implementation easier and faster.”

However, the last election left the government with a majority too small for the average park kick about. Ministers know that to put new NHS legislation through Parliament would need a host of steely defenders to charge off a barrage of unfavourable amendments. This explains why the promise made in the 2017 Conservative Party manifesto to put new NHS legislation before Parliament has already been quietly dropped.

No surprise then that this week that unofficial comments reported on Twitter, from a “government source” to a well-placed journalist, appeared to firmly dismiss the idea of putting new legislation to Parliament.

So what’s plan B? NHS England claim that much of what they want to do can be done without legislation.

On competition, they can remove the obligation for NHS contracts to go out to tender quite easily by revoking the regulations without Parliament’s help – but the NHS is also caught by EU public contract law.

Finding a route around this largely depends on the outcome of Brexit, according to Andrew Parker, a procurement specialist and partner at Hempsons.

Deal means EU law

He concludes that signing a version of May’s deal would keep us under EU law for the whole of the transition period.

In a version of a customs union would mean that procurement rules would stay the same. “No deal” would separate us from EU public contract law, but that would still be a need for other legislation to replace it.

This is a complex landscape and in bypassing Parliament it is becoming clear that all manner of compromises, temporary patches, accountability workarounds and governance issues will emerge.

Without a change in law Clinical Commissioning Groups remain the lead player in terms of the current legislation, but the new integrated structures demand that they hand over control to a new local partnership board.

The plan may be to give NHS foundation trusts the power to create joint committees as the basis for the 42 new integrated care systems (ICSs), but how will they know these will work and how are they accountable?

No legal powers

John Coutts, policy adviser to NHS Providers and a governance specialist has exposed some of the risks in NHS England’s Plan B.

“The partnership ‘boards’ proposed in the long-term plan to replace lead integrated care systems (ICSs) are not bodies corporate.

“They have no legal powers to make decisions and rely on delegations and committees in common to make decisions. This means that there can be no legal basis for the decision making which can lead to lack of clarity about when a decision has been made and by whom.”

Without a change in law Clinical Commissioning Groups remain the lead player in terms of the current legislation

It is clear that the existing market-based structures will be stretched and pushed in ways that were not intended, and there is an unresolved legal debate amongst policy makers about how far they can go.

For all the current public disquiet with Parliament, its role in scrutinising proposed changes to complex systems like the NHS would be reassuring in this situation.

The government may opt to circumvent MPs, the Lords and by significant changes in process, but with that we are depriving ourselves of some our democracy’s built-in safeguards.

There is already concern that this government is abdication its powers by making changes through statutory instruments and avoiding Parliamentary discussion. The Labour leader recently launched a motion, known as a Proven, to object to this tactic being used to adjust the relationship between MPs and the ICSs (see p2).

The need for scrutiny is also highlighted by NHS England’s plan to introduce powers that will force foundation trusts to merge. This move suggests that local democracy will once again be trumped by those at the top of the NHS. And worryingly it flies in the face of a 2012 issue about the success of past mergers.

Research by the University of Bristol on the impact of 102 acute hospital mergers from 1997 to 2006 found that productivity didn’t improve, waiting times increased and so did the debts of merging trusts. Similar negative conclusions were reached in a study of mergers between 2010-15 by the Kings Fund, which also showed that improvements in care such as to stroke and cancer were not achieved by any cooperation without the need for mergers.

Campaigners will be worried that new mergers will be cover for a host of cost-driven decisions aimed at reducing debt and cutting services rather than boosting them.

Personal health budgets

In a similar vein NHS England’s plan to expand personal health budgets in the NHS needs proper public scrutiny.

Giving patients a set sum for their care and allowing them to choose how it is spent is a great idea, but the risk that has been heavily criticised.

What happens when the funds run out, patients will feel the pressure to top-up from their own pockets, but many will not have the means, is this rationing by the backdoor or more charging by the front?

Equally, combining health and social care could be beneficial, but it is full of potential traps.

As Healthcare must remember the point of use and not means tested like social care.

How can too many new or even a small number of community-based health professionals without a commitment for them to work for NHS organisations and not in the private sector?

The implementation document from NHS England does not give cheer to those who were battling against the marketplace of the NHS. However, it also provokes concern that by not including the NHS in the carve-up of primary legislation, controversial and flawed plans will proceed unchallenged.

It proves that to defend the NHS against damaging ideas and to promote the best, we need more democracy, transparency and accountability. Not less, both at the heart of our NHS structures and in our wider society.

End of Section 75?

While campaigning for the NHS Reinstatement Bill, we focus on the

Curate’s egg of NHS England proposals to change the law

John Lister

The joint board meeting of NHS England and NHS Improvement on 28 February discussed the primary legislative changes for the NHS Reinstatement Bill.

This follows a powerful campaign from a group of parties and methods to expose the NHS and independent “Integrated Care Organisations” and the ACO contract that was to have been introduced by April 2018.

The proposal predictably opted to follow the route suggested by the NHS Reinstatement Bill.

However it’s clear that important changes are being proposed, even if the primary focus of the NHS England proposals is definitely positive.

The Lansley Act is being rewritten to make it easier to integrate services.

Two key measures are not reinstating the duty of the Secretary of State to publish comprehensive, publicly-funded NHS is available, free at point of use and funded through general taxation.

End of Section 75?

There seems to be no reason to oppose NHS England’s proposals that: “We propose the section 75 of the Health and Social Care Act 2012 be revoked and the power to override the NHS in contracts and a competitive market.”

There is no reason to oppose NHS England’s proposals that: “We propose the section 75 of the Health and Social Care Act 2012 should be revoked and the power to override the NHS in primary legislation under which they make is should be reassessed.”

We don’t support “Integrated Care Systems” but if NHS/I, in preparing for these, are taking on merger commissioners and providers, we should call for removal, or at least to stop this process, and create new Boards as public bodies, working with listening boards, subject to Foi requests, and bringing in a more transparent and accountable trade union and lay reps? So we do think the Competition and Markets Authority has legitimate role in the NHS or public services. Campaigners will oppose NHS/I being given statutory rights to impose mergers of hospitals/services, and to bypass the public and parliamentary consultation.

The Lansley Act is being rewritten to make it easier to integrate services.
The battle over the future of Urgent Stroke Services continues in Kent and Medway, even after a unanimous decision of the Joint Committee of Clinical Commissioning Groups on February 14 to nod through a controversial plan to centralise services in new specialist units in Maidstone, Dartford and Ashford.

Each of the “Hyper Acute Stroke Units” are also supposed to have an acute stroke unit to give patients expert care after the first 2-3 hours until they are ready to leave hospital, and a clinic for assessing and treating transient ischaemic attacks (TIAs or mini-strokes).

Medway is one of the four hospitals that now stands to permanently lose existing stroke services when the HASU/ASUs are developed: the others are Tunbridge Wells Hospital; Queen Elizabeth, the Olympic, Mother Hospital in Margate; and Kent & Canterbury Hospital (where services are already “temporarily closed”).

Medway Council has confirmed that it will seek a judicial review of the decision. The council has cross-party agreement to allocate £30,000 towards the cost of the challenge. Medway is about 12 miles by road (30 minutes in light traffic) from Maidstone, and 18 miles down the A2 from Dartford; these journey times increase at peak times of congestion, which delay even blue light ambulances.

No local care

Medway’s Conservative leader Cllr Alan Jarrett told Kent Online: “I am deeply concerned by this decision, especially as Medway Maritime Hospital is the local hospital for more than a half a million people across Medway and Swale. When these changes happen, if any of them have a stroke they and their families will no longer be able to receive care locally.”

Even longer journeys are on the cards for stroke patients from Margate: from there to William Harvey Hospital in Ashford is around 40 miles, an hour’s journey by car at off peak times, while the other alternative, Maidstone, is five miles further away.

Journeys from Tunbridge Wells to Maidstone are around 20 miles (40 minutes in light traffic). In each case, public transport options for relatives wishing to visit take even longer.

The business case document argues for the centralisation of stroke services at new specialist units. The business case document argues for the centralisation of stroke services at new specialist units.

Concerns over statistics

Yet campaigners have highlighted a number of concerns over the way the case has been argued and the statistics that have been used, which rely heavily on claims of numbers of lives saved by centralising stroke care in London.

The Business Case also points to the danger that one or the other of the units could close even before the new services come on stream, or as they put it: “the risk of closing units becoming untenable due to an inability to retain and recruit staff”.

This risk is of course multiplied many times over by the blight that will inevitably fall on the doomed stroke units now it is clear they will close in a couple of years at most.

Health campaign group Save Our NHS in Kent claim staff are already leaving QEQM. Speaker popped Jeffrey told the Thanet News: “BONIK has been told that since staff at QEQM’s stroke ward were issued documents stating future job uncertainty, employment, a number of skilled nurses have found new jobs elsewhere, as they were not able to move to Ashford. EKHUFT appears to have effectively decimated its own workforce at a time of national shortages. These are people with specialist skills and experience. We are told only two nurses from the stroke ward are willing to move to Ashford.”

The changes have been under debate for five years: if they are not held up by the judicial review (or staff shortages) they may move into the implementation phase. The CCGs anticipate that the new stroke service will begin at Maidstone and Darent Valley hospitals in about four months, and in William Harvey Hospital in spring of 2021.

The US administration has announced its objectives ahead a new post brexit trade deal with the UK. An analysis by the People’s Vote organisation focuses on the impact upon the NHS. It is warning that they could lead to higher prices for the NHS and a relaxing of the rules surrounding who has access to patient data held by the NHS.

Poppy Voice see significant dangers within a key section relating to “Procedural Fairness for Pharmaceuticals and Medical Devices”. The objective states;

“Seek standards to ensure that governmental regulatory measurement regimes are transparent, provide procedural fairness, are non-discriminatory, and provide full market access for U.S. products.”

Peoples Vote, which favours another referendum, believe that this implies that the US will seek to open up the UK market to US-style direct marketing of drugs and remove restrictions on drug pricing.

Labour MP Jo Stevens, a supporter of the Peoples Vote, which favours another referendum, believes that this implies that the US will seek to open up the UK market to US-style direct marketing of drugs and remove restrictions on drug pricing.

She said: “As we demand for fairness for NHS patients at home, we will also demand fairness overseas. When foreign governments extort unreasonably low prices from US pharmaceutical companies, Americans have to pay more to subsidise the enormous cost of research and development.”

A particular target for criticism by the Trump administration was single-payer healthcare systems, such as the NHS, which imposes a drug price controls. He accuses foreign governments of not paying their fair share of research and development costs to bring innovative drugs to market.
Who we are – and why we are launching The Lowdown

The Lowdown launched earlier in February 2019 with our first 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 and improve their own work.

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

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.

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 issues 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 / 60-63-01) 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