HEALTH EMERGENCY

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INSIDE

Scandal of Mid Staffordshire proves the case …

Health care “market” puts care at risk!

Commissioners and “regulators” cannot ensure quality care

The disastrous and dangerous poor performance uncovered at Mid Staffordshire Hospitals Trust a few weeks ago was more than a one-off local management failure. It was a dramatic systems failure demonstrating that no level of the new “health care market” is able to ensure quality care for patients.

Key culprits were the local management, who slashed staffing levels of nursing and medical staff to half the minimum to cut costs as they pursued their bid for Foundation Trust status. But where were the protests from the professional bodies which are supposed to uphold basic standards of care?

Also remiss was the local Primary Care Trust, “commissioning” services on the basis of the budget, without any scrutiny of the quality of patient care. Of course the traditional patient watchdog, the Community Health Councils were long ago scrapped by ministers wanting a quiet life: not a cheep was heard from the toothless bodies that have been put in their place – the Patient Advocacy Liaison Service, the Patient and Public Involvement Forum or the local council Scrutiny Committee.

Nor were the over-paid, under-worked bureaucrats of the West Midlands Strategic Health Authority on the case: they apparently only find out about quality of care when alerted by

the Healthcare Commission. Their boss at the time, Cynthia Bower, having failed to spot this major failure in the middle of her patch, is now stepping across, ludicrously to head the Care Quality Commission.

NHS boss David Nicholson also held senior management positions in West Midlands SHA up to 2006: small wonder he and Bower are so determined to squash calls for any independent inquiry into what took place and why.

Meanwhile Monitor, the Foundation Trust regulator has been exposed as focused narrowly on the balance sheets and business prospects of those applying, rather than paying any attention to patient care.

All this goes to show that “regulation” as a means to ensure quality and accountability is as inappropriate in a health care market place as it has been shown to be in banking, finance and the wider economy.

Ministers are even now splitting the NHS into fewer, less accountable providers, each seeking to deliver a surplus at all costs; but a serious response to the Mid Staffordshire crisis would be to slam the brakes on this, before more patients die from avoidable sub-standard care, and before the notion of health care as a ‘business’ completely rots the foundations of our NHS.

Contact LHE: email john.lister@virgin.net

SE London: from ‘super-trust’ to super cuts

The ministerial rubber stamp has come down, finalising plans to merge “local” hospital services in Outer South East London into a single, cash-strapped Trust – without even the pretence of a public consultation.

The new so-called “super Trust,” covering 800,000 residents in Bexley, Bromley and Greenwich, and straddling a massive swathe of SE London from the Millennium Dome to the M25, will launch with historic debts of up to £200m.

Bromley’s Princess Royal University Hospital Trust alone has racked up a staggering £110m deficit, fuelled by a PFI hospital contract.

Queen Elizabeth Hospital Trust now admits its PFI hospital is ‘underfunded’ to the tune of £8-£10m a year: it has debts of £65m and projecting another shortfall this year of almost £6m.

Bexley’s Queen Mary’s Hospital, Sidcup, is universally seen as the “soft target” for cuts in services as soon as the new merged Trust starts in earnest to balance its books.

Local health chiefs deliberated avoided any public consultation on the merger process. after failing to win any significant public support at all for their plans back in 2007.

CONDITION CRITICAL

An International Conference on the marketisation of health care and the role of the media

Saturday June 20 10.00 - 3.30 (lunch provided)

Coventry University

Called by the International Association of Health Policy in Europe, supported by Coventry University, People’s Health Movement, the International Journal of Health Services, the Politics of Health Group, the NHS Consultants Association, Keep Our NHS Public and Health Emergency.

Join a discussion with speakers and campaigners from Europe, Africa, the US and Canada on the common threats and issues – and the fight to defend health as a public service.

Free entry for health unions and campaigners, but prior registration required: contact *j.lister@coventry.ac.uk*

"World Class Commissioning" – a smokescreen for privatisation

World Class Privatisation

Many industries and banks may be sliding into recession world-wide, but private health care providers have a smile on their face as they look forward to rich pickings from our National Health Service. They love the government's determination to divert a growing share of the NHS budget from public services to the private and "independent" sector. JOHN LISTER investigates.

The new plans undermine Nye Bevan's principles of a planned, publicly provided service

According to *HealthInvestor* magazine

"The UK healthcare market has remained resilient, stable and remarkably active despite the financial volatility. The combination of the government's NHS reform programme and the sector's strong fundamentals enables venture capitalists, private equity and banks to proceed with opportunities difficult to find in other sectors."

The speculators are right to regard Gordon Brown's government as their sponsors: behind the scenes, and out of the headlines, ministers are forcing through a massive new drive towards fragmentation, privatisation and marketisation of the NHS, reviving proposals which appeared to have been abandoned almost four years ago.

The main target now is primary care and community services, delivered until now by Primary Care Trusts, and employing around 250,000 health workers in England with a budget of over £11 billion. They now face a 3-way onslaught from far-reaching government policies which few people will even be aware of:

■ "World Class Commissioning", the apparently meaningless mantra of clichés promoted in the last year or so by Strategic Health Authorities and Primary Care Trusts as they set about splitting up and outsourcing services;

■ proposals in Lord Darzi's Next Stage Review, and other policy guidance, to boost the creation of "social enterprises" (private sector organisations which generate surpluses from providing health care, but do not distribute profits or dividends to shareholders);

■ and the establishment of a new hard-nosed body – the so-called "Cooperation and Competition Panel" – with a brief to force through a new, competitive, market system in what has until now remained one of the more integrated areas of health care.

In July 2005, just after the general election, then NHS chief executive Nigel Crisp attempted to split directly-provided services off from the PCTs, suggesting they should become simply commissioning bodies, with as many as possible of their services hived off – privatised, handed over to "social enterprises", or run at arms-length until some alternative could be found.

Crisp was looking at a model in which the NHS would effectively cease to be a provider of services. Instead it would become a FUND to purchase – or "commission" – services from a range of providers, whether these be Foundation Trusts, the private sector, or social enterprises – all competing with each other.

This "Commissioning" would be done by Primary Care Trusts as local budget-holders.

Crisp called it "Commissioning a Patient-Led NHS", although there was no hint anywhere in his rambling and vague DoH circular on how patients would have any say at all over the reorganisation he was proposing.

In fact the Crisp plan involved the merger of 25 Strategic Health Authorities into just TEN even more remote and more arrogant super-quangos, and the forcible merger of over 300 PCTs into half that number, mostly much bigger and less accountable organisations than before, paying only lip-service to public involvement.

This part of the plan was carried through: however Crisp's rapid-fire proposals to hive off the PCTs' directly-provided services proved far more controversial. Ministers were eventually forced by a tide of public anger to intervene and slow the process right down. But four years later, long after the disgraced Crisp was dispatched to the House of Lords with a fat pension pot, they are coming back to try again.

The buzz-phrase for commissioning is now "World Class Commissioning". It appears to focus PCTs on eleven "competencies", many of which are only included to divert attention from the central objective of creating a health care market, spelled out in Competency 7:

"Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes".

This means ensuring a variety of providers compete for contracts to deliver services – in other words inviting in the private sector and social enterprises to take a slice of every local NHS budget.

PCTs are now rated on their achievement of the various competencies, and Strategic Health Authorities, not satisfied with the level of privatisation that has been delivered, are piling pressure on many PCTs to step up their efforts and bring in more private sector providers, especially in primary care.

Even Camden PCT, which defied local protests to hand over three GP practices to US-owned corporation UnitedHealth last year, has been found inadequate in its privatising efforts – and given the lowest score by NHS London. Other PCTs can also expect to feel similar pressure.

NHS London is setting up a powerful and costly structure, the London Clinical and Business Support Agency (LCBSA) to harness together the capital's 31 PCTs. It is headed up by a former BUPA boss, Rhona McLeod, and will seek to coordinate the drive towards a health care market in the capital.

Other support is also on tap. The Department of Health guidance on World Class Commissioning repeatedly refers to the "Framework for procuring External Support for Commissioners" (FESC), which brings together 14 companies that have been "approved" by ministers to advise PCTs.

These include three of the four major US health insurers whose trustworthiness was so strongly questioned by Michael Moore's film Sicko. One of them, UnitedHealth in the USA has just again been fined millions of dollars for fleecing elderly people subscribing to its so-called "Evercare" service in Texas.

Nowhere do ministers make clear exactly why these private profit-seeking companies should themselves be seen as "world class", or what appropriate skills and knowledge they may have to offer NHS organisations tasked with delivering universal and comprehensive health care to the whole local population.

Of course World Class Commissioning involves many "competencies" in addition to stimulating local markets: and not all of the competences lead towards fragmenting services, undermining them, and funnelling out NHS cash to bolster private profits.

PCTs are urged to become "recognised as the local leader of the NHS", "work collaboratively with community partners", "proactively build continuous and meaningful engagement with the public and patients", lead "continuous and meaningful engagement of all clinicians" – and many other apparently worthy objectives.

But much of this is window-dressing: ministers know there is no public pressure or support for many of the big changes they are imposing on the PCTs.

And experience shows that the only public views which the PCTs and SHAs will ever take on board are those which seem to echo their proposals.

The PCTs are being fashioned into instruments for top-down control by ministers and Strategic Health Authorities seeking to break our once unified NHS, with its planning and targeting of resources, into a competitive market … whether we like it or not.

Darzi plan heads up a sneak attack

250,000 health workers in England – nurses, midwives, health visitors, therapists and others – face two years or more of turmoil and insecurity as ministers force through yet another unwelcome reorganisation on services: this time the services directly provided by Primary Care Trusts.

Primary Care Trusts which hold budgets to commission care for local people, and also deliver primary care and community health services, are required by April 2009 to have separated their services from their commissioner arm, and established a contractual relationship between them in place of a direct managerial link.

By October 2009, PCTs are required to have developed a detailed plan for "transforming" their community services, and to have decided whether they wish to see them taken over by a Community Foundation Trust (which will at least allow staff to remain NHS employees) or by a social enterprise (which will not).

From October, the PCT commissioner arm is supposed to carry out a service review and an analysis of the local market for services, and by next April PCTs should be implementing their plans to "stimulate a competitive local market for services".

PCTs will have to identify which services will be opened up completely to competition, by allowing patients to choose from "Any Willing PCT-accredited Provider", and then make sure they accredit potential providers who can deliver the required standards of care within the NHS tariff cost.

Given the character and scale of some of the community services, it is clear that by no means all of them are an attractive or profitable prospect for the private sector.

Nevertheless ministers are determined not to let that be an obstacle to privatisation and the creation of a new "market" – hence the central role of "social enterprises", bodies outside the NHS, which run to deliver surpluses, but which do not distribute them as profits to shareholders.

Ministers have become increasingly fixated on handing over large sections of community health services to social enterprises – and a succession of them since Patricia Hewitt in 2006 have somehow convinced themselves that this is a policy which health workers support, despite the absence of any evidence to support the case.

Lord Darzi's report 'High Quality Care for All' incorporates an incredible section on community services which effectively spells out a commitment to extend to staff the right to be privatised.

Recognising that one of the key obstacles to transferring NHS staff to so called "social enterprises" is the issue of pension rights, Darzi offers weasel words, extending NHS pensions to those staff who transfer, but no equivalent guarantee for staff who subsequently join the staff of the social enterprise.

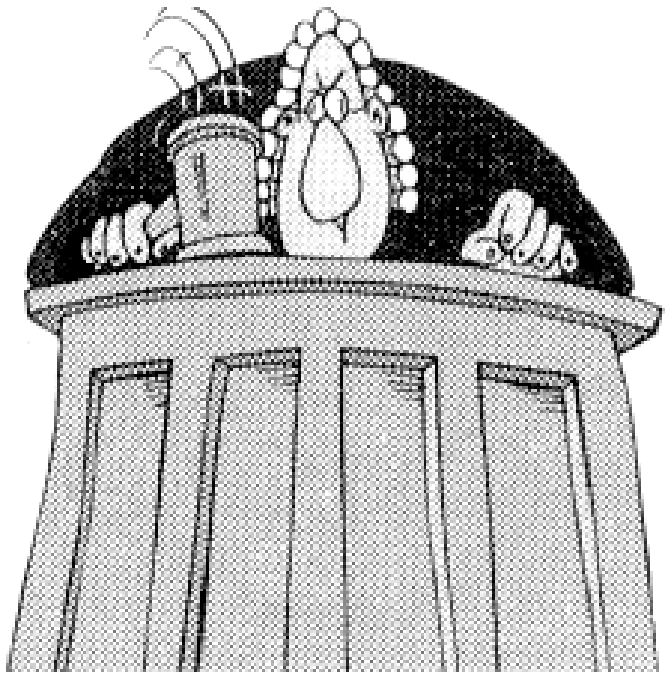
"Where PCTs and staff choose to set up social enterprise organisations, transferred staff can continue to benefit from the NHS Pension Scheme, while they work on wholly NHS funded work."

This makes a two-tier workforce inevitable. Note also the cynical use of the word "choose", suggesting that maybe staff are yearning to leave the security of NHS terms and conditions of employment, and work for an untested "social enterprise".

Of course there is no evi-

Unfair competition panel

The third, and most draconian measure to force the pace of privatisation across the whole of the NHS is the establishment of a new "Cooperation and Competition Panel" chaired by former private healthcare and nursing home boss Lord Carter of Coles, whose appointment was eagerly welcomed by the private sector.



The Panel was set up last year to allow private sector providers to raise complaints that they have been unfairly treated, and that a local area is not sufficiently opened up to competition between would-be providers – whether this be in community services, primary care, mental health or acute hospitals.

In other words the Panel is a bent umpire, with the task of shifting the goalposts to ensure that the private sector gets what it wants.

The Panel sees its role as responding to any private sector complaints against potential mergers of NHS providers, and against what they see as unfair procurement policies, "collusion", or "price fixing". As such, despite its misleading title, the Panel is transparently biased against cooperation, collaboration or planning between different sections of the NHS.

The draft policy guidance for this obscure body has in theory been out to public consultation since January 30, although it has barely been reported even in the health service press. It has been subject to virtually no debate, and few health workers, MPs or members of the public will have any idea what is being proposed. The consultation ends on April 30.

One person who has flagged up the importance of this Panel is Professor Chris Ham, a former advisor to Tony Blair's government, who recently branded the guidelines as "written by a neo-liberal economist on speed", and criticised its "one-eyed" focus which undermines integration of services and regards almost any collaboration between providers as "collusion".

The Competition Panel's total opposition to any form of "price fixing" might even question the Department of Health's policy of establishing a national tariff for treatment costs, warns Prof Ham.

No cooperation

Although the word "cooperation" is included in its title, there is no sign of any commitment to cooperate: the Panel is single-mindedly focused on driving through a competitive system. Its policy documents endlessly reiterate claims for the benefits of competition, despite the total absence of any evidence to support them:

"In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients."

None of these alleged benefits is supported by even a shred of evidence, anywhere in the world. But the Panel goes on to make even more extravagant and absurd claims for the merits of competition against planning:

"As set out in the Framework for Managing Choice and Competition, choice and competition in the NHS can be expected to:

- **improve quality and safety in service provision;**
- **improve health and wellbeing;**
- **improve standards and reduce inequalities in access and outcomes;**
- **lead to better informed patients;**
- **generate greater confidence in the NHS; and**
- **provide better value for money."**

This list is pure fantasy: indeed not even the most fundamentalist of free-market ideologists would dare to claim that markets can "improve health" or "reduce inequalities" – that's not what markets are supposed to do.

Having spelled out its clear, fundamentalist, completely biased free-market approach, the Panel's guidelines go on to claim that:

"The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients (i.e. service contestability).

"Where the process of competition is dampened, or otherwise hindered, by a merger, the enefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost."

Of course all this, too, is a deception, empty words. The private sector does not want genuine competition, because there is no way private medicine is viable in a free market.

The only way New Labour has been able to build up the previously marginal private healthcare sector of 1997 into a slightly less marginal one in 2009 has been through STATE SPONSORSHIP and blatant favouritism – preferential allocation of ring-fenced contracts to private providers, paying above NHS rates for Independent Sector Treatment Centres (ISTCs), paying out sweeteners, start-up subsidies, and guaranteed long-term contracts.

Even now private contracts with the NHS are exempt from the "Payment by Results" system that applies to all NHS and Foundation Trusts, while public sector providers are excluded from even bidding for ISTC contracts.

Genuine competition would kill off the private sector, which delivers marginal minor treatment at higher cost, while leaving all of the more complex and demanding treatment, all emergencies and chronic care, and almost all mental health care, to the NHS.

Private providers don't want competition: they want to split up and carve up the NHS, to slice off (cherry-pick) the bits they find profitable and leave the rest – and the Panel is being set up to help them do it.

The NHS is viewed by the Panel as a business like any other, with no recognition that certain services have to be maintained and made available to meet local health needs.

Any attempt to stabilise NHS Trusts and their services through mergers is seen simply as an obstacle to private sector involvement, and therefore "anti-competitive".

So any planned mergers of NHS organisations with a combined turnover of more than £15m a year in primary care, £35m in community services or £70m in acute and mental health care (i.e. virtually any NHS providers) could be referred by the Panel to the Office of Fair Trading, or even the Competition Commission, and potentially blocked..

Any attempt between two or more NHS providers to cooperate and divide responsibility for services between them – or to agree NOT to provide the same services or to compete with each other for the same pool of patients – could also be branded as "collusion" and outlawed.

And the Panel could even intervene in cases where – even without any collusion – an NHS provider is seen as having too large a share of a local market without sufficient competitive pressure.

With this new team of hanging judges positioned to mete out brutal retribution to any NHS organisations which seek to collaborate, plan or integrate services, ministers are setting an accelerated course to hiving off large sections of the NHS by the time of the next election,.

After that, of course, David Cameron's team of privatisers could happily pick up and use the same apparatus to complete the process of picking bare the NHS carcass to benefit the profiteers.

Health unions, campaigners, MPs, councillors still have a few days to register concerns over the Panel's role and its proposed policies. But time is running out on World Class Commissioning: it is important that PCT direct service staff are not bullied or stampeded into "social enterprises" which then raise long-term problems in terms of employment rights, terms and conditions.

Nobody has asked Labour ministers to smash up our NHS, fragment it, or wheel in grasping private companies and "social enterprises" to take over local services.

There are no votes to be won in carrying out these changes: if there is a loud enough roar of protest, there must be a chance that the process can be halted and rolled back. It's desperately late in the day: but let's start the shouting now.

dence staff wish to leave the NHS for these alternative organisations which offer them less security, fewer rights at work, less prospect of training and promotion, cannot offer a guarantee of pay increments comparable to Agenda for Change, and may well be taken over by an outright private provider or by another social enterprise.

There IS evidence that many who did not want to get involved have in the past been ignored by dictatorial managers and (as with community nurses in Central Surrey) effectively press-ganged into a new set-up – on pain of losing their jobs.

Darzi dresses the whole proposal up as if it flows from staff themselves, pressing the case for innovative social enterprises against stick in the mud NHS management:

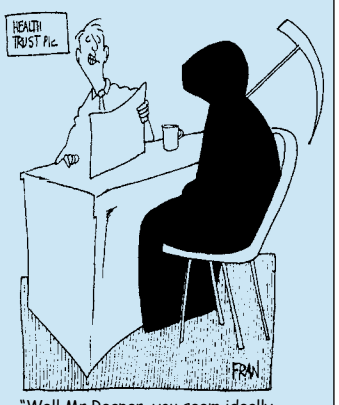
"We will also encourage and enable staff to set up social enterprises by introducing a staff "right to request" to set up social enterprises to deliver services. PCTs will be obliged to consider such requests, and if the PCT approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years."

The wording is deliberately vague on which grades of staff, how many of them, and what proportion of staff involved, would need to support a social enterprise for this to be granted by the PCT.

Past experience would suggest that a tiny hard core of a few gung-ho managers, or a handful of disgruntled professionals would probably be seen as giving sufficient pretext for the process to get under way.

It is clear that behind the scenes the Department of Health is wedded to the model of social enterprises, and applying pressure on key staff to exercise this "right of request".

Behind the velvet glove of Darzi's encouragement is the iron fist threatening that services which do not request may be outsourced in some other way.



"Well Mr Reaper, you seem ideally suited to step into the vacancy on the Board at Mid Staffordshire"

Fewer beds than under Thatcher

Health bosses and ministers now have almost 17,000 fewer acute beds available than when Thatcher was in office.

This leaves t5he NHS vulnerable to any peak in demand such as last winter's combination of the winter vomiting norovirus and a big increase in emergency referrals for cold-weather bronchial problems.

Hospitals are now stretched to capacity – and hemmed in by targets to reduce waiting times to a maximum of 18 weeks from the end of 2008.

But with new cash constraints looming up, old discredited plans for "centralisation" and downgrading of hospitals and A&E services could yet be plucked from the back burner.

Just because it's crazy doesn't mean ministers won't try it.

Saved unit is now a model for the NHS

The new NHS London document 'A Local Hospital Model for London' has a major panel praising the South West London Elective Orthopaedic Centre (SWLEOC), based at Epsom Hospital, describing it as a model for other units.

"This is the largest such centre in western Europe," says NHS London. Its report tells us that the centre, which replaces over 4,000 joints a year, now:

- delivers a surplus for the four trusts;
- has had no MRSA infections and has had a 0.1% infection rate overall for a full year;
- achieves the 18 week target;
- has a low average length of stay for hip and knee replacements;
- achieves theatre utilisation around 95%
- and there have been no complaints received in a full year.

"Given the success of this model, it is recommended that further work should be undertaken to assess the extent to which this can be replicated, the advantages this would bring and what the wider implications would be."

Good. So it's just as well London Health Emergency, UNISON and local campaigners stepped in at an Epsom-St Helier Trust Board meeting four years ago to prevent SWLEOC being flogged off to an American company!

Why LHE needs your branch support to keep campaigning

Since the summer of 2005 London Health Emergency has worked with other organisations to establish a new, broader campaign linking the issues of cuts and privatisation – Keep Our NHS Public.

In many towns and cities local activists and campaigners have got together to build local Keep Our NHS Public branches as broad-based campaigns aiming to stop and roll back the juggernaut of a government policy that is wrecking our NHS.

LHE has provided key campaigning work and research skills to Keep Our NHS Public.

We have also stepped up our own systematic work using the local and national press and media to ensure that the NHS remains high on the political agenda and that journalists looking to cover health stories can always access a hard-hitting quote defending the principles of our NHS.

Solid support from UNISON branches and other health union branches has been the key to LHE's survival as a campaign for over 20 years since the GLC (which first funded us) was abolished.

For over ten years now we have received no grant funding from local government, or core support from any organisation – every pound we spend on campaigning has to be raised through commissioned work and from donations.

If you have not yet done so, please make sure your branch and region affiliates to LHE for 2009 – and where possible add a donation to help the campaigning work that cannot be funded any other way.

Affiliation is just £25 per year, with a lower rate of £15 for the smallest organisations and pensioners' groups.

Affiliates get copies of our campaign newspaper Health Emergency – and a discount rate on any LHE consultancy services, such as publicity and research work.

LHE research and publicity services . . .

What we can do to help your branch

WE KNOW that UNISON branch officers and stewards are busy people. Your time is limited, and so is your scope to take on any additional tasks.

The workload over the last few years, with Agenda for Change panels and processes coming on top of routine grievances and disciplinaries, and new challenges arising from almost constant local and national NHS reorganisation, makes it difficult to keep your head above water.

But you will know that many of the new policies being forced through in the government's incessant "reforms" have serious implications for the jobs and conditions of UNISON members, and for the shape of the local health services that we all depend on for our own health care.

And the pace of change is increasing: the next round of "modernisation" is likely to be pressed forward over the summer, and seems certain to bring the threat of more closures of local hospital services, "centralisation" of more specialist services, ever-increased reliance on private sector Treatment Centres and other private operators to replace NHS services – and even more threats to NHS jobs.

We know that many UNISON branches lack the time or the resources to respond to all the new policies and changes they face: that's why London Health Emergency has for years offered branches a regions a responsive and high quality consultancy service, to assist with the research and publicity issues that may otherwise be left undone.

SWLEOC: opened by the Queen – kept open by LHE and the UNISON branch

Responses

How many times has your branch been asked to respond to proposals involving major reorganisation and rationalisation of services but not felt able to set out a sufficiently detailed answer?

If this has happened in the past, you will know that UNISON's silence is taken for acquiescence, and it is much harder to complain about changes after they are imposed if you have not expressed opposition before hand.

LHE has two decades of experience in working with UNISON branches all over England and Wales to draft hard-hitting, clear and constructive responses which set out the concerns of health staff and service users – and a wealth of experience of different reorganisations and the arguments wheeled out by Trusts and PCTs to justify them.

Recent responses include "Castles in the air" on hospital reconfiguration in Gwent, and "Too high a price to pay", opposing plans to close the Felix Post unit for older mental health patients in SE London.

Research

Some of the policy changes coming down the line are relatively new to the NHS and the health unions.

One example is the proposal in Oxfordshire to transform the old learning disabilities trust, the Ridgeway Partnership Trust into a "social enterprise". Oxfordshire UNISON commissioned LHE to research the implications and draft a response.

LHE has also researched for UNISON nationally – on the views of staff in PFI hospitals, and on the views of cleaning staff across the NHS – producing pamphlets with a campaigning edge to reinforce the union's defence of public services.

Reports

In 24 years of campaigning LHE has worked with UNISON regions including London, Eastern and East and West Midlands to produce overview reports on issues such as mental health services, cash crises and cutbacks, community care eligibility criteria, and the reorganisation of Strategic Health Authorities.

Campaigning

In addition to speaking on Keep Our NHS Public and other campaign platforms LHE has continued to work with branches and regions all over the country on campaigning issues.

We have worked with South London & Maudsley UNISON Branch to help mount its high-profile campaigns against cuts in mental health – campaigns which have enlisted all-party support, involving ministers and MPs as well as linking up with service user groups and local community organisations.

We have worked with Epsom & St Helier UNISON Branch to defend services at both Epsom and St Helier and successfully block the planned privatisation of the successful SWLEOC NHS Treatment Centre.

We have worked with Wakefield and Pontefract UNISON to challenge the costly and complex PFI Business Case and the continued secrecy surrounding it.

We have helped branches respond to PFI, social enterprise bids, Foundation Trust bids and rationalisation of acute services. We provide a unique service, delivering results that branches could not otherwise deliver, at affordable prices and with quality guaranteed.

Publicity/ newspapers

You may be doing splendid work, but do your members know how much you are doing or why progress is not as fast as they would hope?

Big branches need to work hard at communications – but health workers are not journalists, and many branches do not have the skills needed to produce their own newspapers.

LHE has long experience in producing professional quality tabloid newspapers for UNISON branches that project the news and information that YOU want your members to see.

We do the donkey work, collect the information, edit any articles you or your members supply and write up additional material, design the paper and arrange for printing … but YOU remain in control, having the decision on all editorial and policy matters.

And YOU take the credit for the finished job!

We have produced branch newspapers for branches and for campaigners in South Wales, London, West Midlands and Yorkshire.

Helping you

LHE is a resource that can help your branch deliver a better service to members, communicate better with members, and have far greater impact on NHS management and the wider local community.

But to do all this and maintain our broader campaign work we need your support: we need donations to underwrite our campaigning work, and we need more branches to commission work from us – newspapers, reports, responses or help with campaigning.

Our rates are reasonable and we work fast. You are guaranteed control at all times.

So if you want to cover some of those tasks you know have been slipping by, call in some professional help.

Call LHE.

Affiliate now to Health Emergency!

PLEASE AFFILIATE our organisation to Health Emergency.

I enclose £15 ❑ £25 ❑ £……

I also enclose a donation of £……

Value of cheque £ ……

NAME .....

ADDRESS (for mailing) .....

.....

.....

ORGANISATION .....

Position held .....

(Cheques payable to LHE)

London Health Emergency, launched in 1983, works with local campaigns and health union branches and regions all over England, Wales and Scotland.

The campaigning resources of Health Emergency depend upon affiliations and donations from organisations and individuals.

We still offer commissioned research and publicity services to union branches and regions – we can help you unserstand the latest policies and respond, or produce your branch newspaper as a smart 4 or 8-page tabloid in full colour to boost recruitment and keep your members informed.

But we need your support.

■ If you have not already done so, please affiliate your organisation for 2009: the annual fee is still the same as 1983 – £25 for larger organisations (over 500 members).

■ If you have affiliated, please consider a donation.

■ **Send to LHE at BCM Health Emergency, London WC1N 3XX**

■ **You can call JOHN LISTER on 07774-264112.**

■ **or email *john.lister@virgin.net***

The LHE website is at ***www.healthemergency.org.uk***

Keep Our NHS Public is at ***www.keepournhspublic.com***

Contact LHE: give John Lister a call on 07774 264112, or email info@healthemergency.org.uk