Few people could have had any illusions that the British public would react positively to American corporations moving in on our NHS.

So what have we learned from the huge public reaction to the US Ambassador and then Donald Trump himself insisting that the NHS – and of course its budget of £120 billion a year – had to be on the table in any trade negotiations?

Tory leadership hopefuls predictably hastened to distance themselves from any toxic association with Trump’s demands.

The public view was shown by over 300,000 people rushing to sign the petition launched by Dr Sonia Adesara, and promoted by Keep Our NHS Public, to “send a message to Donald Trump to keep his hands off our NHS, and ask the UK government to explicitly guarantee that it will never form part of a trade deal with America”.

Trump himself appeared to retreat slightly from his original statement in an interview the next day with Piers Morgan; but it would be a mistake to take either his opening gambit or his subsequent statement at face value – or to trust any British government rejection.

Trump will have known that the NHS is already open to private companies to bid for contracts.

But up to now the main US health corporations have shown little interest in bidding for under-funded contracts to deliver patient care.

Nor are the major US insurers significantly engaged in the UK, even as gaps appear in the NHS. US hospital giants HCA and Tenet also have only a minimal foothold, but no large scale commitment to expand in Britain’s small private hospital sector.

Instead US companies like UnitedHealth subsidiary Optum have focused on selling technology, IT expertise and “back office” systems. And of course the main potential money-spinner is pharmaceuticals, especially if Trump could strip away existing regulations and NICE guidelines, and force British prices up to the inflated levels they are able to charge in the US market.

The government have shown they are happy to accept all of these, except perhaps the drug price hikes, which would push up public spending.

So their denials are as phony as Trump’s retreat.

Remember it was British governments that created a competitive market in the NHS. They have opened it up to EU competition laws more than any other EU country.

It’s been possible for governments, like the Canadian government, to reject any US involvement in their health care system, even while signing free trade deals.

France and Germany have also protected their much bigger health care against competition laws and have little if any US penetration.

It’s not Trump or the US who have privatised sections of our NHS but British governments, and predominantly British companies such as Virgin.

To make sure we keep our NHS public, we need a government committed to do just that – not one led by any of the right wing hopefuls lining up to replace Mrs May.
Brum trust gambles on Babylon’s chatbot

John Lister

The massive £95m PFI-funded Queen Elizabeth Hospital in Birmingham is struggling with a rising tide of emergency admissions (up almost 8% since last year) and emergency admissions (also up by 8%). In 1200 beds are not enough to cope with local needs, the once prestigious hospital is slipping down the performance league table – and its chief executive Dr David Rosser is getting desperate.

The scale of the emergency caseload is so great, with its pressure on, that the trust is feeling insufficient capacity to meet targets for treating elective patients, leading numbers treated from Birmingham & Solihull CCG 11% below last year.

But these are also the type of patient most likely to be among the rising numbers of A&E attenders... Dr Rosser is trying to deter from coming to QEH. So it’s hard to see how Babylon can help, even if it works as well as the company claims.

The report also fails to answer key question of the cost-effectiveness or sustainability of the GP at Hand model. This is both because of the absence of data on patient outcomes (effectiveness) – but also because Babylon itself evoked “commercial sensitivity reasons” for refusing to divulge data on the costs involved.

Babylon’s chatbot software is NOT based on AI, and does not satisfy the mostly youthful and affluent punters who questioned the validity of the test, and revealed many errors in its diagnoses which have been increasing critical fire from doctors and AI experts, describing the chatbot has also been deleted; in other words all of the company’s boldest claims for the AI symptom checker through a chatbot, backed up by AI experts... has been presented as superior to that of real trainee GPs. The many errors in its diagnoses which have been increasing critical fire from doctors and AI experts, describing the chatbot has also been deleted; in other words all of the company’s boldest claims for the AI symptom checker through a chatbot, backed up by AI experts... has been presented as superior to that of real trainee GPs.

Babylon covers its tracks

Babylon, the controversial company behind GP at Hand, which is destabilising primary care in London and set to expand to Birmingham, appears to be keeping up the traces of a debunked test of its online triage service last summer.

The company has been hard at work deleting all of the details of what was at first a much-vaunted comparative test, in which the chatbot’s performance was presented as superior to that of real trainee GPs.

At first the company was quick to boast that this test proved that its software was superior to real doctors. But Babylon’s claims immediately came under increasing critical fire from doctors and AI experts, who were quick to point out the absurdity of the test, and to expose the various ways in which it was skewed to make the chatbot’s performance look better.

‘Al News’ has since discovered that the video of the test event has now been deleted from Babylon You Tube account. The company lost money in 2016 and 2017, and appears to be spending contract income as soon as it comes in.

But now it appears that a contributing factor to this has been the opening of a brand new £100m A&E department, almost 2 years later than scheduled, last December. There had been problems with contractors, plumbing and asbestos.

Babylon is led by Ali Parsa, the mercurial salesman best known for creating Circle Health, which runs small, unsuccessful private hospitals and which failed so spectacularly on a 10-year contract to manage Hitchinbrooke Hospital.

Parsa left Circle before it hit the buffers at Hitchinbrooke, and is now busy taking up what he claims is an “artificial intelligence” chatbot, and using this and a huge expansion of the workforce as the basis to attract up to £40m in investment. The company lost money in 2016 and 2017, and appears to be spending contract income as soon as it comes in.

The trust has now agreed to explore using Babylon’s services, including video appointments and digital triage, in the hope it might help divert pressure from its severely strained hospitals.

“We would like to explore whether an AI symptom checking tool, such as Babylon’s AI symptom checker, currently designed for and aimed at primary care, could be developed for use in relation to urgent and emergency care. … Used in this way, it would provide the AI symptom checker through a chatbot, backed up by Dr's clinicians.”

The trust has now agreed to explore using Babylon’s services, including video appointments and digital triage, in the hope it might help divert pressure from its severely strained hospitals.

“Looking at the unproven technological solutions offered by Babylon, the company behind GP at Hand, the online GP service controversially co-founded by Dr Ali Parsa, it is easy to see why the trust in Ali Parsa’s questionable role as ‘a key player, Dr Rosser has decided to change its path, and which failed so spectacularly on a 10-year contract to manage Hitchinbrooke Hospital.

A&E) in 2010/11, have been faced with the biggest delays and do not require beds. Meanwhile they have been paying little attention to the growing delays for those in most serious need.

Croydon's overstretched University Hospital has been bumping along at the bottom of the performance tables for some time.

In January 2019 it became the first hospital to dip below 50% of the most serious Type 1 A&E patients to be treated or admitted within 4 hours. Indeed Croydon Health Services Trust’s 29 percentage point drop over 2 years to just 49.1% type 1 performance in January 2019 made it the worst in the NHS, 27 points behind the 76.1% average.

The report also fails to answer key question of the cost-effectiveness or sustainability of the GP at Hand model. This is both because of the absence of data on patient outcomes (effectiveness) – but also because Babylon itself evoked “commercial sensitivity reasons” for refusing to divulge data on the costs involved.

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But these are also the type of patient most likely to...
**Swindon primary care left stranded by contract failure**

By Samantha Wathen (Media/Press Officer and writer for Keep Our NHS Public)

The future of 54,000 patients is uncertain after private company InHealth (IMH) has withdrawn from five Swindon GP practices it was contracted to run.

The mismanagement of general practice in Swindon and subsequent abrupt withdrawal of IMH means that five GP surgeries, owned by members of staff and 54,000 patients now face an uncertain future.

Three partners are due to resign over the shambolic takeover of surgeries that took two practices from a CQC rating of good to requiring improvement or inadequate earlier this year.

*Dangerous practices* IMH have a troubled history.

Following an *unannounced inspection* at one of the surgeries affected Prof Steve Field, chief inspector of practice at the CQC, said:

> “We found there has been insufficient management infrastructure and insufficient leadership capacity and capability. There are significant concerns regarding the lack of effective governance and oversight to ensure quality and safety are not compromised.”

Primary Care Networks will be introduced in a matter of weeks and NHS England have no plans to ease this deadline for the practices affected.

The way private company IMH has run the five GP surgeries in the town has meant significant problems for patients accessing appointments since autumn.

The arrangement was presented as a way to relieve the burden on clinicians to focus on patient care and ease the crippling financial pressures caused by sustained underfunding of general practice.

However, those employing this company should have done their homework. IMH have a troubled history.

In March 2017 the company was refused the contract heads when one of their practices in Kent was found to have five **receptionists** but no **doctors** after full time members of staff resigned, leaving the practice relying on locums.

There are also other examples of practices across the country going from good to inadequate as a result of an IMH takeover.

**Dangerous practices**

In Swindon the company quickly cut their costs by reducing essential administrative staff in practices by 50%. Without informing patient participation groups 75 staff were squeezed into the equivalent of 36 full-time employees.

54,000 patients now face an uncertain future.

A new call handling hub was introduced, immediately taking the time spent waiting on the phone to around an hour on average.

In addition, patients complained of dangerously muddled prescriptions, and long delays to access appointments.

According to a local member of staff working at the Great Western Hospital one patient even required emergency surgery due to not being able to access their GP.

The situation deteriorated to such an extent that it drew the attention of the shadow health secretary Jonathon Ashworth who in November waded into the debate, raising the issue in parliament.

Following an *unannounced inspection* last month, the CQC issued IMH (now trading in Swindon as the Better Health Partnership) with an enforcement order to improve.

This prompted the resignation of Dr Peter Mack, the lead partner from his director role at the CCG, IMH CEO Martin Diaper followed suit a week later.

After a protest outside the CQC by Keep Our NHS Public campaigners who have been exerting pressure for months, the CGC finally informed IMH that the contract had been breached, issuing a remedial notice requiring improvements.

The next day IMH announced their **intention to withdraw** from the five surgeries they were managing.

**What next?**

With hundreds of GP surgeries closing around the country the CCG and campaigners have a difficult time ahead but a solution must be reached, ideally with an NHS provider taking over the reins. Kate Linnegar, Labour prospective parliamentary candidate who has been campaigning on this with Keep Our NHS Public since the problems started, says:

> “It is vital important that the CCG oversee a smooth transition for patients who have suffered enough. Some NHS Foundation Trusts have taken GP surgeries in house, cutting out the need for a private profit-making company to be involved. I would urge Swindon CCG to consider this alternative.”

IMH have effectively driven a wrecking ball through general practice in Swindon and should be held accountable. Private firms can and will walk away when the going gets tough, leaving the NHS to pick up the pieces.

The NHS cannot and will not do this, and that is just one reason why privatisation poses such a threat to our health system.

The abrupt withdrawal of IMH means five GP surgeries over 100 members of staff and 54,000 patients now face an uncertain future.

**NHS England retreats – to insist lead providers must be NHS bodies**

NHS England has made an ungraceful climbdown from its initial plan to allow private sector providers to play a role in allocating specialist mental health commissioning budgets with a total of more than £2 billion.

In a move which Health Service Journal report links to criticism by campaigners of this new level of involvement of private companies, NHS England has written again to all providers of specialised mental health, learning disability and autism services to make clear that private firms are excluded from leading the new models of care.

NHS England’s letter includes public and private sector in an invitation to “all providers of specialised mental health, learning disability and autism services to make submissions, through a regional process, to form NHS led provider collaboratives from April 2020.”

But it makes clear that the leading role in each collaborative has to be an NHS organisation with experience of delivering specialised mental health and/or learning disability and autism services.
What's the government's plan to help our GP services - and will it work?

PAUL EVANS

The pressure on GPs is evident across the NHS and a recent study shows that numbers have actually fallen for the first time since 1960s. NHS England are reorganising primary care into Primary Care Networks which they say will solve many of the current problems.

Being a family GP is not as desirable as it used to be. Patient demand is rising. Millions more are living with chronic conditions. Our needs as patients are more complex and often dealing with them won't fit into the average 10 minutes consultation time - the short end in Europe.

GPs don't shy away from the challenge, but often when their patients talk about their symptoms they are also describing society's lack family breakdown, money worries, social exclusion, which need a wide set of policy answers, not simply a prescription. We now know that society has blunted our response, limited the treatment options and caused thousands of unnecessary deaths. Delays in mental health are dangerously high. Drug and alcohol services have been cut back, social care is by popular view on its knees and spending on preventing illness has gone down when it needs to be a high priority.

It's easy to see how a GP could be overwhelmed and despondent. This is why many are leaving the profession. Plans to raise GPs numbers have been tried but have so far failed. Despite a government promise in 2015 to bring in 5,000 more GPs, data from NHS Digital shows that there are now 1,180 fewer than three years ago.

PRIMARY CARE NETWORKS

In an attempt to lift the pressures on GPs, NHS England are reorganising primary care to help spread the workload. NHS England claim that the process is well underway.

"Practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. GP leaders are being asked to merge their practices together to serve larger groups of patients. These new Primary Care Networks will care for 30,000-50,000 patients each."

The vision is that GPs will work more closely with a wider group of health professionals including pharmacists, district nurses, community geriatricians, physiotherapists and podiatrists. A network of community activities will also be created to provide care that is more "personalised" and more often sighted in the community.

New money is already being targeted at these areas. NHS England believe that introducing new ways of working will help to make GPs more efficient and also create better organised care that is more "personalised" and more often sighted in the community.

The Health Foundation has criticised the size of the funding settlement and has also said that the extra money will not be shared out according to an equitable weighting system.

The detail on how PCNs will vault from their fledgling status into something capable of satisfying these new demands is unclear ...
Billions are spent by the NHS on drugs every year – but how does it work?

How much does the NHS spend on drugs per year?
According to the most recent data from NHS Digital, in 2017/18 the overall drugs cost at list price in the NHS, before any discounts, was £18.2 billion. This is an increase of 4.6% from £17.4 billion in 2016/17 and an increase of 39.6% from 2010/11. Hospital drug use accounted for just over half (50.4%) of the total at £9.2 billion (2017/18). In fact total hospital costs are up by 10.8%, compared to a 1% decrease in the primary care sector over the most recent year.

How are prices set in the UK?
Pharmaceutical products in the UK are priced by the manufacturer and are not subject to direct price controls. Companies set the price of drugs based on a number of factors, including the number of patients it will benefit, how many similar drugs are on the market and the price of competing products.

Although, there are no direct price controls in the UK, the price of pharmaceutical products are controlled via indirect processes, discussed below. The prices that the NHS will pay for a pharmaceutical product are published monthly in the drug tariff. This price is known as the list price and is normally what pharmacies will be reimbursed when they dispense the product.

How do prices in the UK compare to other countries?
It is not easy to compare drug prices across markets due to the complicated nature of rebates and discounts that operate. It is however clear that drug prices in the UK are much lower than in several other developed markets and substantially lower than in some other markets.

In 2017, the Commons Health Committee investigated why health spending was so much higher in the USA, than in nine other developed market economies. The committee found that:

- “While drug utilization appears to be similar in the US and the nine other countries considered, the prices at which drugs are sold in the UK are substantially higher.”

The report noted that the reasons for markets outside the USA, having much lower prices included certain price control strategies, like centralised price negotiations.

According to the report, one example of high prices in the USA compared to the UK is the cost of insulin. Reports in the Daily Mail highlighted the difference in pricing between the drug - insulin aspart, which costs £204 for a 28 day course in the UK, compared to £258.19, up 1,605%.

As a result of the price rise, the prescribing of the drug was restricted to specialists and even in this situation, some patients were unable to get it on prescription due to restrictions.

In 2017, the Competition and Markets Authority (CMA) began to investigate the price hikes. Advanz Pharma maintains that it has not infringed competition law and all price increases were legal and approved by the Department of Health and Social Care over a period of ten years.

The CMA disagreed and has found that the company breached UK and EU competition laws from at least 1 January 2009 to at least 31 July 2017.

Unfortunately for patients, despite the CMA’s decision’s the drug continues to be priced at £204 for a 28 day course from £5.15 to £258.19, far higher than is acceptable.

Explainer

NHS our best defence against big pharma profit grab

Two instances of high drug prices are denying thousands of NHS patients the care they need, despite the power of the NHS in negotations and indirect pricing controls.

In September 2019, the Guardian reported on ten medicines supplied by the scheme’s members exceeds an agreed percentage. In January 2019, the PPRS was revised and renamed the Voluntary Scheme for Branded Medicines. The cap, for increase in costs to the NHS was set at 2%.

If in any of the next five years, the rise in drug spending by the NHS is above 2%, then the industry that has signed up to the scheme is required to pay back the NHS the overspend.

Around 80% of branded products are covered by the voluntary scheme. Branded products not covered by the scheme are included automatically in a statutory scheme, which also has a payback mechanism.

What products aren’t covered by the Voluntary or statutory schemes?
Generics medicines, those that are not protected by patents, are not covered by any price control scheme. UK government’s have relied on market competition to control the prices of these products.

This has worked to a large extent, generic versions of best-selling branded drugs are sometimes 90% cheaper than the original branded products.

There have been problems however, with relying on market competition. Although a product may be old and produced as a generic, it will not necessarily have many or in some cases any competitors on the market.

Some manufacturers took advantage of this situation and hiked the price of a generic product year on year knowing that there could be no comeback.

There have been cases where prices for some generics rose dramatically leading to a sudden increase in NHS costs.

An article in Pharmaphorum reported that dramatic price increases included the anti-epilepsy drug phenytoin sodium, the price of which was reportedly increased by 1,600%.

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Unfortunately for patients, despite the CMA’s decision’s the drug continues to be priced at £204 for a 28 day course, far higher than is acceptable to the NHS.

The restrictions on prescribing, therefore, remain in place in many areas of the country.
The Competition and Markets Authority (CMA) has investigated these cases of dramatic price hikes. A change in law in mid-2017, however, should close the ‘loophole’ in the existing legislation that prevented the control of prices of unbranded generics supplied by companies that are members of the voluntary scheme for branded products.

What other ways does the NHS control prices?

New innovative products are assessed by NICE (National Institute for Clinical Effectiveness) for cost-effectiveness, using measures of improved ‘quality of life’ compared to existing therapeutics. If NICE considers that the drug’s effect on quality of life is not great enough to justify its price tag, then the drug is not recommended for use by the NHS.

The decisions by NICE often lead to discussions and negotiations with the manufacturers and the result is often a deal under which the NHS pays a lower price for the drug.

In particular, new medicines that NICE considers to be cost-effective, but which would not be cost-effective to produce, are subject to negotiation and price cuts. The NHS pays a lower price for the drug.

What will happen to drug prices post Brexit?

Drug prices and costs for the NHS will inevitably rise sharply under a no deal Brexit scenario, according to the Nuffield Trust, which has investigated the scenario using data and reports from multiple sources.

The estimate was produced in November 2018, but the scenario still holds if we leave the EU without a deal in October.

Other versions of Brexit will also increase the price of pharmaceutical products but by varying amounts. According to the Nuffield Trust, a no deal Brexit will increase the cost of unbranded (generic) drugs by £830 million and branded drugs by £20 billion by the end of 2019/20.

Overall, the cost to the NHS is estimated to be £2.3 billion by the end of 2019/20.

Some of these increased costs have already happened due to the effect on prices of the drop in the value of sterling after the EU referendum.

Mark Dayan estimates that this seems to have added around £500 million to the NHS trust deficits in 2016/17.

Pharmaceutical spending

As % of total health spending, 2017, or latest available

CREASED BY UP TO 2.600%

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What happens when the drug pricing mechanism doesn’t work?

Recent years have seen a number of situations where the drug pricing mechanism has failed and NHS patients have been unable to access certain drugs.

The failure to agree a price for Vertex’s Orkambi, to treat cystic fibrosis, has resulted in many patients being unable to access what is the only treatment for this condition.

Vertex is refusing to reduce its price for the product, which the NHS says it cannot afford.

As already noted, in other cases, generic manufacturers have taken advantage of a loophole that existed for generic product prices and priced the product so high that the NHS has restricted its prescribing.

This has led to patients either not receiving the drug or buying overseas where the drug is much cheaper.

What will happen to drug prices post Brexit?

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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.

Since then we have published every 2 weeks as a 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, 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 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

In our first year we will:

● establish a regular 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