The National Health Service

A manager's tale

1946–1992

SIXTH
H.M. QUEES ELIZABETH
THE QUEEN MOTHER FELLOWSHIP

1993

The National Health Service

A manager's tale 1946–1992

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THE NUFFIELD PROVINCIAL
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Her Majesty Queen Elizabeth the Queen Mother, who is the Patron of the Trust and has always shown a keen interest in its work, approved the founding of the Fellowship by the Trust to commemorate her 80th birthday.

The Trustees of the Nuffield Provincial Hospitals Trust will select a Fellow who will be invited to undertake to review in a monograph a subject within the sphere of the Trust which is believed to be of particular interest to Her Majesty. The monograph will be launched by a lecture.

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A number of colleagues and friends have helped in the preparation. They know who they are and how much I appreciated their frank comments.

Special thanks go to Rachel Cobbold and her colleagues at Trent RHA who lived with the manuscript for many months and whose sense of ownership was as strong as mine and my two colleaguesJackie Linton and Claire Potter. Special thanks also go to Glenis Roddis, the Regional Librarian at Trent.

The tale was written to be read . . . we hope our readers will enjoy it as much as we have enjoyed telling it.

INTRODUCTION

THIS BOOK IS ABOUT MANAGING HEALTH CARE. BECAUSE OF THE unique role of the NHS in British Society; it is also about the management of a large, complex public service; a service that has experienced dramatic growth in the science and technology that drives its range of services; strong public support for its place in the public sector but growing expectations by the people it serves about the service they are entitled to receive. It is about a service with enormous demand trapped within a government cash limit. It is about struggles for power and political ideologies. It is also a story of talented and dedicated professionals serving the community and their patients as well as they know how but constantly struggling with the harsh dilemmas of choices and rationing. At the clinicians' point in the service the choice has a face; it becomes a citizen and a patient.

Health services have been organised and managed since they assumed even the simplest form... so this story is about the managers.

The problem with telling the story of the NHS with a managerial perspective is how far to go back. We could go back to the 19th Century.

Ayers review of the Asylum Boards' created in 1867, has much to say about personal service for patients, the need for management information systems, the nature of leadership and the need for professional management. Ayers also reflects upon a problem as challenging one hundred years ago as it is today — the relationship between Departments of State and the local management of public services. She describes the conflict between the demands of public accountability on the one hand and the need for managerial flexibility on the other. She quotes Bagehot writing in 1872 'a skilled bureaucracy . . . though it boasts the appearance of science is quite inconsistent with the true principles of the art of business'.[2] This issue of management in the public service is one we shall return to. Sir Kenneth Stowe, writing at the invitation of

the Nuffield Provincial Hospitals Trust, was to use different words to express the same sentiment 100 years later. 'Government never was and never will be like commercial business'.[53]

Florence Nightingale also had a lot to say about managing health care and much of it is still relevant today. Sir Roy Griffiths called her in to support his argument for the introduction of General Management to the NHS 'If Florence Nightingale walked the wards of the NHS today she would want to know who was in charge'.

Sir Henry Burdett was never short of a word of advice on his favourite theme that hospitals must be soundly and effectively managed. The Radcliffe Infirmary in Oxford was the object of his challenge of slumbering inefficiency. It was not alone, many others received similar challenging appraisals. Some commentators would argue that Burdett could be described as the first hospital general manager, laying the foundations of health service accountancy and hospital information systems.

But one has to start somewhere and to be practical we start in a period just before the formation of a National service. We start at this point because the NHS of the future might have as much in common with the pluralistic systems of the thirties as the monolithic structure of the NHS at the start of the 1990s.

The tale is set in England. Events in Scotland, Wales and Northern Ireland followed the same broad path except that the timing and detail were sometimes different.

GLOSSARY

AHA	Area Health Authority
BMA	British Medical Association
BMJ	British Medical Journal
Centre	Central Health Departments/Central Government
CHC	Community Health Council
CIP	Cost Improvement Programme
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COHSE	Confederation of Health Service Employees
DGM	District General Manager
DGH	District General Hospital
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMT	District Management Team
DoH	Department of Health
DRG	Diagnostic Related Groups
EL	Executive Letter
ESMI	Elderly Severely Mentally Infirm
FHSA	Family Health Service Authority
FPC	Family Practitioner Committee
GMC	General Medical Council
GNP	Gross National Product
GP	General Practitioner
HMC	Hospital Management Committee
IHSM	Institute of Health Services Management
KING'S FUND	King Edward's Hospital Fund for London
JCC	Joint Consultative Committee
MAF	Management Accountancy Framework
MESOL	Management Education Scheme by Open Learning
MOH	Medical Officer of Health
NAHA	National Association of Health Authorities
NHS	National Health Service

GLOSSARY

NHSMB	National Health Service Management Board
NHSME	National Health Service Management Executive
NVQ	National Vocational Qualification
NUPE	National Union of Public Employees
PAMs	Professions Allied to Medicine
PSMs	Professions Supplementary to Medicine
QALY	Quality Adjusted Life Year
RAWP	Resource Allocation Working Party
RCN	Royal College of Nursing
RGM	Regional General Manager
RHA	Regional Health Authority
RHB	Regional Hospital Board
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
RT	Regional Treasurer
SAMO	Senior Administrative Medical Officer
TUC	Trades Union Congress
UGM	Unit General Manager
Unit	A unit of management e.g. a hospital
VFM	Value for Money
WHO	World Health Organisation

1

THE NHS IS BORN

BEFORE THE NHS

THE NATIONAL HEALTH SERVICE THAT WAS FORMED IN 1948 WAS A product of nearly 50 years of debate about the creation of a unified network of health services. The financial difficulties those services faced in the inter-war years were also influential in building up the pressure for change, as was the creation of the Emergency Medical Service during the war. But perhaps most powerful of all was the mood of the nation at the time as it fought and emerged from the Second World War.

Prior to 1939, health services in England comprised a patchwork quilt of services in the public, private and charitable sectors. General practice was already well established, as was a system of what we now call public health services which was organised by Local Government and led by Medical Officers of Health. Local Government provided a network of some 2,000 municipal hospitals with about 400,000 beds (of which 40 per cent were used for patients with mental health problems). Running alongside this were 1,000 voluntary hospitals which ranged from small cottage hospitals with less than 10 beds to the largest and most powerful teaching general hospitals in the country. There was little effective co-operation between the municipal and the voluntary sectors. Their respective management styles were very different with one locked into Local Government administration, the other committed to the great and good with Superintendents like Sir Henry Burdett who combined an active career in hospital management with one in the City.

AN INSURANCE BASED SYSTEM

A compulsory system of contributory health insurance for workers had been in place since 1911 and by 1938 provided cover for 43

per cent of the population. The system drew in employees whose income was below the specified limit (£160 per year in 1911 and £420 in 1948). Each made a contribution out of his wages of 4 pence a week to which the employer added 3 pence and the State a further 3 pence. The '10 pence for 4 pence' scheme survived with little modification through until 1948. In addition to weekly cash benefits, members received 'adequate medical attendance and treatment' without payment from their chosen general practitioner (called in those days the 'panel'). Most general practitioners were part of this system. The scheme was organised through 7,000 approved societies and, as a consequence, there was a considerable diversity in the precise range of the benefits provided, although almost none included hospital treatment or provision for dependents. (Attempts to encompass dependents always ran into the ground.) Running alongside this were a wide variety of voluntary subscription schemes which offered cover for hospital treatment and were largely developed to provide the voluntary hospitals with a regular income. By 1939 these schemes provided cover for about half the population. The whole community could claim admission to the municipal hospitals where patients were expected to pay according to their means.

For Britain as a whole investment in health care from all sources was around 3 per cent of GNP by 1937. Services were however concentrated in prosperous, urban areas with the north and west of England having the lowest levels of service.

By 1939, the voluntary hospitals sector, which had expanded its range of services and staff significantly in the 1930s (and at a much faster rate than the municipal hospital sector) was facing a major financial crisis. Voluntary hospitals were dependent for their income on endowments, subscriptions and donations as well as fund raising ventures such as flag days, and a wide variety of contributory insurance schemes. The role of the manager in the voluntary hospital sector was inexorably associated with fund raising. (Generating income may well prove to be a dominating theme for the Trust Chief Executives of the 1990s.)

Many were saved from financial ruin by the creation of the Emergency Medical Service at the outbreak of war, which bought access to many of their beds for anticipated casualties, thus supplying a welcome injection of exchequer revenue. Although intended originally for casualties, these beds became increasingly available

during the course of the war to the general community as a means of reducing waiting lists. The experience of the Emergency Medical service was a crucial conditioning factor for the development of thinking about the National Health Service, for it demonstrated the benefits of a national planned and rationalised hospital service and provided practical proof that such a thing was possible[3].

BEVERIDGE AND IDEAS FOR CHANGE

Whilst the war was in progress, Sir William Beveridge was asked to review existing schemes for social insurance. He interpreted this widely and produced proposals for a National Health Service that went far beyond earlier ideas which had centred around sponsoring simply a rationalisation of the hospital services. He envisaged that a National Health Service would be funded partly by an extension of national insurance but mainly from the Exchequer.[90] He did consider whether health should be free at the point of use like police protection, or the use of roads, or whether instead it should be charged on consumption like public transport. He concluded that a medical service without a charge at any point for any person was the right answer, particularly as access to the system was guarded by doctors who could deal with frivolous use. His report caught the mood of the country that in the words of J. B. Priestly 'the seeds of civilisation could be sowed to take root and to flower afterwards', but it was not without its critics. The Ministry of Health regarded his ideas as Utopian, the doctors were suspicious of central control and the voluntary hospital sector simply did not believe it would happen. The years that followed saw a series of Government proposals for taking forward Beveridge's basic ideas, all of which were challenged by the doctors' leaders or other vested interests.

BEVAN TAKES CHARGE

1945 saw the election of a Labour Government and Nye Bevan became Minister for Health. He picked up the work that had been done by his predecessors and concluded that the proposals for implementation as they stood had been so compromised in negotiations with all the vested interests as to be unworkable. He produced his own White Paper in 1946 which retained and

strengthened the commitment to a free, comprehensive service and went on to propose the nationalisation of all hospitals in order to create a truly national service. Bevan's Act passed into law on 6 November 1946, setting 5 July 1948 as the day the National Health Service would be born. The founding principle was that health care was to be made available to the whole community and was to be free at the point of use.

As Nye Bevan himself put it 'medical treatment and care was to be made available to rich and to poor alike in accordance with medical needs and no other criteria'. The Act placed 'a duty on the Minister to promote a comprehensive health service designed to secure and achieve improvements in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of disease.'

Health service funding was to be met by the Government from compulsory national insurance for workers and general taxation.

The resources available to the new service seem paltry now, but at the time they were enormous. 3,105 hospitals (with over $\frac{1}{2}$ m beds); 20,000 hospital doctors and 150,000 nurses; 20,000 general practitioners.

A NEW ORGANISATION

The organisation of the health service was laid out in the Act and set out in Figure 1. It had essentially three arms and became known as the tripartite structure.

GENERAL PRACTICE

Every member of the community was expected to register with a general practitioner of their choice who provided them with the major part of their health care and controlled access to the hospital system (except for emergencies). General practitioners were not employees but independent contractors to Executive Councils—a status they have vigorously maintained to this day, although the shape of the organisation with whom they are in contract has changed a number of times in the intervening years. Dentists, Pharmacists and Opticians also became contracted professions. Each Council had a Clerk as its Chief Officer.

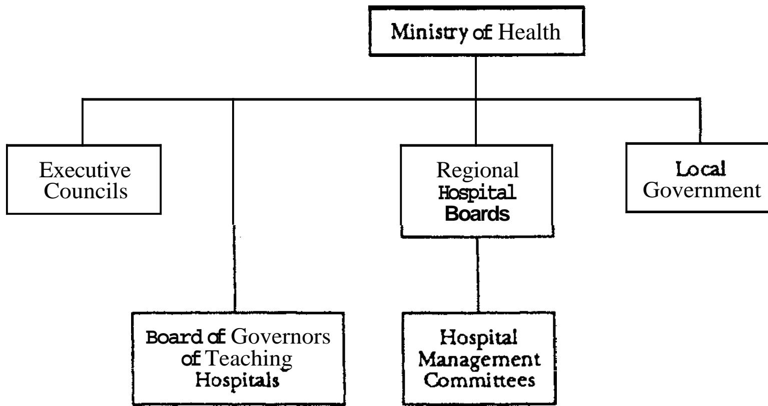

FIGURE 1

HOSPITALS

The hospitals were managed either individually or in groups by Hospital Management Committees who reported to Regional Hospital Boards. Those hospitals who participated in medical teaching were managed by Boards of Governors who reported directly to the Ministry of Health. Each hospital board or Committee had a Secretary who managed their business.

COMMUNITY SERVICES

A range of community services and responsibility for public health were retained by local government and managed by a local Health Sub-committee and the Medical Officer of Health who was its Chief Officer. He was usually supported by a Chief Administrative Officer.

MEMBERS

The Health Boards and Committees and the Executive Councils were made up of a mixture of people drawn from the local community and individuals representing the health care professions. They were unpaid and very part-time. The thinking that underpinned them was that the judgement of experts should always

have to undergo the scrutiny of men and women of common sense (a concept developed in the 19th century and described by Bagehot). Even in these early days, members were clearly unsure about their own role. In practice, services at the level of the patient were managed by the professions and the rest by full-time officers. As a consequence members did a lot of visiting, although as the service developed and grew they became heavily involved in the minutiae of financial control. These authorities had no claim to be democratic — the members were appointed by the Minister. The local Health Committee, an integral part of local government could, of course, claim to be part of the democratic process.

UNITED KINGDOM

At the level of the patient, the NHS in Scotland, Wales and Northern Ireland runs exactly the same as in England, but right from the beginning of the NHS the organisational framework has always been slightly different.

2

EARLY PROBLEMS

FINANCIAL CRISIS

ALMOST AS SOON AS THE NEW ORGANISATION HAD BEEN CREATED it ran into one of its recurring problems; financial crisis. The cost for 1948/1949 had been estimated at £179 m—the actual was £242 m. For the second year (1949–50) the service had exceeded its estimate by £77 m as expenditure rose to £305 m per year. In the economic setting immediately following the war these overruns in expenditure caused a political storm, and by March 1950 the Chancellor of the Exchequer had imposed a ceiling on health service expenditure of £352 m, and in 1951–52 charges were introduced for spectacles, dentures, dental treatment and drugs as a means of dampening down demand.

A Committee of Inquiry, chaired by C. W. Guillebaud[4] was appointed in 1953 to inquire into the NHS and reported in 1956. The Committee found that the NHS had not been extravagant, indeed as a proportion of GSP, expenditure had actually reduced from 3.75 per cent in 1949 to 3.25 per cent in 1953–54. The early estimates of the cost of the service had clearly been too low.

By 1960 expenditure on the National Health Service was 30 per cent greater in real terms than in 1949, although it represented a slightly lower proportion of GNP. Hospital activity in particular had risen sharply—out-patient attendances rose from 36.1 m in 1949 to 41.7 m in 1960 and in-patients treated from 2.9 m to 4.1 m. The early years of the service also produced significant shifts in the shape of general practice. At the start of the service about half of all general practitioners worked on their own, but by 1960 the proportion of general practitioners in partnerships of 3 and more had risen to 35 per cent. The health centre development programme that was designed to bring together under one roof general practitioners and other community based

health professionals moved ahead much more slowly. There were still enormous geographic imbalances in service and the best provided Regions in the country (primarily the Thames Regions) were still receiving nearly twice as much per head of the population as the poorest Regions.

ORGANISATIONAL TENSIONS

These early years were not without their organisational tensions as Health Departments, Regional Hospital Boards, Hospital Management Committees and Boards of Governors of Teaching Hospitals jostled for power. In April 1950 the Ministry of Health intervened directly to influence cost containment by Hospital Management Committees, removing the power of virement from Regional Hospital Boards and introducing central reviews of hospital staffing.

It looked very much as if the Ministry was about to run the service from Whitehall and its Regional offices. Hospital Management Committees saw their chance and some agreed that Regional Hospital Boards could be 'washed out entirely' as an unnecessary cog in the wheel. Indeed the Labour Government accepted advice from an Inquiry led by Sir Cyril Jones that Regional Hospital Boards be abolished. However, it was not to be, as the Guillebaud Report intervened and commented that 'the period of uncertainty about the future of Regions did real harm to the service'. Regions remained but their somewhat ambiguous authority over Hospital Management Committees remained unclear. One of the principal reasons for this ambiguity was that the line of accountability was between two Statutory Authorities (e.g. Hospital Management Committee to Regional Hospital Board) and not their Chief Officers. As Winston Churchill remarked 'The English never draw a line without blurring it'.

Tension between the various levels in the management hierarchy is a recurrent theme in the history of the NHS. In part this represents a legitimate tension between local aspirations, the needs of wider communities, and the problems of controlling public expenditure. In some respects it also reflects traditional attitudes of Central and Local Government to each other. Perhaps most of all it demonstrates the natural tension in any

hierarchical structure. Organisations without such tension quickly become moribund.

MANAGING HOSPITALS

In 1954 'The Bradbeer Report' on the *Internal Administration of Hospitals* was published.[5] This confirmed the notion of a management triumvirate at hospital level comprising a lay administrator, a doctor (usually Chairman of the Medical Staff Committee) and the Matron. Partnership amongst equals was the theme. Sometimes this tri-partite arrangement was formalised as a team but more often the three rubbed along together looking after their own territory with the Administrator acting in a loose co-ordinating role. Medical Superintendents, where they existed, (mainly in Sanatoria, Infectious Disease Hospitals and Mental Hospitals; and very strong in Scotland) were left in place, although expected to operate in the tri-partite mode.

At the level above the individual hospital (group or board) the Bradbeer Committee took a different view—that a single focus of co-ordination and advice was essential and that this be vested in the Chief Administrator. As the role of the HMC or Board Secretary grew, it began to impact on his subordinate at hospital level, particularly when both were located on the same site. On the question of appointing officers as members of the Committee the 'Bradbeer Report' was very firm. With the exception of doctors it deplored any move in the direction of a syndicalist structure which would, in its view, be the logical result of extending the principle to other officers.

The relative decline in the role of the Hospital Secretary was commented upon particularly by the 'Noel Hall Report'' in 1957 'If Hospital Secretaries are not given suitable remuneration and really satisfactory status . . . the basic tri-partite administration which the unit hospital requires will be weakened at the most critical point—the hospital itself. However the Sir Noel Hall report did result in the simplification of the administrative grading structure of the hospital service.

In 1956 the first National Administrative Training Scheme was inaugurated. An intake of young graduates was offered a 2 year intensive training programme with a mixture of academic teaching and extended field work at the King's Fund in London or the

University of Manchester. The scheme was expanded in 1963 when the Nuffield Centre for Health Service Studies in Leeds joined the scheme to provide additional academic input. Over the next 30 years this programme was to produce many of the country's leading administrators and managers.

MANAGING PRIMARY AND COMMUNITY SERVICES

The community and domiciliary health service run by local government from 1948 (preventive health, health centres, maternity and child welfare, ambulance, community nursing) developed relatively smoothly under the leadership of Medical Officers of Health, who often ran the Welfare Services as well.

Executive Councils which held the contracts of General Practitioners, Dentists, Chemists and Opticians operated in a pre-dominantly passive role, which in turn reflected on the officers they recruited as Clerks to the Council.

COMMITTEES, COMMITTEES, COMMITTEES

The process of decision-making was centred around committee structures at all levels. Statutory Authorities created a range of Standing Committees and often a myriad of Sub-Committees through which business was conducted. Even minor items of expenditure required committee approval, as did the appointment of additional staff. Tension between Committees and their respective Chairmen was not at all uncommon. The Statutory Authority itself became pretty much a rubber stamping business. The bureaucracy and delay this created became a source of increasing criticism over the years.

Guillebaud in 1956 was direct and forthright 'There is a real danger of the administrative side of the NHS getting bogged down in a morass of committees. Any unnecessary committee work is an unmixed evil.' Two years' later the Lancet joined the growing chorus of criticism 'The Health Service is only one of many National organs whose effectiveness is impaired by having too many committees with too many members'. The same leader did however qualify his criticism with a caution that a committee system was better than a system of authoritarian rule.

PAY IN THE NHS

Pay in the National Health Service was negotiated nationally through a number of joint management/Trade Union councils (Whitley). This was to have a profound impact on the management of the NHS. It focused a tremendous amount of fiscal power in the Department of Health who actually ran the management side. It left almost no room for local bargaining or management discretion and left local management with the task of applying (to the letter) national agreements. It also meant that when negotiations broke down, as they began to in the 1970s, the conflict had an inevitable national dimension.

3

OPTIMISM AND GROWTH 1960–1974

THE HOSPITAL PLAN

AS BRITAIN'S ECONOMY IMPROVED THE NHS GOT A HIGHER RATE OF development and services began to expand quite quickly. In 1962 Enoch Powell published his Hospital *Plan*[6] which was designed to improve Britain's ageing and dilapidated stock of hospital buildings, 45 per cent of which were by that time more than 70 years old. Bed provision for the acute sector was set at four per 1,000 population and capital investment did, for a short time, increase. In a related ministerial initiative, Local Authorities and Health Authorities were asked to produce 10 year development plans which they did in a mood of considerable optimism.

GENERAL PRACTICE AND THE PRIMARY CARE TEAM

Outside the hospital sector, the services provided by Local Authorities and those provided by general practitioners had been growing steadily together. Many Medical Officers of Health had by this time seen the value of developing a more integrated primary care team and even where there was no health centre development they began to attach the nursing and health visiting staff to general practices. This would eventually blossom into the concept of the Primary Health Care Team led by the general practitioner.

In 1966 the Doctor's Charter, as it became known, radically changed the method of remuneration for general practitioners and introduced the General Practice Finance Corporation, which made loans to GPs who were buying, building or improving their premises. There were also new financial incentives for doctors working in unattractive areas and for those working in group practice. During this period the number of health centres climbed

to 523 in 1973, by which time about one doctor in seven worked from a health centre. Maternity services had also changed to the point whereby by 1974, 90 per cent of all deliveries took place in hospital (66 per cent in 1960). Out-patient referrals to hospitals continued to climb sharply during this period, which some commentators ascribe, in part, to the difficulties general practitioners experienced in gaining access to the new diagnostic tools which were firmly locked into hospital service.

MENTAL HEALTH SERVICES

Mental health services were also changing as new drugs made it easier to control and relieve symptoms. A major piece of legislation in 1959, The Mental Health Act,[8] reduced sharply the number of patients admitted on a legal order. From that date local magistrates played no part in compulsory admissions, and responsibility for these decisions was placed firmly on the shoulders of doctors and social workers.

Management in the mental health services was poorly regarded by colleagues in the acute sector, almost entirely pre-occupied, as it was, with the support services of the large mental hospitals. The Medical Superintendents, of whom there were many, and the Chief Nursing Officers (one for the male side and one for the female side of the hospital) ran their own affairs. But the first signs of change were in the wind as in-patient numbers declined. The number of in-patient residents in the large mental illness hospitals had by 1974 fallen by nearly a third from the 1948 levels and lengths of stay had shortened dramatically—over 50 per cent of patients being admitted for less than a month.

HEALTH IMPROVES. . . IN SOME RESPECTS

The crude death rate had hardly shifted between 1938 (the last full year of peace) and the early 1970s. It was stuck at around 11·6 but there had been a dramatic drop in infant deaths from 53 per 1,000 in 1938 to 17 per 1,000 in the early 1970s (although by this time Sweden had got its rate down to 11 per 1,000). Tuberculosis had been largely defeated, producing large numbers of empty hospital beds in the old TB sanatoria. The hospital service was also begin-

ning to get the benefits of the new technologies. Medicine was on the move.

MANAGERIAL CONFIDENCE GROWS

In 1963 the issue of administrative careers was addressed again by the Lycett Green Committee[g] which recommended in its report a national approach to recruitment and training. This resulted in the creation of a National Staff Committee to produce a recruitment, training and development policy for hospital administrative staff.

NHS management had grown in confidence and authority during this period. The Group Secretaries of the Hospital Management Committees and their counterparts, the Governors of the Teaching Hospitals, had usually emerged as *de facto* Chief Executives although their brief stopped short of the clinical services actually being provided for patients. Their concerns were budgetary control, buildings, overall manpower control, community relations and house-keeping services. Clinical freedom and independence was fiercely defended by the professions. The position at the Regional level was rather different where a powerful doctor (SAMO) had equal status with the Secretary to the Board. This position was mirrored at the Ministry of Health with the Permanent Secretary and the Chief Medical Officer. When these two characters operated together they represented a very powerful force indeed. Where the chemistry did not work the tension and rivalry between the two was the source of much folklore in the organisation.

TALK ABOUT ORGANISATIONAL CHANGE

The rapid economic expansion of the 1960s created an air of optimism. From Carnaby Street to Whitehall people thought they could achieve real change for the better and as the 1960s progressed this blossomed into a whole range of proposals for reforming institutions and services, including local government and the civil service. It is not surprising that in this climate the Ministry of Health lighted on organisational reform of the NHS as a means of delivering national standards of effective health care with efficiently used resources. Although the re-organisation pro-

posals, when they finally came to be implemented, had gone through a 12 year gestation period, the seeds were sown not by the Ministry, but by the medical profession and the King's Fund.

Organisational reform had been fore-shadowed as early as 1962 when a committee established by the medical profession and representing its key pressure groups had issued a report ('The Porritt Report'[10]) recommending organisational change. The tri-partite structure of local health authorities, executive councils and hospital management committees and its inherent lack of co-ordination was a major cause of concern. 'The Porritt Report' recommended unification under area health boards. The exception to this (not surprisingly since the proposals came from the medical profession) was the teaching hospitals, who were to retain their governing bodies and their direct access to the Minister.

These proposals lay on the table for some years whilst Ministers got on with implementing Enoch Powell's hospital plan, devising planning systems and introducing structured management arrangements into nursing and trying to introduce them into medicine. Then in 1967 the King's Fund published a report called *The Shape of Hospital Management in 1980*[11] making radical proposals for a clear chain of command with the appointment of a general manager and a medical director and a reduction in the number of committees. The report was not widely welcomed . . . it was too far ahead of its time.

A year later the Minister published the first of what was to be three consultative documents on NHS re-organisation.[12,13,14] It proposed that the tri-partite structural problem should be resolved by combining the responsibilities of regional hospital boards, hospital management committees, local authority personal health services and executive councils under 40–50 area boards. The first official scenario of NHS re-organisation, then, had no regional tier but in the end only Wales and Scotland kept to this pattern.

Meanwhile there had been some relaxation of bureaucracy with Regional Hospital Boards being allowed to approve their HMC's expenditure (instead of referring it to the Minister) and HMCs being allowed to hire and fire their own staff, with the exception of senior medical and dental staff.

The concept of the district general hospital was also expanding. 'The Bonham-Carter Report'[15], in 1969 described a General Hospital that covered all basic specialties, served at least 200,000

people, achieved economies of scale and ensured that no consultant in a particular specialty should have to work alone. The Committee did not think there was "any good case" for retaining small hospitals.

'SANS EVERYTHING' AND THE SCANDALS

It had become increasingly clear during the 1960s that the NHS was not delivering consistent quality—some hospitals in particular were extremely bad. The root causes were poor or fragmented leadership; inadequate staffing levels as a result of low investment; the problems of recruitment to hospitals that were geographically isolated; and the poor condition of many of the hospitals concerned. It was a vicious circle of deprivation.

The appalling conditions in some hospitals began to come out into the public domain when Barbara Robb published her book *Sans Everything* in 1967[16]. The book was a compilation of stories from nurses and social workers about their experiences of working with elderly patients in hospitals where they were routinely robbed of all dignity, often inappropriately treated and sometimes positively cruelly treated. Richard Crossman's diaries reveal his alarm and concern at the low level of care in some long-stay hospitals and the Permanent Secretary of the Ministry of Health wrote to all Regional Hospital Boards asking them to 'satisfy themselves that there are not grounds for complaint in their hospitals'. However, the perpetrators were adept at covering their tracks and many a hospital secretary confidently reported a problem-free hospital when the reverse was true. One has to wonder whether he ever knew what was really happening on his own patch at the level of the patient. If the senior doctors and nurses knew what was going on they felt no compulsion to act. There followed a number of scandals which focused public concern still further.

The oft-quoted example is the scandal at the Ely Hospital in Cardiff, which arose out of allegations of cruelty and theft published in the *News of the World* in August 1967[17]. There were also scandals at Fairleigh,[18] Whittingham,[19] Napsbury and South Ockendon[128] hospitals arising out of allegations of cruelty resulting in patient deaths, and also of maladministration and theft. These

resulted in committees of inquiry whose findings were not just made public by the relevant health authority, but were published through HMSO.

In 1969 Richard Crossman set up the Hospital Advisory Service to visit long-stay hospitals and give advice locally on the management of patient care.

THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY IS CREATED

The Ministry of Health itself was re-organised in late 1968 when it joined with the Ministry of Social Security to form the Department of Health and Social Security, combining the wish for better integration of services with the 'big is beautiful' theory. Richard Crossman became the Secretary of State and health regained its seat in the cabinet after nearly 20 years.

MANAGING NURSING SERVICES: SALMON

By the mid-1960s, nurses were increasingly frustrated by what they perceived as their lack of involvement in NHS management. It was not until 1961 that they secured the right to attend Hospital Management Committee meetings when matters affecting nursing were on the agenda. However, radical ideas were stirring. In 1966 'The Salmon Report'[20] on the senior nursing structure in hospitals was published, and a similar 'Mayston Report'[21] on local authority nursing services followed in 1969. In the latter case, the report heralded the appointment of a Chief Nurse responsible directly to the Local Authority rather than the Medical Officer of Health.

In the hospital world Salmon recommended a new grading structure; an emphasis on managing nursing services rather than support services (the end of the Sister in charge of the nurses home) and a Chief Nursing Officer whose role encompassed teaching, general nursing and midwifery.

'The Salmon Report' recommendations were tested in a series of pilot schemes in the late 1960s and by 1974 Salmon structures were commonplace. Senior nurses liked Salmon, it recognised their importance in the organisation and gave the profession managerial status. Doctors did not like it much for it built a hierarchy

above the Ward Sister/Charge Nurse and so diminished the status of the nurses they regarded as being most important to high quality clinical practice.

From a manager's perspective Salmon was a mixed blessing. It did indeed provide a more robust framework for managing nursing and defending the profession's corner. Sometimes though this self assertion went too far and the profession closed the door on any outside help or interference. Nurse personnel specialists emerged (because apparently only a nurse could understand the employment problems of nurses!) and no meeting on any subject was legitimate and complete without the statutory nurse being present.

Looking back Salmon was a vital part of a profession maturing and gaining managerial self confidence. It is a pity it had to be such a painful process for their colleagues in other disciplines. The Briggs Committee had reviewed nurse training in 1972[31] (with Christine Hancock and Ken Jarrold as research assistants) which eventually led to the creation of a single body for professional standards, education and discipline — the United Kingdom Central Council for Nursing, Midwifery and Health Visiting... UKCC.

DOCTORS IN MANAGEMENT: COGWHEEL

During the late 1960s and early 1970s, attention was at last being paid to the Medical Advisory Machinery within NHS hospitals. Sir George Godber, CMO, had chaired a Working Party that eventually produced 'The Cogwheel Report' (so named because of the Cogwheel motif on the cover).[22] He recommended that doctors organise themselves into clinical divisions. The Chairmen of each of the divisions would form a small Executive Committee which could provide powerful managerial leadership for the clinical community. Most hospitals introduced such a system during the period 1967–1974, although a few stubbornly clung to the old machinery where every doctor could participate at will. Meetings involving 100 or more Consultants at the same time had a life and fascination of their own. They rarely produced worthwhile results . . . but some survived into the 1980s.

SECOND AND THIRD CONSULTATIVE PAPERS ON RE-ORGANISATION

Crossman produced the second of the consultative documents on NHS re-organisation in 1970. It re-introduced the idea of the regional tier but only in an advisory role. The chain of command ran direct from the Minister to about 90 area boards — about double the number proposed earlier. It also proposed district committees below the area tier in larger areas to involve health service workers and the community in running the NHS.

However, the Crossman proposals did not remain long; the Conservatives won the General Election later in the year but continued, at least as far as re-organisation went, to operate very much in the 1960s mode. KeithJoseph became Secretary of State and naturally produced his own consultative document on re-organisation. This finally resulted in a White Paper in 1972[23], which in turn became an Act of Parliament in 1973. The nub of the planned re-organisation was the creation of 90 Area Health Authorities to manage hospital, community and GP services in their areas — unifying the old tri-partite structure. Regional Hospital Boards became Regional Health Authorities and stood in a direct management line between Ministers and AHAs.

1972 and 1973 were years dominated by the preparation for change. One piece of work commissioned by the Nuffield Provincial Hospitals Trust was aptly titled "*Si Vis Pacem*" . . .[41] if you desire peace prepare for war. Joint Liaison Committees had been formed in each of the territories of the proposed Area boards. For the first time it seemed senior officers of HMCs, Executive Councils and Local Government met and talked together. There was obviously quite a lot of vying for power in the new order but for the most part the preparation proceeded with energy and increasing enthusiasm. Integration felt right for the NHS.

4

DIFFICULT YEARS . . . STRIKES, CUTBACKS, ANGER (1974–1979)

FRAMEWORK OF THE ORGANIZATION STRUCTURE

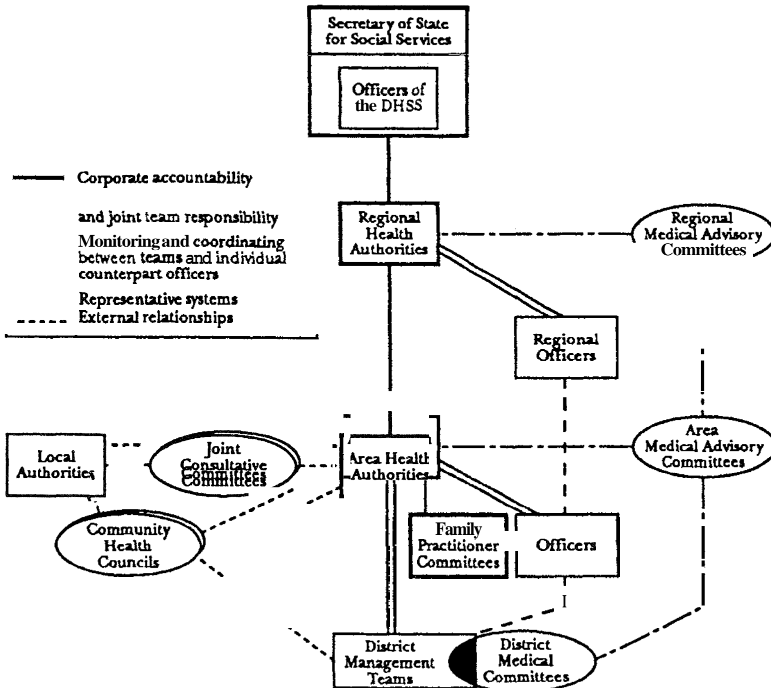

FIGURE 2
(Reference: The Grey Book)

RE-ORGANISATION GETS OFF THE GROUND AND GOES WRONG

1 APRIL 1974 SHOULD HAVE BEEN THE START OF THE MOST successful re-organisation in the history of the NHS. The fulfilment of Bevan's dream, for the first time it had brought

together public health medical services, community health services, family health services and hospital services into a single unified National Health Service. It was a grand design on a grand scale which threw down a new challenge to management, delivering a new vision of health care; which would take the nation forward into the twenty-first century and keep the NHS the envy of the world—a service which met the total health needs of individuals and whole communities. The changes had been thoroughly prepared, staff training had gone well, the professions were on board.

Yet in October 1975, barely 19 months later, the Prime Minister, Harold Wilson was on his feet in the House of Commons, announcing the establishment of a Royal Commission 'to consider in the interests both ofpatients and of those who work in the NHS, the best use and management of the financial and manpower resources of the NHS'.

The 1974 re-organisation was effectively over. The Bevan dream had been tarnished and somehow slipped away. What had gone wrong?

THE OIL CRISIS

Bevan's dream of a single unified National Health Service had taken root during a time of unprecedented international emergency—the Second World War—which had exposed the inadequacies of the country's health care system and its perilous financial state. However, it was a world crisis of a very different nature which was to tarnish his dream—the price of a barrel of oil.

In the mid-1970s, after 30 years of rapid growth and unprecedented prosperity for the major Western economies, the economic bubble burst. The price of oil, on which the West was now heavily dependent, shot through the roof, causing high inflation, severe balance of payments problems and a damaging world recession.

This was bad news for Britain and bad news for the National Health Service. The oil crisis led to cutbacks in public expenditure and for the first time in its history, the NHS faced a no-growth situation. In addition, public sector wage restraint policies were to spark off a series of damaging industrial disputes between NHS workers and central government. As a result, NHS Managers

were to find themselves caught up in a series of industrial confrontations, the like of which the NHS had never seen before.

STRIKES AND CONFRONTATION

The first major national dispute—the ancillary workers strike in 1972—was triggered off by the accidental breaking of traditional pay links with local government (local government workers had agreed terms just prior to the start of a pay freeze). Around 750 hospitals were affected nationwide and it came as an enormous shock to the service. The emotional barriers against strike action in the NHS had been breached. Trade union membership was increasing and there was a hardening of attitudes amongst staff over pay and increasingly pay differentials.

Soon, other groups and professions were to follow the ancillary workers' lead.

In 1973, as NHS managers were caught up in the preparations for re-structuring, there were 18 stoppages or strikes, involving an estimated 59,000 staff with the loss of nearly 298,000 working days—the most in any year of the decade.

Away from the health service, a pay freeze provoked a confrontation between the Heath government and the miners and by the year end, as coal supplies dwindled, a 'State of National Emergency' was declared: power cuts plunged the country into darkness; industry was put on a three day week and the share index collapsed to 156—its lowest for decades. A general election became inevitable, but no party gained a clear majority when the nation went to the polls in February 1974. Within a few short days, however, Edward Heath resigned, bringing Labour back into power.

MRS CASTLE AND DR OWEN TAKE, CHARGE

Barbara Castle took over from Keith Joseph as Secretary of State for Social Services with David Owen as her number two. They decided it was too late to stop or radically change the re-organisation due on 1st April but they displayed little enthusiasm for it. Thus the changes were launched with luke-warm political support. Mrs Castle did, however, secure a few changes in the months that followed. In May 1974 she published *Democracy in the NHS*.[24]

This strengthened the role of the new Community Health Councils and provided for increased local Government representation on the new Area Health Authorities as well as the introduction of staff representatives.

The 1974 re-organisation was more fundamental than simply merging a range of functions into Area Health Authorities. It was also planned to radically re-shape and update the management of the service.

THE GREY BOOK

A large multi-disciplinary steering group had been created and chaired by the then Permanent Secretary, Sir Philip Rogers. The group was supported in its work by the Management Consultants McKinsey and Co Incorporated and the Health Services Organisational Research Unit of Brunel University led by Professor Jaques. Their report, *Management Arrangements for the Re-organised NHS*, which was published in 1972, came to be known as The Grey Book (the colour of its cover).[25] The Secretary to the group was Eric Caines, who was later to become the Director of Personnel for the NHS between 1990 and 1993.

The report presented an astonishingly detailed management prescription. The respective roles of officers and members, the membership of planning teams, the organisation of nursing, speech therapy, works, chiropody, pharmacy and supplies were all dealt with in detail. It covered the allocation of responsibility between the various levels in the new organisation, problems of overlap and included a job description for each of the major managerial and professional heads. The health district was the essential organisational building block and represented the smallest practical patch within which a reasonably comprehensive network of services could be provided to a community.

The Grey Book team had rejected the idea of Chief Executives as being inappropriate to a complex organisation like the NHS. Instead they settled on multi-disciplinary management teams as the way forward. Each Authority had its own top management team and some had as many as six teams. Most Authorities had a top management team at headquarters and one or more operational districts each with its own team. The operational district teams retained an accountability direct to the main Authority.

The Area Team provided support to the Authority itself in shaping its strategic agenda. This was another example of how to blur a straight line and was to prove to be a focus for conflict and tension in the years to come. The team's membership, indeed the whole structure, was imposed on the total system. No variations were permitted. The teams were 'consensus' bodies and decisions needed the agreement of all members. Where agreement was impossible, the issue concerned was referred to the Authority for a decision. There were six team members at District level—Administrator; Treasurer; Nurse; Consultant; General Practitioner and Community Physician.

The Grey Book also consolidated the role of functional managers like works and catering and heads of professions at both district and area levels.

CONSENSUS MANAGEMENT

A key component of the new managerial arrangements and the feature that will always be associated with The Grey Book was the introduction of consensus management... at that time a very fashionable idea amongst organisational gurus.

The NHS had traditionally been managed by a partnership between medical, nursing and administrative staff at hospital level and nobody could really see any reason why this partnership should not be widened and successfully transferred to planning and managing a District Health Service. The concept was simple—services would be managed by small multi-disciplinary teams who worked by consensus. Each team would elect a chairman, whose job was to ensure that no team became ineffective through failure to initiate ideas or lack of drive to carry them through. The administrator (who might also act as chairman) would exercise a co-ordinating role in terms of providing both secretariat support and general administrative co-ordination to ensure that the total programme was co-ordinated in its planning and development.

The case for and against consensus management structures was well documented a few years later by the Royal Commission (who liked it). At its best consensus management drew in to the decision-making process a wide range of skills and perspectives, built a stronger commitment to decisions and created a better chance

of enthusiastic and effective implementation. (A favourite management game in these years was one that first invited individuals and then secondly teams to decide which of an unusual range of commodities . . . guns, matches, water, pen-knives, bandages, etc would be most useful to them as an astronaut stranded on the moon. The team score was invariably better than any individuals.) However, the reality was not to match the dream in some parts of the NHS over the next few years. Internal rivalry, unresolved arguments and confusion, plus a lack of visible leadership quickly became apparent. A few bad apples were to have their inevitable effect.

1ST APRIL 1974—INDUSTRIAL TURMOIL AGAIN

All was quiet within the NHS on 1 April 1974. Many managers were still unsure of their future as the merry-go-round of selection committees continued. However, the service was quickly in industrial turmoil again with the nurses and radiographers taking action over pay differentials. In April, the Confederation of Health Service Employees launched its campaign for better nurses pay, followed by the Royal College of Nursing, whose President demanded an inquiry within three weeks or the College would privately employ all its nurse members and offer them for hire to the NHS. At that time, a hospital ward sister took home about 60p an hour for a 40 hour week excluding all meal breaks. The Confederation of Health Service Employees quickly joined the attack, threatened strike action and implemented a work to rule (condemned by the National Union of Public Employees as 'the irresponsible act of adventurers'). Inter-union rivalry was strong and corrosive.

After demonstrations and marches and much publicity in the national media, the nurses' dispute was averted by the establishment of a Special Committee of Inquiry into nurses' pay (with no trade union representation) in June 1974,[29] chaired by Lord Halsbury, whose recommendations were expected to be generous. Its remit was subsequently extended to cover the Professions Supplementary to Medicine, including radiographers. The Inquiry reported on nursing in September and its proposals were duly accepted. For nurses, this meant an average pay rise of 30 per

cent. The report on the Professions Supplementary to Medicine followed in 1975 and recommended similar large pay rises.[30]

DOCTORS IN DISPUTE

1974/75 was a winter of intense unrest — dustmen, car workers, airline staff, lorry drivers, steelworkers, engineering workers, fire service staff, teachers, bus drivers — were just a few of the groups which took to the streets in pursuit of their wage claims. A second general election was held in October 1974. Labour remained in power but with a working majority of only three. Media coverage of events was also interrupted by industrial action by journalists and TV workers.

Nevertheless, the public was still stunned by stories on 4 November 1974 that, as signalmen brought chaos to commuters in the Southern Railway and Liverpool areas, and as sugar workers blockaded Tate and Lyle's London refinery in Silvertown, 80 Hospital Consultants and doctors had begun an unofficial work to rule in the North-East. They were equally alarmed by reports on 17 December that hospital consultants in Blackburn had unilaterally decided to work to contract and that their 'wildcat' action was quickly spreading to neighbouring towns.

By 1 January 1975 it was official — Hospital Consultants were working to rule. 'We are in a jungle gentlemen and unless we fight like the others we will go down'!

The doctors' grievances over this winter ostensibly took three forms. The first was a straightforward dispute over pay and their declining pay differentials relative to other professions and NHS workers. The Hospital Consultants had been negotiating a new contract since 1972 and they had reached the end of their tether, but all branches of the profession were up in arms over pay. Family doctors were urged by the British Medical Association on 9 January to send in signed but undated resignation forms from the NHS. In the face of this professional pressure Barbara Castle, the Secretary of State for Social Services, was eventually forced to concede pay rises averaging 30 per cent in April 1975.

Secondly, there was a rebellion by the junior doctors who had had enough of their long hours of working and had begun campaigning for a shorter working week. (In 1968, the Royal Commission on Medical Education ('The Todd Report'[26]) had

also recommended an increase in the numbers of British medical students to lessen the NHS dependence on non-UK doctors which the juniors could see in time would reduce their chance of progression to Consultant posts.) Threats of a national work to contract were averted by Barbara Castle's promise of a 40 hour week with set payments for additional overtime from October 1975. Trouble surfaced again later in the year when rivalry between the British Medical Association and the Junior Hospital Doctors' Association was to trigger unwarranted fears that some doctors would be worse off financially under the new system of 'work sensitive' overtime payments. This sparked off spontaneous outbreaks of industrial action, restricting admissions to emergencies only. The action lasted until December 1975 and was generally viewed as a wholly unnecessary dispute. Some senior registrars ended up earning more than the Consultants to whom they were responsible but the underlying cause was more important: the junior doctors felt strongly that management did not value them or recognise their importance to the service. (This issue was to re-emerge time and time again during the next 15 years and it was not until 1991 that a breakthrough was made in the morass of conflicting professional and organisational objectives and rivalry that had prevented a solution emerging for so long.)

PAY BEDS

Finally, there was a highly public confrontation over the government's decision to phase pay beds out of NHS hospitals. This struck at the heart of the consultants' right to private practice, one of their most hard fought and highly prized concessions won from Bevan at the time of the NHS' establishment. Trouble flared up again in late 1975 after the Labour Party passed a resolution at its conference demanding the withdrawal of all private medical facilities from the NHS. The BMA threatened to canvas its members for undated resignations from the NHS and to advise consultants to operate an emergency only service.

The public was now treated to the unseemly spectacle of different groups of NHS workers, openly wrangling between themselves over the implementation of the reduction in pay beds policy as the dispute brought doctors into headlong conflict with ancillary staff workers who were prime movers and supporters of this policy. In

1974 the lads and lasses of the National Union of Public Employees' had 'blacked' the private wing of the new Charing Cross Hospital. In other places, for example Manchester, ancillary workers were openly challenging the admitting rights of Consultants to hospital through vetting private patient admissions. A compromise was eventually negotiated by Lord Goodman which centred upon the establishment of the NHS Health Services Board in 1977 to regulate the process and permit the retention of pay beds in those areas where the demand for private medicine was insufficient to support alternative facilities. However, the dispute was not fully resolved until the new Conservative government came into power in 1979 and reversed the policy (The Health Service Board was abolished under the Health Services Act of 1980). The new Consultants' contract of 1979 would also allow even a whole-time Consultant to earn up to 10 per cent of his NHS earnings from private practice.

A WATERSHED IN NHS HISTORY

The doctors' dispute was a watershed in NHS history. It finally removed any lingering deep rooted ethical objections to industrial action in the NHS. As the Royal Commission was to find in 1979, 'NHS workers at all levels are now prepared to risk the well-being of patients by disrupting or withdrawing services'. When it was over, an estimated additional 100,000 people had been added to waiting lists, not to mention the suffering caused to individual patients by delays in diagnosis and treatment. Interestingly, the doctors' dispute did not appear to seriously damage public confidence in the medical profession.

'The NHS has grown up hand in hand with the growth of the media and its story—probably the longest running soap of all time—is a never-ending source of fascination for the public. Like the other great British institution, the Royal Family, it sells newspapers and also makes good TV. Several episodes of the real life *Bolton Hospital Story* screened in 1977, which made television history as the first 'fly on the wall' documentary, attracted viewing audiences of over 5 million. (As the *Daily Mail* put it 'Birth, death, humour, pathos, even union action—this is the everyday face of the Health Service TV's never dared show before'.) The heroes of

the story are inevitably the doctors and its heroines or 'angels'—the nurses—and its villains invariably heartless bureaucrats and striking ancillary workers. A MORI/*Sunday Times* survey in 1983 found that 82 per cent of the public believed doctors always told the truth, compared to 16 per cent in the case of Ministers.

The industrial action undoubtedly dented public confidence in the NHS and its management, The doctors had successfully projected the image of an organisation on the point of collapse.

The dispute provided a platform for doctors to speak out publicly about their underlying concerns. For the first time the clinical freedoms provided by the NHS, which enabled doctors to practice medicine as they thought fit, were under serious threat due to economic cutbacks. They complained vociferously that shortages of money were placing patient services at risk. The doctors said this was all due to the plagues of administrators now infesting the service—a cancer which needed to be cut from the body. 'The health service has an administrative stranglehold on doctors, who are being suffocated by a paper mushroom of atomic proportions' the President of the Blackburn and District Medical and Dental Society told the *Lancashire Evening Telegraph* in November 1976. The Chairman of the Faculty of Medicine at the General Infirmary at Leeds used Churchill's phrase 'never have so many administrators done so much to make life difficult for so few... the clinicians'. The Administrators were now under attack from all sides... it was a tough and unfriendly climate in which to work. At face value the statistics existed to back up the doctors claims of excessive bureaucracy—at the same time as patient services were coming under financial pressure, the Royal Commission was to report the number of Administrative and Clerical staff had increased by 28 per cent between 1973 and 1977 to a level of nearly 99,000. Barbara Castle was quick to disown the re-organisation when it suited her (one of the advantages to Ministers of a re-organisation which was the product of another party was the ease with which it could be disowned). 'We never designed this bureaucracy' she declared and claimed it had resulted in an additional £4·5 m of extra unnecessary recurrent administrative costs.

NHS key workers—its doctors and nurses appeared to feel dissatisfied and devalued. The Confederation of Health Service Employees' 'forgotten army' was on the march, the service

seemed poor at handling industrial relations, and its managers bad at managing staff.

There was a general feeling abroad that there was something amiss with the NHS and it was against this background, though reluctantly at first, that the government conceded the need for a fundamental review of the service—a Royal Commission.

THE THREE CHAIRMEN'S REPORT

In December 1975, in a separate initiative, David Owen, the Minister of State for Health also asked three Regional Health Authority Chairmen to review the relationship between the Centre and the service.[36] The review was completed in May 1976 and was described by David Ennals as 'open government at its best'. It recommended the slimming down of the Department to relieve it of the 'unessential and enormous volume of the trivial', together with the streamlining of the information flow. Not a lot happened for in 1979, Basil Bush, the President of the Institute of Health Service Administrators, criticised the physical thickness of the 58 circulars and 304 health notices issued in 1977. 'This appalling weight of paper is killing the health service. No wonder the administrators are hard pressed, no wonder there are criticisms of what health service administrators do. They have to spend so much of their time reading. . . we can no longer carry this weight upon our backs.'

By March 1984 the Department, spurred on by the government's clamp down on civil service expenditure and scrutinies into civil service efficiency, was to report it had achieved a 20 per cent reduction in staffing in the past 5 years and a major pruning of the number of Circulars issued.

A DECADE OF INDUSTRIAL UNREST

The Royal Commission*' started its work in 1976. Its deliberations took place against the background of a decade when industrial relations were dominating much of the day-to-day agenda of managers in the NHS.

Disputes which made national or local headlines were just the tip of the iceberg.

'Health service unionism grew out of the new health factories' (i.e. the new District General Hospitals). Because of the structure

of the NHS Workforce, most of the new members were women.

The period 1974–78 saw a rapid growth in trade union membership. The National Union of Public Employees grew from 165,000 to 250,000; the National and Local Government Officers Association from 64,500 to 84,000; the Confederation of Health Service Employees from 143,500 to 212,000 and the Royal College of Nursing from 91,000 to 120,000. The Trades Union Congress estimated that by 1978 membership of affilitated unions alone covered about two thirds of NHS staff. For most unions (but not the National Union of Public Employees) this trend was to continue, helped by the system of deduction of union contributions at source (i.e. direct from pay) known by its initials as DOCAS.

This growth was accompanied by a rapid rise in the number of shop stewards supported by intensive union training programmes. The National Union of Public Employees was the first to develop its steward system in response to the introduction of incentive bonus schemes in the late 1960s/early 1970s. This period also saw the emergence of what Professor Roger Dyson was to describe as the 'super steward', that is the senior steward, branch secretary or convenor. The stewards organised their members, stimulated recruitment and increasingly sought to establish local negotiating positions with management.

The 1970s also generated a wealth of labour legislation—the Trade Union and Labour Relations Act of 1974, the Health and Safety at Work Act of 1974, the Employment Protection Act of 1975 and the Trade Union and Labour Relations (Amendment) Act of 1976 to name but a few.

Allied to this, the Advisory Conciliation and Arbitration Service (ACAS) established in 1974 produced codes of practice on disciplinary and dismissal procedures, disclosure of information and time off for trade union activities.

All of these changes encouraged or required employers to enter into negotiation with staff representatives to ensure local practices and procedures were in line with legislation and good managerial practice.

Managers were also called upon from 1976 to extend participative management approaches throughout the service i.e. involve staff more closely in decision-making as industrial democracy became more fashionable. In 1977 the Department of Trade

published the *Report of the Committee of Inquiry on Industrial Democracy*, chaired by Lord Bullock,[28] which had implications for both the public and the private sector.

The report made recommendations on the way in which industrial democracy could be extended through representation on boards of directors and emphasised that the relationship between capital and labour needed to be put on a new basis, involving not just management but the whole workforce in sharing responsibility for the success and profitability of the enterprise. (Trade Union representation on Area Health Authorities had been introduced in 1976 as a result of Barbara Castle's consultative document *Democracy in the NHS*. This was discontinued In the 1980s.)

Ancillary staff bonus schemes had been introduced into the service, starting with mixed success. They had not been implemented very well nor managed effectively by supervisors and line managers. They were, however, a fruitful area for local shop stewards to test their negotiating skills and use their power. They were the cause of many a future dispute.

Lastly, re-organisation itself had created an environment in which festering grievances gained positive expression which the Trade Unions were not slow to exploit (often with good cause it must be said).

GRIEVANCES SPILL OVER INTO DISPUTES

Staff groups were feeling disgruntled about the direction in which the NHS was heading. There had been tremendous strides in medicine and in new buildings and staff. The service was treating more patients than ever before. But management and staff no longer appeared to be on the same side. Throughout its history, the NHS and its staff have been dogged by 'a sense of doing better and feeling worse'.

In nursing, for example, in 1975/76 for the first time in many years, as a result of economic pressure and a fall in labour turnover there were not enough jobs to go round for newly qualified nurses. What was worse, nobody seemed to care.

The combined impact of reducing the nursing working week to 40 hours, increased annual leave and changed shift patterns was affecting the numbers of staff actually on duty. Progressive

changes in nurse training programmes following the government's acceptance in 1974 of the Briggs Report[31] recommendations of 1972 meant less 'pairs of learner hands' were available on wards. Added to this, there was a much quicker throughput of patients, earlier discharges of less dependent cases, and a growth in the number of elderly patients to be cared for. Increasingly nurses were to become more vocal in their complaints, especially about nurse shortages on wards.

All grievances from the most trivial to the most serious demanded an answer, but NHS management was ill-equipped to respond to this challenge. The centralised pay bargaining system based on the Whitley Councils, created on the establishment of the NHS, did not help. Despite minor modifications following Lord McCarthy's report of 1976 on *Making Whitley Work*[32] it was still not functioning effectively. The cash limit system introduced in 1976 also did not exactly help national pay bargaining as allocations were often announced prior to the settlement of pay claims and led to the under-funding of awards negotiated nationally. Managers were inexperienced in local workplace bargaining, and the personnel function was under resourced and underdeveloped. Compared to many parts of the private sector, NHS managers were also faced with a more daunting task because of the diversity of the NHS professions and occupational groups and the intense rivalry between different unions and professional associations. In parts of British industry where effective trade relations were established, managers were dealing with a handful of unions. When NHS managers sat down to talk they did so with many trade unions and professional groups. The total number recognised for negotiating purposes in the NHS was 40 although in practice not all of these would usually be active in any one District.

The focus of the conduct of relations was also wrong—because of the Management Structure it was centred at District/Area level and was often confused by functional, line and staff management relationships. Workplace bargaining was taking place remote from the workplace and it left local (i.e. unit) management stranded like a whale. Militancy grew in the vacuum of operational leadership and inevitably at times, grievances spilled over into disputes 'like a dirty infectious disease, breaking out here and there where management hygiene has been insufficient to prevent or contain the problem'.

THE UNIONS CHALLENGE LOCAL MANAGEMENT

By and large, the mid-1970s saw a shift away from the national to the local industrial scene. Union tactics also shifted from all-out strikes involving mass walk-outs to selective withdrawal of small key groups of workers. For example, workers in Central Sterile Supply Departments or porters, who could cause major disruption and effectively hold hospitals to ransom. During these periods, emergency cover was normally maintained but decisions on what constituted an emergency were often being made by the trade unions and not by the managers or the doctors. These disputes left a bitter legacy of disharmony in working relations between the professions and the ancillary workers, and a lack of empathy for ancillary worker claims for better pay. It also put immense pressure on management who often made local concessions on pay during disputes simply to try and keep the service running. Often it appeared that unions were in charge of hospitals rather than local management. For managers it was a no win situation—if they were not criticised for being too 'soft', they were chastised for being too hard. As *The Times* put it 'we want less of the definitive thud of legal boots and more of the tactful tiptoe of human understanding'.

Managers had reacted sternly against the first waves of industrial action by ancillary workers in the early 1970s. As doctors and nurses joined in it became difficult to sustain this approach. Many managers and their Authorities did whatever had to be done to preserve services . . . usually conceding to local deals and often speaking out publicly on the side of the staff concerned. It was not until the end of the decade that management attitudes again stiffened (e.g. by stopping pay and sending home staff who were working to rule.)[34]

Ambulance services were a cause of considerable trouble. Prior to 1974 these had been managed by Local Authorities and on April 1st 1974 some Area Health Authorities had found themselves responsible for managing ambulance services with men drawn from up to 15 former authorities—all on different rates of pay. Naturally they wanted pay to be levelled up—not levelled down.

There was a marked concentration of industrial disputes in London and Liverpool. In London these included a dispute at

Bart's Hospital over new rotas and cuts (January 1977), action over cuts in service and porters' duties at Great Ormond Street (April 1977), a dispute over back pay at the London Hospital (June 1977), a sudden stoppage over allegedly inadequate medical treatment for a porter at Westminster Hospital (February 1978) and a dispute about a porter's bicycle in the operating theatres at Dulwich Hospital (February–March 1978). A Mersey Regional Health Authority Enquiry (chaired by Professor Roger Dyson) into the management and deployment of resources and the conduct of industrial relations in Liverpool in 1978 was to find a state of chronic 'guerilla warfare' in existence between managers and staff in the Central and Southern Health Districts.[33]

In London these disputes were partly a reaction against the financial squeeze caused by the policy of reallocating financial resources to deprived parts of the country (Resource Allocation Working Party policy[35]), and in Liverpool partly a reaction to the turbulence accompanying wholesale reshaping of services as a result of a capital development programme.

There were also difficulties at some psychiatric hospitals. At Brookwood Hospital, a large psychiatric hospital in Knaphill, Surrey with over 860 patients and 1000 staff, members of the Confederation of Health Service Employees, inflamed by a proposal to increase crèche charges by 35p to £1.10 per day, set up a Workers' Council in May 1978 and produced a list of 20 long standing grievances, chief amongst which were complaints about the remoteness of the District Management Team.

In 1978 there were more national disputes, involving maintenance supervisors, electricians and telephonists which could only be resolved through the Whitley Councils and the so called 'winter of discontent' of 1978/79 saw many workers, including NHS workers, on strike against the government's 5 per cent pay policy.

The action in the NHS lasted from January to March 1979 and primarily involved ancillary staff and ambulancemen, with more muted protests from nurses and the professions supplementary to medicine. In an attempt to find a way out of this dilemma and with the prospect of a general election looming, the government established the Clegg Commission on Pay Comparability. This looked at comparability across a wide range of workers, including NHS staff. Ambulancemen fared relatively well but ancillary staff,

nurses and the professions supplementary to medicine received less generous treatment, resulting in widespread disappointment with the findings.

By 1979, however, outside commentators were saying the tide was beginning to turn against the unions, though it may not have felt like it to NHS managers. There was now little extra union membership to be had. The unions had failed to influence government allocation policies in favour of a bigger share of resources for the NHS. There had been some gains in pay but they had not been spectacular. Ancillary staff, in particular, were still at the bottom end of the public sector pay league. The avenue of industrial action was beginning to close.

ANOTHER ELECTION

In the wake of the winter of discontent and with unemployment on the rise again, the Labour Government, with Jim Callaghan now at the helm, lost a vote of confidence by a single vote and a General Election ensued. In May 1979 Labour lost and Mrs Thatcher became the first woman Prime Minister of the United Kingdom.

The election of the Conservative government was quickly followed by the passage of the Employment Act of 1980, which restricted picketing to the immediate place of work and limited thenumber of pickets to six. The Department of Health and Social Security began encouraging managers to send staff who took industrial action home or dock their pay. The unions were losing public sympathy and staff attitudes were beginning to change. Managers were getting more street-wise in workplace bargaining but the unions would not go down without fighting, as one would see in the explosion of one further spectacular offensive—the industrial dispute of 1982—but this lay in the future.

5

LOOKING BACKWARDS FOR LESSONS

THE ROYAL COMMISSION REFLECTS ON HEALTH SERVICE MANAGEMENT BETWEEN 1976–1979

SIR ALEC MERRISON, VICE-CHANCELLOR OF THE UNIVERSITY OF Bristol and Chairman of the Royal Commission on the NHS presented his report to the new Conservative government in July 1979. It had been a mammoth undertaking but its outcome was an anti-climax. As the *Hospital and Health Services Review* commented somewhat wryly in its September editorial, 'The Royal Commission cost £918,000. We could have produced as good a report for a third of that sum, though we could not have hoped for a third as much attention or influence.'

This criticism is unjust, as looked at with hindsight 13 years later it is a remarkable document, probably one of the most comprehensive reviews of a Health Service undertaken anywhere in the world.

The Royal Commission had been hard pressed to find patients who wanted to say anything about the NHS, let alone criticise standards of treatment and care. Most were generally satisfied and appreciative of the service, though through seeking out evidence from Community Health Councils, consumer groups and a survey of patient attitudes, concerns were pinpointed about certain aspects of quality such as waiting times for treatment, patient transport, lack of information, General Practice deputising services, attitude of receptionists, closure of pharmacies, especially in rural areas, the lack of emergency dental services and confusion over dental charges—most of which produced little or no response from Health Authorities.

NHS workers were not as shy as the public. Of 2,460 written submissions received, 1,640 were from organisations in, or concerned with, the NHS and 820 were from individuals. Of the 820 individuals, nearly half were workers or ex-workers in the NHS.

Most were doctors and they were full of complaints. 'If patients give too rosy a picture of the state of the NHS, health workers paint one that is too gloomy' concluded the Royal Commission. Once more, one was witnessing what Enoch Powell (who was Minister for Health from 1960 to 1963) described in the 1960s as the 'unique spectacle of an undertaking that is run down by everyone engaged in it.'

Its reception at the time was, however, a sign of the growing impatience and frustration of Health Service managers and professionals at the time taken to produce the report. The pace of change in the modern world was now such that one could not afford the luxury of a wait of three years for a review of this type, even of an enterprise as large and important as the NHS, which by 1977 consumed 5.6 per cent of the gross domestic product and employed 1 in 20 of the total working population.

When it did pronounce, many within the NHS found what it had to say disappointing; it was a masterly account of the problems and challenges facing the service but most health care managers knew what these were already.

The Commission's overall conclusion was 'that the NHS is not suffering from a mortal disease susceptible only to heroic surgery'. The Commission offered no 'blinding revelations' but instead the 'long slogging job' of improving performance. Its conclusions were well balanced and absolutely right. Indeed, with the benefit of hindsight the Commission put its finger on many of the problems that remain unresolved in 1993. In the event, the Commission's Report was politely filed . . . the NHS world had moved on.

THE NEW ADMINISTRATORS

The combination of extended industrial action and a major reorganisation had put tremendous pressure on administrators who bore the brunt of the problem in a climate of unprecedented public criticism about the bureaucracy of the NHS. But it was also a time of tremendous career opportunity, especially for young administrators. Many got promoted years ahead of their own career expectations. In part this was due to a major exodus of experienced administrators who were close to the end of their careers by 1974 and a clear out of those who had not been performing well for years. The new salary structures reflected the

importance of the new posts at area and district levels and they quickly attracted the most talented people.

However, the process of selection for senior posts had been cumbersome and slow. (It had been organised nationally by a Staff Commission) The competition for some posts was still in process well into 1975.

The Chief Officer posts at Regional level were filled after national competition but the posts in the new Areas and Districts were the subject of regional competition. Each eligible officer could apply for up to five jobs in their own discipline. The results of the interviews, where candidates were ranked, were then submitted to a regional appointments unit which acted as a clearing house. There were many surprises and not a few disappointments when the announcements were made. (The consultant and general practitioner were elected by their colleagues). Given the need to demonstrate equity between officers of all the merging Authorities, this process may well have been inevitable. It was a random and unsatisfactory way to build teams that were required to manage by consensus.

Workforce surveys showed that in 1975 30 per cent of senior administrative posts in the NHS were held by people below the age of 35. Forty-one out of 159 District Administrators in post in October 1975 were under 39. More graduates (22 per cent of post holders in senior administrative posts by 1979) were now entering the service so civil servants could no longer liken talking to NHS managers to 'striking sparks off cowpats' (a jibe in the early 1950s). However, nearly 40 per cent of administrators under 35 did not hold any formal managerial qualification. There were also more women though only 9.5 per cent in 1979 held senior administrative posts. By 1981/82, 49.2 per cent of new registrations for Institute of Health Service Administrators examinations were graduates and the ratio of females to males was 10 to 8.2.

The youth and lack of managerial training was a problem vexing the National Staff Committee for Administrative and Clerical staff, which in 1978 produced a consultative document on future recruitment and career development of administrative and clerical staff to the year 2000.[37] The Committee judged (wrongly as it turned out) that the average age of promotion would inevitably increase over the next 20 years as a consequence of the

early promotions in 1974. Already newly qualified administrative trainees were finding it hard to get jobs in some Regions. Amongst other measures the Committee recommended that the intake of the National Administrative Scheme should be reduced from 60 to 45 (the fast stream training scheme for potential top managers). In 1978 at least three Regional, 12 Area and 48 District Administrators had been former National Administrative Trainees . . . the scheme had been extraordinarily successful.

The National Staff Committee made a range of recommendations for improving training and the Institute of Health Service Administrators worked hard during the 1970s to promote the concept that possession of an appropriate professional qualification, such as its own diploma, should be a pre-requisite to holding a senior administrative post.

Posts at hospital level came well down the pecking order in terms of status and pay and as a consequence were usually filled by managers who were young and upwardly mobile as they pursued their career on the typical two year change cycle.

This was to prove a costly and disastrous error. All the doctors saw were the Administrators moving up the organisation (away from them) with vastly enhanced salaries leaving them with the juniors. In the 1990s with Chief Executives of Trusts commanding large salaries on a par with senior colleagues at other levels in the organisation, it is hard to grasp that in May 1979, for example, the post of Sector Administrator of Doncaster Royal Infirmary—a modern 804 bed District General Hospital and now a first wave NHS Trust—was being advertised on Administrative and Clerical Scale 18 (a maximum of £20,800 in 1992/93 salary terms) which was a low to middle grading in NHS organisations at District, Area and Region.

The re-organisation and its appointment process had generated an unusually high rate of personal mobility. Managers at all levels found themselves in unfamiliar places, doing unfamiliar jobs and working alongside new colleagues who were equally unfamiliar with their work. Even people who had ostensibly retained their old jobs, now found themselves operating in an entirely new health care environment. With these changes came a weakening of the formal and informal communication networks. The social cement which had bound the organisation together had to be reset.

DAY-TO-DAY BUSINESS AND THE FINANCIAL CRISIS

Nevertheless, every-day services kept going and indeed expanded, though this was accompanied by an apparent loss of financial control. The production of 1974/75 Final Accounts was seriously delayed, leading the Comptroller and Auditor General to report to the Public Accounts Committee that 'the accounting standards of a considerable number of Authorities had deteriorated unacceptably'.[42] The Public Accounts Committee was also concerned about the lack of control over ancillary staff meal catering subsidies, the wastage of money on computerised information systems, and the escalating costs of building projects such as the new Liverpool Teaching Hospital, which had risen from £14m to £49m, and was predicted to go higher. If this was the private sector, said the Chairman, 'someone' would be facing the sack.

RAWP: FAIR SHARES ALL ROUND

However, major changes were being quietly developed in the financial structure of the NHS. The inequality of investment between English Regions had been a bone of contention for years. A survey in the *Lancet* claimed that expenditure per head of the population on hospital services in the Sheffield Region was only 55 per cent of investment levels in the South West Metropolitan Region in 1971–72. In September 1976 the 'RAWP Report' was published (Resource Allocation Working Party: *Sharing Resources for Health in England*).[35] It recommended a new method of sharing out the cash available to the NHS between Health Authorities. The recommended formula balanced up population size, age and sex structure, as well as morbidity in the communities concerned. There were also to be adjustments for cross boundary flows. A similar report in Scotland was aptly named 'SHARE' (Scottish Health Authorities Revenue Allocations).[132]

When the formula was first applied, it demonstrated a gap in 1977–78 of 25 per cent between Regions. North Western Region was 10.8 per cent away from a target of 100, North West Thames was 14.9 per cent ahead of target. There was a strong north:south imbalance as expected. Within individual Regions there were wide disparities between Health Authorities which all Regions set about trying to correct.

New hospitals had sprung up outside the major cities which began to shift the pattern of revenue investment. Building new hospitals was a major managerial pre-occupation in the 1960s and 1970s. The tension that developed over the next 10 years as the equalisation formula was applied was very powerful. Managing in an Authority facing significant reduction in base allocation became really tough and demanding... particularly if it was in London.

For the most part, the underlying equity of resource re-allocation was accepted, the battles that were to develop were usually about the pace of change.

AREA AND DISTRICT HEALTH AUTHORITIES: A VOYAGE INTO UNCHARTERED WATERS

For those at the 'top' (i.e. Managers at Area and District level described by John Spencer as 'the new breed of management tiger'), the 1974 re-organisation presented the greatest and perhaps the most exciting challenge—a blank sheet on which to create and manage a health service for the whole community. The NHS now embraced the public health function and the focus had to be shifted from providing services for individuals towards the more 'diffuse and difficult goal' of improving health for defined communities.

The blank sheet of paper (which was of course full of day-to-day problems) did result in new thinking. Strategies for developing services for the elderly and the mentally ill began to be debated. Until this time NHS managers had traditionally worked within 'systems'. They were experts at interpreting and bending rules and regulations; they were good in committee but suddenly their managerial horizon extended sharply. *Better Services for the Mentally Ill*[46] published in 1975 gave a clear signal for accelerated change in the Mental Health Services that needed a decisive managerial response. The Department's *Priorities for Health and Personal Social Services* in 1976[38] and *The Way Forward* in 1977[39] were, therefore, eagerly awaited for they talked about service development and priorities. For the first time the Department of Health was trying to establish "rational and systematic priorities". Growth in the acute sector was to be reined back (to 1·2 per cent) and maternity services reduced because of a drop in the birth rate (by 2 per cent). Primary care (3·8 per cent), children's services (2.2 per cent), the

elderly (3.2 per cent) and the physically handicapped (9 per cent) were planned to benefit with increased investment. At Districts, Areas and Regions the focus and tenor of the managerial debate shifted. The doctors and nurses made the debates more 'clinical' and service-focused. The General Practitioner team member usually added breadth and reality to the discussion about service priorities. The service had moved on.

Managers found they needed to develop an entirely new range of skills to move their role from hospital service managers to change agents. First they had to adapt their own personal management style to working within the new framework of consensus management, where the division between personal and team responsibility was often unclear. They had to find ways of influencing activities in primary care—the herculean task of influencing hospital consultants paled into insignificance beside that of influencing General Practitioners, who were independent contractors. They had to develop relationships with Local Authorities" (some of whom were feeling sore about losing some of their functions) and through the joint planning procedures reshape the delivery of care to the priority care groups. This was made easier in 1976 when the DHSS made Joint Finance funds available to be used in collaborative projects with local authority social services. Finally, they had to enter into meaningful debate with the public through the newly created Community Health Councils.[40]

But management teams at all levels found it difficult to concentrate on the strategic dimension of health care and avoid being sucked into the day-to-day operational issues of the tier below. Arguments and posturing between teams began to emerge as they each staked out their territory. The most senior former operational managers were now supposed to be leading the planning and policy development, and the temptation to meddle in what was now somebody else's area of responsibility was enormous. For many the temptation was too great. The managerial hierarchy left the operational posts at the bottom of the pyramid.

This was to foreshadow one of the fundamental management recruitment and development challenges for the future in terms of the purchaser and provider split. Does service management equate with managing (or now purchasing or commissioning) the provision of health care for a whole community? Are the same or different skills required? Is one job superior to the other or are

they on different career paths? If so, since most staff are in provider units, where will future generations of purchasers come from? To what extent is knowledge and experience of the health care system relevant to the management of purchasing and providing? These were questions for the future.

PERFECTION PROVES TO BE IMPERFECTION

1974 had represented what was for some the perfect structural solution to managing the NHS. It was rational, logical, looked great on paper and created an organisation of absolute geographical symmetry—the pyramids of Egypt were nothing compared to this feat of building and engineering! It has been variously described as the zenith of the scientific management approach or a monument to the false God of administrative tidiness.

In practice, it was not as tidy as critics sometimes imply—it was always somewhat ragged about the edges as there was a choice of models to apply—hence one found single District as well as multi-District Areas and a variety of organisational arrangements below District level.

The Royal Commission found, however, that in seeking to promote innovation and the rapid implementation of improved approaches to care, the 1974 Re-organisation had produced an over-elaborate system of administration; with too many tiers; long lines of communication; too much uncertainty about who was responsible for what; excessive consultation; and too slow decisions taken too far removed from the point of service delivery.

The Commission was also critical of the failure of the NHS to effect service changes in line with national policies, and perceived shortcomings in the quality of primary health and hospital care. It had harsh things to say about management practices. The NHS was wasteful in its use of manpower, characterised by restrictive staffing practices and inflexible working patterns. There was a need for incentives for change and clearer agreement between professions on their roles. Improvements were required in the handling of pay bargaining and the conduct of industrial relations. There was also evidence of slack financial management with no incentives to examine obsolete patterns of spending or develop a coherent plan for the future.

In spite of these and other criticisms, the Royal Commission felt

that generally the NHS was providing a good service. They did, however, have something important to say about the NHS and its place in the public sector. They chose to quote the words of Sir Richard Clarke who, when Second Secretary to the Treasury, had spoken in 1964 about the management of public expenditure in the following terms: —

'In the dispersed services such as education and hospitals . . . units of administration are small, and their performance must be uneven. It is difficult to form judgement about how efficient those relatively small independent units are, and how much scope there may be for saving, and by what management techniques and services this potential saving can be realised — without of course endangering the quality of local responsibility and flexibility to local circumstances which is fundamental to those services.'

The Commission concluded 'Altogether there is clearly no room for complacency. But it would seem difficult to argue that there is widespread inadequacy; or to point to substantial improvements which could be made readily. To improve performance is a long slogging job.'

One message was clear however. Structure was getting in the way of management; it was making management even more of a long slogging job.

HOSPITAL MANAGEMENT

Nowhere was this most felt more keenly than at hospital level. This was somewhat ironic as the The Grey Book's watchword was maximum delegation downwards and matching accountability upwards. Yet, if you read the The Grey Book it becomes less surprising as very little is actually said about management arrangements at hospital and community services level. There are passing references to the concept of grouping hospitals and health centres and clinics in 'sectors' (i.e. an intermediate tier below District level—but not all Health Authorities combined hospital and community services or implemented 'sectors') and to the need for co-ordination below District level. 'Someone must also see that the plans for different support services are mutually consistent and that they are co-ordinated on a day-to-day basis' but it was not clear who this someone was.

With the benefit of hindsight, it is possible to identify a number of reasons why this should have happened.

THE CHANGING FACE OF HOSPITALS

It was only in the mid 1970s that worries began to emerge for the first time about services in the acute sector. Up to that time there had been a belief that professionalism guaranteed good quality care and service. The large acute hospitals were not closed communities like the long-stay institutions, but in building the large District General Hospitals the health authorities had unwittingly created 'warehouses' in which professionals found it increasingly difficult to give one-to-one care because of sheer weight of numbers. Patients were beginning to roll off ward and outpatient conveyer belts like products on a factory production line. This perhaps remains the greatest challenge—how to deliver a traditional 'hand-crafted' service within the environment of a shopping mall.

It was also not until the mid 1970s that people began to realise that big was not necessarily beautiful and brought with it problems of impersonal service and social alienation for both patients and staff. Just as society began to have second thoughts about living in tall tower blocks of flats so, too, doubts began to creep in about the wisdom of building very large hospitals . . . particularly in tower blocks. Many patients and staff alike found what Crossman described as the 'great marble palaces' alienating.

CAPITAL INVESTMENT

The aim of the 1962 Hospital Plan had been to create a network of 250 District General Hospitals of between 600–800 beds. 'The Bonham-Carter Report' of 1969[15] had taken this concept further by suggesting 1,200—1,800-bedded District General Hospitals for populations between 200,000 and 300,000. This policy of creating a critical mass of clinical expertise in the hospital service strongly influenced hospital building plans for the next 25 years. Many small hospitals began to close, usually with a public row, on the grounds that they were uneconomic and unsafe.

The cash required to run the new hospitals was held at national and regional levels (RCCS: revenue consequences of capital

schemes). Many a local manager secured his hospital's future by negotiating a favourable RCCS allocation once the capital scheme concerned was nearing completion. Eventually RCCS formulae were developed as a means of limiting at least the over-inflation of costs at a local level.

There was a review of capital expenditure in the NHS in 1979–80. The review showed that only 15 per cent of acute hospital beds were in Units within the DGH target range of 600–800 beds; that only 18 per cent of the larger General Hospitals were actually providing the range of services specified in the Hospital Plan and that 33 per cent of larger hospitals still dated back to beyond the end of the First World War. The idea of developing community hospitals to support the network of DGHs which had been advanced in 1974 also appeared to have failed to take root in the service.

As a result of the review the government published a consultative document on the future pattern of hospital provision in 1980. It introduced a more flexible approach to health service building and effectively put a brake on a whole-scale move to very large hospitals.

MANAGING PEOPLE

The challenges of human resource management were by themselves enormous. In 1980 there were nearly 1m staff working in the NHS. The majority of these worked in hospitals. Here the range of occupations and professions to be found was probably the most complex of any organisation in the world. Hospitals had grown too large and impersonal for staff to identify with in the same way as in the past and new strategies and approaches were needed to build up group loyalties, effective communications and good industrial relations. The specialist personnel function was still in its infancy and its most senior and experienced practitioners located at the higher tiers in the organisation away from the action.

Management theories tended to assume that large units of organisation automatically meant economies of scale. In reality it proved to be quite the reverse—they consume more resources and thus require a more pro-active management approach. Managers were to find that practising twentieth century medicine in

twentieth century hospitals was to prove more expensive than practising it in nineteenth century hospitals. There was a growing recognition of the problems of engaging clinicians in any meaningful management dialogue even though they had the major influence on the use of resources (the average Consultant committed an estimated £250,000 of resources per year in 1977).

Beliefs also still lingered on that professionals could be left to co-ordinate their own activities and there was an implicit, if somewhat naive, assumption that the day-to-day management of hospitals would be largely undisturbed by the 1974 Re-organisation.

Indeed, Griffiths was to comment in 1983 that it was surprising given the welter of reports on almost every aspect of the NHS over the past 30 years that since the 'Bradbeer Report' of 1954 no-one had given hospital management a second thought for so long.

Despite protestations to the contrary, the architects of the 1974 re-organisation had designed their structure from the 'top down' rather than the 'bottom up' and this was perhaps the fatal flaw in their thinking. There was no longer a natural focus of senior management at hospital level. The management presence was slimmed down to the 'bare bones' and a large top heavy infrastructure created on top.

LIFE AT THE SHARP END: MANAGERIAL FRUSTRATION

As a result, the hospital administrator presence on site had been whittled down to the proverbial 'one man and his dog'. The core of the job was that of co-ordinator, which meant fixing, chasing, problem solving. Housekeeping services were also an important responsibility but here the administrators had to cope with a myriad of functional heads (catering, domestic, laundry) based at the tier above because they managed services across a number of hospitals.

Administrators were finding it increasingly hard 'to get things done'. Decisions which could previously have been taken on the spot now had to be referred 'upstairs'. Making progress was like playing a game of organisational 'snakes and ladders'. Just when you thought you had scaled the ladder and secured approval for action, it turned out you needed to convince at least another ten

individuals, bodies or groups and you slithered back down the snake with a bump. Strong Personnel Departments at District level developed District-wide personnel and employment policies in pursuit of equity. The hospital manager's role was simply implementation.

Even relatively routine everyday matters such as getting extra linen or altering patient menus, often proved to be herculean tasks. The hospital administrator was no longer 'master' in his own house of catering, domestics, laundry, works, supplies and other support services. The powerful 'functional' managers for these services at higher tiers often had the final say and their support had to be assiduously courted if changes were to be made. At times these services seemed to be organised for their own convenience rather than the front line staff and patients they served. This muddle was largely of the administrative profession's own making and the best District Administrators began to recognise the problem and thin out their District structures, but not quickly enough.

It was little wonder that nurse managers became frustrated at the apparent helplessness of hospital administrators to get even simple jobs done, such as mending a broken window. It often seemed harder to get a light bulb changed than to secure approval for a multi-million pound building project.

In turn administrators felt frustrated by the nursing hierarchies—the so-called 'Salmon Nurses'. Most hospitals no longer had a Matron or Chief Nurse. In large, or even smaller size hospitals, with general and acute, maternity and psychiatry services and a School of Nursing, there could be four (or even more) Senior Nurses to whom the administrator had to relate. If nursing issues arose, these too often had to be referred upwards to District level.

As nurses sought to assert their own professional identity, rigid demarcation lines began to be drawn between nursing and non-nursing duties. This often placed ward sisters under pressure to withdraw from their pivotal role as ward managers on the grounds that this involved them in non-nursing duties, and as a consequence administrators found themselves getting sucked into problems which would be more appropriately and more effectively resolved at ward level.

Hospital Consultants were equally unenthusiastic about the

new arrangements. Most were appointed in their thirties and expected to spend the rest of their working life in the same location. Whilst their administrative and nursing colleagues had to go through a long, drawn out selection process to secure a post in the new order, the consultant was secure, if static.

In the clinical arena, the authority of the hospital Consultant was being challenged by the other health professions. Role relationships were being re-shaped. Hospital Consultants could no longer dictate what happened in wards and departments. No longer would nurses carry out their orders in a 'suitably humble and deferential way'. The consultant was expected increasingly to work as the leader of a team whose members retained their own professional identity and independence. Many older doctors found difficulty in adapting to this new role in the same way as some found it hard to accept the legitimacy of junior doctors' claims for improvements in their working hours and conditions. Ward sisters were no longer 'theirs' to command; at every twist and turn they seemingly encountered legions of 'Salmon' women, ready to thwart their every move, and if they negotiated these hurdles there was always District and Area Nursing Officers waiting to pounce.

Hospital Consultants had traditionally enjoyed a one-to-one relationship with administrators. As Philip Strong and Jane Robinson were told by one contributor to their book *The NHS under New Management* published in 1990,[57] 'One hospital administrator said to me the other day he was answerable to 96 doctors who were answerable only to God—and four of them didn't even accept that!'

They looked on administrators as the 'fixers'—people who were paid to personally sort out their problems for them. Many of the old House Governors were an invaluable source of advice to consultants about all sorts of things . . . private practice, children's education, as well as relationships with difficult colleagues. Most Consultants, or so it seemed to the younger administrators, liked nothing better than to burst through the door with tales of impending doom or crisis and demands for instantaneous action. But now when they burst through the hospital administrator's door instead of finding worthy sparring partners, wily old hospital secretaries who were past masters at dealing with the most awkward of Consultants or problems, they came face to face with fresh

faced youths (or even young women) sitting in oversized chairs who looked and talked more like medical students. Bright, enthusiastic, keen and hardworking, but try as they might, they could not get things done. It was even worse when it came to money as resources were in short supply and power very firmly centralised at the higher tiers of the organisation. It was therefore little wonder that Consultants found ways of bypassing local administrators and started to knock on doors at District or Area level but it was difficult to know on whose door to knock. As the Consultants pressed their claims at higher levels they weakened even further the fragile influence and authority of the Hospital Administrator.

It was true that in theory there were plenty of channels open to them. There were medical representatives on management teams but many hospital doctors made sure they kept relationships with these colleagues at 'arms length'. Most studies point to the weakness of the medical representatives on teams as they were unable to speak authoritatively for colleagues or commit them to action. There was also the professional advisory machinery but most consultants were still not properly organised along 'Cogwheel' lines and the decision-making structure was extremely laborious and time-consuming. The Second Cogwheel Report[43] of 1972 had shown that just over half of the hospital groups in England and Wales had no 'Cogwheel' system at all. The Royal Commission commented unfavourably on the extravagant use of professional time on the consultative process. A survey carried out for the Doctors and Dentists' Review Body found 95 per cent of Consultants were members of one or more Committees; one in six served on five or more.[44] There were also other avenues to explore such as planning teams of various shapes and sizes, or nobbling the Area Medical Officer but many Consultants lacked confidence in public health physicians as advocates of their cause—in the words of a famous training event of the time—were these 'Monitors—Friend or Foe?' Certainly Hospital Consultants could not accept they had any 'managerial' relationship to them. As Enthoven was to comment in 1985 'For better or for worse prestige in medicine goes with the possession of skills to apply advanced technology'.

The administrators and the nurses were equally fed up with the doctors. By now there were just too many of them to relate to

individually, and it was becoming increasingly difficult to organise efficient modern hospital services around their idiosyncratic demands.

Things were not right. . . they had to change.

6

WAITING FOR PATIENTS FIRST

WAITING FOR CHANGE

THE 1970s WERE ALMOST OVER; THEY HAD BEEN A DECADE THAT HAD been dominated by structure and industrial relations.

In many ways the service had gone 'unmanaged' during this period in the sense that NHS Managers were not grappling with the health care issues which had led to the re-organisation or the new challenges of the future. As Klein and Lewis put it in 1977 'If anyone were to ask whether the NHS was providing a better service in 1976 than in 1966, there would be a stunned silence'.[146] The NHS never really had the chance to deeply root the 1974 re-organisation. A change of Government a month before vesting day and the later decision to establish the Royal Commission weakened the commitment to making the management structure work. After all the hard work of putting re-organisation in place, disillusionment had rapidly set in. More importantly, management was now in retreat — administrator bashing was the order of the day—and would remain so until the 'Griffiths Report' of 1983.

The criticism was unfair. What NHS managers do continues to defy stereotyping despite the best efforts of researchers to capture the role on paper. But one thing is certain. He or she was never a 'bureaucrat'. All studies throughout the NHS's life have shown that administrators never conformed or behaved according to expected 'bureaucratic' patterns of behaviour. This is not particularly strange as the NHS is not a typical bureaucracy. Chair, shaper, planter, monitor, evaluator, company worker, resource investigator, completer, proactive, reactive, administrator, co-ordinator, innovator, general manager—there was no archetypical administrator. Here indeed was a 'man for all seasons', who varied his/her style to suit circumstance and environment.

If doctors had been hoping that the Royal Commission would demand greater resources for the NHS they were to be disappointed, for neither a Labour nor a Conservative government could put more resources on the table in the chill economic climate of the 1970s. (Tames Callaghan had been forced to call in the International Monetary Fund, which signalled the beginning of an even fiercer battle against inflation, characterised by further cut-backs in public expenditure and fast rising unemployment.)

For both political parties there was, however, an eminently sensible political solution to the problems of the NHS. The doctors had complained that there were too many administrators and too little money so the answer was simple, cut back on administrators and plough the money back into patient care.

This policy had already been put in train by the Labour government through the introduction of a ceiling on management costs in 1976 by David Ennals, who had succeeded Barbara Castle as Secretary of State for Social Services in April of that year. All Health Authorities were required to reduce their management costs to contribute towards the achievement of a national target of reducing expenditure from 6 per cent to 5.25 per cent of total costs by March 1980. ByJune 1978, 2,750 posts had already been saved and this policy was to be pursued even more vigorously by the new Conservative government.

Even politicians, however, realised it was not the total answer 'Bashing administrators is a Saloon Bar solution. It doesn't begin to get to grips with the whole complex of human problems we face in trying to meet infinite demands out of an all too finite budget.'

The Royal Commission had indicated that one tier of management had to go but this was increasingly clear before the report was presented. In Liverpool, Bristol, Sheffield and Gloucestershire, the Area Health Authorities had already asked themselves whether they ought to reduce the number of operational districts and proposals for rationalisation had subsequently been approved by the Secretary of State, who had stated in 1977 that he wanted Authorities to look flexibly at structure.

Whilst the Royal Commission had little influence on events, it did contain one or two radical and interesting suggestions about structure. An intriguing proposal that formal responsibility, including Parliamentary accountability for the delivery of health care services, should be transferred from the Secretary of State to

Regional Health Authorities was immediately ruled out of court as a political non-starter. It was also suggested that Family Practitioner Committees should be merged with Health Authorities and a study should be undertaken into the desirability and feasibility of common budgets for family practitioner services and hospital and community services expenditure. Both of these came to nought at the time but were to re-emerge a decade later.

However, PatrickJenkin, the new Secretary of State for Health who had worked hard in opposition with many of the leading figures in the NHS, had already made up his mind about what needed to be done.

In future it would be *Patients First!*

PATIENTS FIRST: THE PROPOSALS

The government's response to the Commission's findings came within seven months with the publication of the consultative paper *Patients First* on 12 December 1979.[45] All in all, 1974 had been an enterprise which was 'too ambitious, was in some ways ill-conceived and created a number of undesirable effects'. The main proposals for change were:

- strengthening management arrangements at local level with greater delegation of responsibility to those in the hospital and the community services
- simplification of the structure in England by the removal of the area tier and the establishment of District Health Authorities
- simplification of the professional advisory machinery
- simplification of the planning system

Of these proposals, the strengthening of management arrangements at local level was viewed as the single most important change and the paper made a number of detailed proposals:

- for each major hospital or group of hospitals and associated community services, there should be an administrator and a nurse of appropriate seniority to discharge an individual responsibility in conjunction with medical staff

- there should not be an intermediate managerial tier (e.g. sectors) between hospital and community services level and district headquarters
- the administrator and nurse should wherever possible be directly responsible to the District Administrator and District Nursing Officer respectively
- whenever possible staff working within hospitals in non-clinical support functions (e.g. laundries, domestic services, catering services) should be accountable to the hospital administrator rather than to district level managers
- in general there should be no line management hierarchy above hospital level.

Patients First also contained one or two more controversial proposals. It questioned the need to retain Community Health Councils, 'tigers without teeth', and also suggested District Health Authorities should hold Consultant Contracts in preference to Regional Health Authorities.

CONSENSUS MANAGEMENT

One key element of the 1974 re-organisation emerged unscathed. This was consensus management which had been hailed as one of the success stories of the new management arrangements but was not without its critics.

Decision making was sometimes slow due to the need to reach compromises. These compromises often resulted in poor decisions (i.e. the lowest common denominator prevailed). Personality clashes were very disruptive and teams were often dominated by strong personalities. There was also a tendency for problems to be brought before the team which should have been dealt with by individual managers and for issues which created tension to be shelved. Risk taking was usually severely inhibited.

The Statutory Authorities became increasingly frustrated with single option policy papers that themselves represented a compromise amongst officers. By and large the attitude of the medical and nursing professions and the Treasurers to consensus management was conditioned by their fear of a loss of influence in any other organisational setting.

A study by Schulz and Harrison of Area Management Teams in 1981 confirmed there was strong support for consensus management. Nurses and Treasurers were especially strong supporters as they felt it had elevated and broadened their input into management. . . as it had. Many team members, however, said that ideally they would prefer a Chief Executive Officer if they could be that person but they were not all confident that an 'effective' person could be appointed irrespective of discipline because of the nature of the NHS, hence their preference for consensus management.

Where problems did exist they were usually ascribed to people rather than structure. A Committee of Enquiry set up by the North Western Regional Health Authority at the request of the Community Health Council had been critical in 1976 of the closed system of management at Rochdale, which had resulted in an insufficient flow of information upwards to enable the Area Health Authority to monitor the team's work. The Committee found that these problems were due far more to shortcomings of human beings than to any deficiencies identified in formal management structures. Likewise, problems at Solihull, the third smallest Area Health Authority in the country, were put down in 1977 to personality clashes. Though all the key players were hard working and able in their own right as individuals, they simply could not get on together as a team.

Patients First re-affirmed the commitment to consensus management and indeed extended it to unit level but the tide was beginning to turn against the concept. Nowhere was the problem brought home more sharply than through Normansfield.

GRASPING THE NETTLE

Normansfield was the Inquiry which really worried NHS managers. Normansfield brought together a number of themes of the 1970s. It was precipitated by a strike 'unprecedented in the history of the NHS'—an unofficial withdrawal of labour by nurses at the Normansfield Hospital, Teddington, Middlesex on 5 May 1976 in protest at the failure of management to respond to their grievances against the Consultant Psychiatrist in charge. The strike was to place at risk 202 mentally handicapped patients of varying ages, many of whom were suffering from multiple handi-

caps, some to the point of helplessness. It was about a long-stay hospital and involved the type of scandal the NHS had hoped it had put well behind it in the 1960s. Though no actual cruelty to patients was involved, it was clear that the quality of care lagged behind modern standards. It was an enquiry which made many Authorities look long and hard at their own institutions (whither for the grace of God go I?) as it clearly signalled that much still needed to be done to improve the quality of management of the 'cinderella services' but more than this it made managers sit up and think about the nature of management in the NHS.

A Committee of Inquiry into Normansfield was subsequently established under the chairmanship of Mr M. Sherard, QC, at a cost of £350,000, and when its report was published in November 1978, it caused a sensation.[47] Her Majesty's Stationery Office was on strike and duplicated versions had to be issued. Copies were like 'gold dust'. A conference 'After Normansfield' organised by the Institute of Health Service Administrators in July 1979 was heavily over-subscribed, causing the Institute to take the unusual step of selling special versions of the transcripts.

Normansfield was a hard hitting report—all 464 pages—and the Committee was out for sacrificial blood—it demanded dismissals.

The Committee found that hostility between a Consultant Psychiatrist and virtually all the other nursing, paramedical and ancillary services was the principal factor giving rise to trouble at the hospital. The main cause of the shortcomings in patient care and development was not lack of finance but a failure of duty on the part of the Area Health Authority and in particular the Area Management Team. The Area Management Team was well aware that the situation was deteriorating but lacked either the will or the skill to do anything about it.

During the past six years at least, the quality of life of patients at Normansfield had been impaired by a failure of the senior medical, nursing and administrative officers at the hospital to co-operate with each other in the delivery of care. The standard of nursing care was generally extremely low but the Area Nursing Officer had failed to respond to the urgent need for improvement.

The Regional Health Authority had failed adequately to monitor the work of the Area Health Authority and did not ensure that its policy in relation to the delivery of care to the mentally handi-

capped was carried out. It adopted a 'wait and see' attitude, regardless of the knowledge that the price was being paid by patients.

In short, the Inquiry concluded 'the essential message we have to convey is that many things became worse at Normansfield because they were ignored. The basic error in most instances was that there was a failure to act soon enough. The metaphorical 'nettle' grew to frightening proportions and became almost impossible to 'grasp'.'

In the end, the blood letting was somewhat restrained, largely because it was unclear where the buck should stop but the report raised a number of key managerial issues. Where did the boundaries lie between professional and managerial responsibilities? Where did the dividing line lie between team and individual responsibilities? Who was responsible for managing consultant performance? What was the relationship between managerial tiers in the structure? When should monitoring trigger managerial intervention?

Normansfield was swept into the background by the publication of the 'Royal Commission report' and ***Patients First*** but one question still demanded an answer. Whose job was it to grasp the nettle in the first place? In the absence of anyone else, the administrator often stepped into the breach and it was the administrator by virtue of his co-ordinating role who was often singled out for special blame in reports of the Health Service Ombudsman and formal enquiries for organisational and service failures.

The writing was on the wall. Managerial leadership was weak and something had to be done!

7

IMPLEMENTING THE 1982 RE-ORGANISATION: THE ROAD TO GRIFFITHS

A TURBULENT NEW YEAR

'MAY WE WISH OUR READERS HAPPINESS AND PROSPERITY IN THIS turbulent New Year!' the Journal of the *Institute of Health Service Administrators* welcomed managers to 1982.

Patients First attracted over 3,500 comments in the period of just over four months allowed for consultation. By August 1980, the Circular on re-structuring had been issued (HC(80)8). Flexibility on pace of implementation was to be allowed but all new District Health Authorities were to be in place by 1 April 1982. The circular contained few surprises—a reprieve for Community Health Councils and an agreement to have further talks with the medical profession on proposals to transfer responsibility for holding consultant contracts from Regional to District level. In the end, the Consultants successfully resisted these plans. As one observer remarked 'The British Medical Association's Central Committee for Hospital Medical Services would be prepared to die in a ditch to keep contracts at Regional level'. The fact that in teaching Districts the contracts were already at District level was blithely ignored.

MORE THAN A FOOTNOTE IN HISTORY

At the time, Haywood and Alaszewski were to comment in *Crisis in the Health Service*[4] that the only historical point of significance of the 1982 re-structuring might well be the 'intensity of interest of so many highly placed people in an exercise that proved to be so peripheral to the main problems of the NHS', but 1982 was more than a footnote in NHS history because it introduced a number of important principles.

- The concept of strong management at provider level—to be taken further again with the advent of NHS Trust status.

  A movement away from homogeneity in management arrangements. Health Authorities and hospitals would increasingly have freedom to determine the shape of their own structures. No longer would health service managers be arranged in never ending, but standard, rows of terracotta soldiers. Flexibility was seen as the key to success.

- The devolution of responsibility for determining the pace of change and reconciling conflicts inherent in health care decision-making to health authorities. There would no longer be any national master plan. This was to be re-affirmed by the publication of *Care in Action* in 1981,[49] often nicknamed for this reason 'Care Inaction' within the NHS.

- A break in the linkage between Health Authorities and Local Authorities. Coterminosity was to take second place to health service catchments. Local Authority representatives on Health Authorities were reduced. For the next few years the two Authorities would increasingly go their separate ways.

- The concept of a mixed economy of health care with the NHS co-existing alongside a thriving private health care sector.

- The philosophy of 'plurality of organisations providing health care'.

- Essentially the NHS was no longer seen as a giant, single, integrated system but a whole series of local health services, serving local communities, and managed by local people. This concept was to be taken further with the introduction of the health care market, the separation of purchaser and provider roles and the introduction of General Practice Fundholding in 1991. It represents the basic organisational philosophy in which the NHS is developing towards the twenty-first century. Pluralism rather than monolith.

NO MORE RE-STRUCTURING IN OUR LIFETIME!

Everyone was agreed that the last thing the NHS wanted was an

upheaval like 1974 but if the 1974 Re-organisation was traumatic, the 1982 re-structuring turned out to be bloody. It was the NHS equivalent of the 'night of the long knives'.

Firstly, the map of England had to be re-drawn into new single District Health Authorities. In many places the old operational districts were simply converted into independent District Health Authorities. In some Regions, however, there was a determination to get away from divided cities with multiple management teams. Cities like Sheffield and Nottingham had single Authorities. In some cases whole counties like Leicestershire got its own single District Health Authority, although only after a major battle between the Region concerned and the DHSS. Other cities like Leeds, Manchester and Birmingham ended up with more than one District Health Authority which caused much tension and frustration in the coming years. Having redrawn the map, the whole process of developing and staffing management structures had to begin all over again. 'Managerial' staff in all the key professions and administrative and clerical staff of all ranks were again put through the turmoil of applying for their own jobs but this time there was a difference. Everyone knew that there were not enough jobs to go round. Many were disappearing. Even staff in previous single District Area Health Authorities which one might have expected would have been relatively undisturbed by this process were thrown back into the melting pot in the interests of fair play. Junior staff waited patiently as grade after grade was reviewed in the hope that they would be 'slotted in'.

Some groups came out of the re-structuring comparatively badly, especially the functional managers, nurse managers at District level, and some of the professional service heads who lost District level accountabilities. It would be wrong to think that all these changes were motivated by higher principles, (i.e. the greater good of the service). The opportunity was taken in some parts of the NHS to settle a lot of old scores and clear out people judged to be incompetent or difficult.

Nearly all contemporary accounts express disquiet at the human and financial costs of the 1982 re-structuring.

The Department of Health and Social Security had predicted around 435 early retirements at a cost of £8·6m. When the dust had settled there were 2,830 at a cost to the tax payer of £54m. The Public Accounts Committee was not amused by the error in

the calculations but Normal Fowler, by then Secretary of State for Social Services, having succeeded Patrick Jenkin in September 1981, stoutly defended the government's record. 'The 1982 re-organisation removed a whole, unnecessary tier of administration and has led to management costs being £64m a year lower than they would otherwise have been — more than twice the saving we predicted'.

Now it was over, 'Chief Officers should form a union and have no more re-structuring in their lifetime!' joked Brendan Devlin, Consultant Surgeon at North Tees Hospital.

MINISTERS BEGIN TO LOSE PATIENCE

'It is high time that managers in the NHS, and perhaps more importantly politicians of all parties, stopped playing organisational Lego with public services as soon as they come into office' I said in July 1982, in my role as President of the Institute of Health Service Administrators. My remarks were targeted at Kenneth Clarke, the Minister of Health who sat at my side on the conference platform, but were to prove to be wishful thinking. Clarke had succeeded Dr Gerard Vaughan as Minister of Health in March 1982.

Because of the need to manage the pace of contraction, the re-structuring process took longer than anticipated. Health Authorities were still advertising unit jobs in the summer of 1983 but events were already overtaking them. A number of commentators were already beginning to say that there appeared to be powerful feeling abroad in Whitehall that District Health Authorities were moving too slowly and handling the devolution of powers to units badly.

A King's Fund Survey of units and the grading of unit managers after the 1982 re-organisation found that only 4 of the 36 responding Health Authorities had created units where just one administrator and director of nursing service managed the same service. A significant number of Unit Administrators still related to three Directors of Nursing Services or more. A large scale study by the Health Services Management Centre of the University of Birmingham in 1984 demonstrated that it was common for works and paramedical services still to be managed on a District-wide

basis. 25 per cent of Unit Administrators felt there had been no change in their level of responsibility since 1 April 1982.

Though there had been considerable enthusiasm and support for team management (not surprisingly as team building skills formed the bedrock of management training in the 1970s), the membership of Unit Management Teams varied considerably; 45 per cent had the expected three members, 49 per cent four/five members and 6 per cent more than five.

The King's Fund survey highlighted significant variations in the gradings of administrators and nurses who were ostensibly equals. Nursing directors were often paid considerably more than their administrative opposite numbers, especially in the community. Unit Administrators working in the priority and community services were also paid considerably less than colleagues in the acute services. 77 per cent of Administrators in acute units were on the top salary bands, whereas 69 per cent of priority Service Administrators and 91 per cent of community Unit Administrators were on the lower managerial grades. The priority care and community services were still the backwater of management, despite the national priority attached to the development of these services.

Responses to the Birmingham survey showed that around 50 per cent of unit administrators were still excluded from meetings of hospital consultants. Even after general management, District General Managers were commonly to complain 'They won't allow either me or my Deputy in there and there are 50 people on the Medical Advisory Committee'.

Health Authorities had not reduced the number of units, which showed remarkable diversity in their size and complexity, ranging from 100 to 4,000 whole-time equivalent staff and from £1m to £30m budgets.

Health Authorities had also failed to devolve real power and budgetary control to unit level—most noticeably in the District/Unit struggles over who should control the right of 'virement'. The 1984 study was to show that only one third of Unit Management Groups managed a comprehensive unit budget and one Unit Management Group in five were not allowed to vire planned savings within or between units.

District Health Authorities appeared reluctant to let go and this was perceived as an obstruction of Ministerial policy. Ministers were right, devolution had been slow.

LMNG WITHIN ONE'S MEANS: THE SEARCH FOR EFFICIENCY

What brought matters to a head was money. If the dominant theme of the seventies was industrial relations, the major theme of the eighties was to be money, and in particular the 'search for efficiency'. Indeed, there are those who would argue money 'made' managers; their power and influence in the NHS increased relative to the importance of money.

Money continued to be in short supply in the late 1970s and early 1980s and an essential plank of the Conservative government's policy was not just to control, but whenever possible reduce, public sector expenditure, reflecting the shift from Keynesian to monetarist economic policies. From 1976/77 the Labour government had successfully 'capped' NHS expenditure on hospital and community services by introducing the 'cash limit' system which ended the prospect of government 'bail-outs' if Health Authorities ran into financial problems during the year. (Expenditure on family practitioner services remained open-ended . . . that was too difficult a political nut to crack.) The NHS had to live within its means. It might expect a modicum of growth but it would by no means be sufficient to meets its ambitions. If it was to grow and develop as an organisation it had to increasingly find ways of re-directing investment from within its own resources. This presented a particular challenge for a service such as the NHS which faces infinite demand. These policies were not popular with the people who worked within the service, particularly when the savings they generated were 'stolen' to meet shortfalls in funding pay awards that had been negotiated nationally.

The problem for the government was, therefore, how to unlock these resources and how to ensure they were unlocked in as sensible a way as possible. It needed determined and resourceful managers to work their way through these issues and the process was not helped by the poor quality of financial information and perverse incentives to change.

The NHS was good at financial accounting–paying the bills and keeping accounts. It was good at guarding against the misuse of public funds and it had developed over the years an outstanding record for balancing the books. It knew how much money was spent, who it paid and what services and equipment it purchased,

but it was bad at tracking how and why this money was spent (for example on what wards and on what type of cases). It was not geared up to producing and interpreting financial information for management purposes. In addition, clinicians, the prime users of resources, were not actively involved in the management of resources and received almost no worthwhile information that would help or encourage them to take an interest. They, perhaps naturally, left the problem of balancing the books to administrators and treasurers.

Furthermore, there were a number of over-lapping and sometimes conflicting national initiatives in progress on re-directing resources, all sensible in their own right but in combination confusing. These meant that money was moving around the NHS in all directions.

RAWP POLICY AND LONDON

By early 1982 the Resource Allocation Working Party Policy had been operating for nearly five years and it was beginning to bite. From the outset, implementation had caused political difficulties as it led to a series of high profile clashes with the London Health Authorities and hospitals right in the backyard of the seat of central government and in full gaze of Fleet Street.

The London teaching hospitals were especially vocal in their opposition to this policy, claiming that it threatened national centres of excellence and rallied the national media to their defence. *The Daily Telegraph* had fanned public fears in November 1976 by reporting that 'more than 100,000 doctors throughout Europe may be called upon to take industrial action in support of British doctors who oppose Health Service plans for massive cuts in London's hospitals'.

The ancillary staff unions had already shown themselves ready in the pay beds dispute to take industrial action over matters not directly related to their pay and conditions — a characteristic which was to manifest itself again in confrontations with successive governments over closures of beds in the London area.

The troubles in London had started when the Labour government was in power, when spirited defence campaigns against the closure or cuts at particular hospitals, such as Elizabeth Garrett

Anderson, had secured partial victories or stays of execution. In October 1977, the so called 'Hounslow Raid' attracted widespread media attention when 21 elderly patients were suddenly and unexpectedly moved, in what the press termed a Commando style raid, from Hounslow Hospital where nurses had been staging a protest 'work in' against closure. Within three months of the new Conservative government taking office in 1979, Patrick Jenkin invoked powers under the NHS Act of 1977 to remove the Members of the Lambeth, Southwark and Lewisham Area Health Authority over their refusal to implement spending cuts and installed Crown Commissioners. To the government's acute embarrassment this action was later ruled illegal by the courts. The Resource Allocation Working Party policy was to be a thorn in the side of successive Ministers for many years to come. In the provinces the policy was welcomed . . . but quietly.

INVESTING IN THE CINDERELLA SERVICES

Policies aimed at switching money into priority services and prevention were set out in *Priorities for Health and Personal Social Services*[38] published in 1976, *Prevention and Health—Everybody's Business* in 1976[50] and *The Way Forward* in 1977.[39] Investing in the cinderella services was everybody's public objective from then on . . . particularly in the light of the scandals and inquiries.

Implementation inevitably implied less growth for the acute sector (or in a few cases actual cuts) and was thus strongly disliked by the hospital consultants. *The British Medical Journal* leader had thundered its opposition to *The Way Forward* in 1977, 'By putting people before buildings and giving practical expression to the public sympathy for the old and handicapped, Mrs Castle has perhaps allowed sentiment to over-rule intellect'.

The policies also highlighted a continuing dilemma for top management in the NHS. Managers need to maintain the support of the community they manage—how do they do this when they are charged with withdrawing and giving away resources from the most powerful and influential group within that community and without whose support they cannot function effectively? In addition how could one develop incentives for doctors to make savings when these were to be invested outside their own unit? Generating

effective incentives still cut against the philosophical grain of the NHS.

The immediate answer was pragmatic. Most health authorities chose to try and hold down acute sector costs and concentrated on putting the 'increment' (i.e. the modicum of growth they received) into the priority care services and into prevention. They also started switching funds from institutional to community care in mental health and mental handicap but even this policy proved in the 1980s to be difficult to sustain in many parts of the country. Losers under the Resource Allocation Working Party policy had little or no growth money to invest. Community care proved to be a more expensive form of care for the mentally handicapped and mentally ill and hospitals needed 'bridging funds' to maintain and improve the quality of care for residents continuing to live in the large institutions whilst developing modern community-based services. Re-investing the sale of surplus land from the large mental illness hospitals back into mental health was blocked in many Regions for years by a stubborn policy of putting the proceeds into a general capital pool rather than earmarking it for specific reinvestment in mental health. Again, the incentive structure was ineffective. Dowry schemes did eventually develop in some Regions which eased the process of change but they were by no means commonplace.

But despite these problems the cinderella services did begin to change and improve. The pressure for change was largely generated outside the professions directly involved who had often become as inured to poor quality as had their patients. But move they did. . . if slowly.

CUTTING OVERHEADS AND IMPROVING COSTS

By 1980 the NHS had succeeded in reducing its management costs to 5.05 per cent of total costs, compared to Ennals' target of 5.25 per cent but this was not judged to be enough. It was decided costs must fall by a further 10 per cent and a new and more challenging target was set in 1981 to get the percentage down to 4.6 per cent by the end of 1984/85 (the targets are not directly comparable because of a change in definition of management costs).

Ministers also started to urge District Health Authorities to look

for savings in other areas. At first this was voluntary but from 1982/83 District Health Authorities were required to make compulsory efficiency savings (later re-named cost improvements). The target initially was to generate savings equivalent to $\frac{1}{2}$ per cent of the cash limit; this was later raised to 1 per cent. The custom quickly developed of assuming in advance this would be achieved and was therefore added to public statements about the growth investment available to the NHS. Technically accurate this was regarded as a fraud by many managers who had developed their own local incentive schemes which permitted Departments which made savings to keep them in whole or in part for agreed investments. The cash could not be spent twice.

The screw was turned on hotel services. The organisation of NHS supplies seemed permanently in the spotlight. Spending on administrative and hotel functions fell from 42·3 per cent to 36.9 per cent of the total budget between 1974/75 to 1980/81. Unit Administrators were urged in articles on useful tips such as 'Seventy Ways to Cut Costs' to go out and check that lawn mower sizes were compatible with the areas to be mowed. 'Every time you pass 'go', a highwayman from the Department of Health takes £200 out of your pocket' one District Administrator was to write in 1983.

The policy resulted in a general improvement in good housekeeping but by the mid 1980s it was beginning to be felt that the flesh had been trimmed back to the bone and the savings were beginning to cut too deep into support services. Managers had gone for soft easily defendable targets. Some of these initiatives had led to a deterioration in staff working conditions. The rationalisation of staff dining rooms had, for example, led in some cases to staff seemingly walking 'miles' on large spread out sites to get a drink. Night staff catering services had been decimated. Staff residences had been left in a state of disrepair.

Compulsory competitive tendering of domestic, catering and laundry services was introduced in 1983, and continued throughout the period, although some of the early (and dramatic) savings had eventually to be put back in order to lift up specifications which had been rushed and badly done for the early contracts.

The search for savings had also been rolling closer and closer to clinical care. In some units porters were in danger of becoming an extinct species, often leading to complaints from doctors and

nurses that they had to wheel patients down to theatres themselves, or that wards had been left with low cover whilst nurses went to deliver laboratory specimens, or queued to pick up drugs. Administrators were beginning to get close to the end of their tethers. The nursing budget, until now sacrosanct, would have to be reviewed.

This was the biggest budget and therefore must hold the greatest potential for efficiency gain. The first target was the long-standing problem of nurse staffing and shift overlaps. 'The word 'virement' has arrived recently in the NHS vocabulary' said one observer. 'It appears to mean how to get a share of the nursing budget'.

Increasingly the relentless search for efficiency was moving away from non-patient care to direct patient care, from savings around the periphery to the heart of the service.

THE MOBILE IN THE WIND

The reluctance with which Health Authorities often yielded up savings and the whinging that went on about this task was by now beginning to irritate Ministers.

There was probably some element of truth in the belief that Authorities were dragging their feet. Not all Authorities were convinced that the government was right. No one liked making the savings and health care professionals were slow to come to terms with the reality that the NHS had to live in future within limited resources. There was a lurking belief that politicians still had a hidden 'crock of gold' that could be prised open with effective shroud waving.

In addition, the NHS had lived through a period when government had changed hands between parties like a political 'yo—yo'. That it had survived intact was in some ways a testament to the ability of its managers. They had become masters at damage limitation, protecting the heart of the NHS — the services it delivered to its patients — from the buffeting of political change. A contemporary writer observed that new national policy initiatives were rapidly filtered as they were passed down the organisation and re-adjusted to fit local political agendas. Griffiths was to liken the NHS structure to a 'mobile — designed to move with any breath of air, but which in fact never changes its position and gives

no clear indication of direction'. Many NHS Authorities dragged their feet on competitive tendering of ancillary services either because of profound philosophical distrust of the policy or because of the row it would cause locally. Large early savings by some authorities and continued ministerial and managerial pressure on the system (sometimes very heavy indeed) was necessary to make things happen.

Overtly political initiatives presented an increasing dilemma for the NHS managers from the mid 1970s onwards. They had a clear public duty to implement the policies of the Government of the day even if it meant doing so in the teeth of fierce opposition from their professional colleagues and local communities. It was not easy. In its early years the Thatcher government (prior to the Falkland's War in 1982) looked extremely shaky. Inflation was continuing to soar; public opinion polls showed weakening support for the government. No-one could have anticipated that the Conservatives would be re-elected for a further three terms, thus creating one of the longest periods of continuous government in the hands of one party that the country has ever known. Courage was now a vital part of the successful manager's make up.

PARLIAMENT TAKES AN INTEREST

By now Parliament too was beginning to take an interest in efficiency. Ministers were themselves under constant pressure. It would soon be time to go back to the polls. Besides they were beginning to feel the heat of the Public Accounts Committee.

At Regional level Ministers and Parliament often feel very close—there are Ministerial requests for briefing on a wide range of topics, all manner of Parliamentary questions to be dealt with, MPs correspondence to be answered and so on, but it never feels closer than when the Public Accounts Committee or a Select Committee is at work.

Select Committees are bodies with special powers and privileges to which the House of Commons has delegated its authority for the purpose of discovering information, examining witnesses, securing evidence and drawing up conclusions to put before the House. Of these undoubtedly the most powerful is the Public Accounts Committee, supported in its work by the National Audit

Office. In 1980 in response to the recommendations of the Royal Commission, a new Select Committee was created for Social Services (including health), whose output exceeded that of any other Select Committee between 1980–1987. (The other Select Committee concerned with the work of the NHS is the Select Committee on Parliamentary Administration to which the Health Ombudsman reports).

These Committees are well briefed, well informed and leave few stones unturned in their enquiries. If one reads accounts of their proceedings, for most hearings take place in public, one will see that they have scant regard for the rank or privilege of Ministers let alone humble 'bureaucrats' or NHS managers. As Sir Kenneth Stowe, Permanent Secretary of the Department of Health and Social Security between 1981–87 was to comment 'the chastening experience of being summoned to appear in person to answer before this Select Committee of the House of Commons does not stop with the few individuals who had to obey this command. It concentrates the minds of their peers too—they might be next'. (First wave NHS Trust Chief Executives were to discover it was an unexpected privilege that went with Trust status in 1991).

In the early 1980s the Public Accounts Committee was growing increasingly strident in its criticisms of the management of the NHS.

In particular, in July 1981 the Committee made clear its view that the 1982 re-organisation of the NHS, with its emphasis on greater delegation of day-to-day management decisions to Health Authorities, would make the job of Accounting Officers, and especially the Permanent Secretary at the Department of Health and Social Security, more difficult in accounting for the expenditure of the NHS funds. In the words of Stowe 'it had blown the whistle' on the NHS by saying that 'the hands off policy was delegation without accountability and incompatible with statutory obligations'.

The need to respond to these criticisms triggered off one of the most discernible trends of the 1980s—an increasing tendency towards more centralist control and intervention in the NHS. There was a general feeling within Parliament that the Department of Health and Social Security did not have a sufficient grip on the running of the NHS. As one Minister is alleged to have

said, it was like trying to turn an aircraft carrier, a long and slow process. The initiatives flowed thick and fast.

AN EFFICIENCY OVERDRIVE

In January 1982 Norman Fowler announced the introduction of the new performance review process. Ministers would in future lead a review of the long-term plans, objectives and effectiveness of each Region. Action plans would be lodged in the House of Commons' Library. The new process would commence immediately with a review of the Mersey Region. Regional Health Authority Chairmen would be expected to carry out reviews of District Health Authorities on a similar basis. (The review process would be extended to units in 1984.)

Simultaneously, Norman Fowler reported that a new compulsory national package of 'Performance Indicators' would be developed, to be tested in the Northern Region (essentially a tool for using routine health care statistics to compare the performance of individual Regions and Districts). This was published in September 1983 and caused considerable scratching of heads. Predictably the Performance Indicators showed that 191 different National Health Services existed in the country rather than one single National Health Service operating in 191 Districts.

In March 1982, barely two months later, Mr Fowler made a further announcement. A national enquiry was to be launched, headed by Ceri Davies (a senior Departmental Architect) with the aim of 'identifying under-used and surplus land and property and where appropriate disposing of it'. The Report's recommendations were accepted by the government in November 1983 and introduced a system of notional rents for NHS property as a basis of a performance measure of estates utilisation and the disposal of unused and under-used assets.[138] (This accelerated the programme of hospital land sales was to contribute £280m towards the NHS building programme from 1984–85 to 1986–87.)

Mr Fowler also announced in the same month (March 1982) plans for the experimental use of private firms to audit accounts of health authorities.

Then on 1 April 1982, the very day that re-structuring came into effect, there came another initiative. 'Rayner Scrutinies'

named after Sir Derek Rayner, Managing Director of Marks and Spencer and part-time efficiency adviser to the government, were to be extended from the civil service to the NHS. The topics were announced later and comprised a motley assortment — vacancy advertising, the storage of supplies, catering costs, the cost-effectiveness of meetings, NHS residential property, the recovery of aids loaned to patients, ambulance service control systems, collection of income due to health authorities, and the administration of project briefs for hospital building schemes. Management Advisory Service trials were also launched that month to explore the value of establishing independent sources of advice to health authorities on the efficiency of services. Two trials were carried out, one in Wessex and the other in Oxford and the South Western Regions. The Wessex work was eventually integrated into mainstream management activity when the trial finished in March 1985. The service in Oxford and the South-West developed into the present day Management Advisory Service. This became a charitable trust in 1987. Both had done useful work without dramatic results.

The Falkland's War then diverted attention from domestic politics but on 27 August 1982, a review of NHS Audit Arrangements was announced. The recommendations published a year later suggested more emphasis needed to be placed on 'Value for Money' rather than narrow financial propriety.

Then on 19 January 1983 central control of NHS Manpower numbers was introduced, subsequently confirmed by Circular HC(83)16, on Cash Limits and Manpower Targets. It was a return to the central control of the 1950s.

Regional Health Authorities were to agree with the Department by September of that year indicative figures which would achieve by 31 March 1984 a reduction of 0.75 per cent to 1 per cent in overall staff numbers from the total employed at 31 March 1983. Within this target posts other than doctors and dentists, nurses and midwives, and professional and technical staff were expected to reduce more sharply by between 1.35 per cent and 1·8 per cent. Manpower accounted for 75 per cent of the revenue budget of the Hospital and Community Health Services and the Public Accounts Committee had realised the effective and efficient management of the NHS must primarily be focused on the effective and efficient management of staff. It was a very blunt

instrument. The pressure to continue competitive tendering was reinforced further in 1983.

NHS managers were of course used to living within tight budgets. AsJohn Spencer said in 1988 'The road along which the NHS has come is littered with the wreckage of burnt out efficiency machinery' but it had never experienced anything like this before.

A Ministerial whirlwind had been unleashed on the service—it was an efficiency overdrive. That it should be unleashed at this time was itself fairly ironic as the government's own *Health Care* and Its Costs, published on the eve of the 1983 election, demonstrated that productivity in the NHS had grown faster than resources over the period 1976–1981.[137]

Griffiths was to warn that 'units and authorities were being swamped with directives without being given directions' and advised that the service needed to move to a system where means of effecting change in the use of resources should be left much more to local management, who were best placed to take decisions in the light of the local situation operating within the framework of a tighter budgetary system, and within the context of the total management process.

THE THINK TANK REPORT

In September 1982 alarm bells began to ring in the NHS as tales began to circulate of a 'think tank' report, recommending a move to health insurance. There was such a report. It had been prepared without the knowledge of Health Ministers, by the Central Policy Review Staff set up by Edward Heath to advise the Prime Minister on long-term policy development. Described by Norman Fowler in his memoirs as a blunderbuss, he records that it had been 'consigned to the dustbin' by the Cabinet within a couple of weeks of it first appearing. Despite being disowned, the report would dog the government in the run-up to the next election.

THE 1982 STRIKE

Norman Fowler had a long stint as Secretary of State for Health and Social Services (1981–1987).He concluded 'Health provides just about the bloodiest battleground in British politics today'."

1982 was to produce the longest running industrial dispute in NHS history, and until the miners' dispute of 1984, the biggest ever industrial dispute in the United Kingdom. The 13 unions represented on the Trades Union Congress Health Services Committee had begun action in March 1982 in pursuit of a uniform flat rate pay settlement of 12 per cent from 1 April 1982, following the rejection of a management offer which would have given a 6.4 per cent rise to nurses and other key professional staff and 4 per cent rise to other health workers, which was in line with Government pay policy.

The dispute was over-shadowed in its early days by the Falkland's crisis, but as soon as that was over the unions embarked upon a series of selective one-day stoppages which soon increased in length and intensity and began to attract widespread media coverage over the early summer of 1982.

Throughout the dispute the Royal College of Nursing stuck fiercely to its policy that nurses should not strike. Hopes rose that a Royal College of Nursing ballot would result in nurses accepting a revised pay offer of 7.5 per cent for nurses and 6 per cent for the rest, so pulling the rug out from beneath the feet of the other unions. These hopes were quickly dashed by a clear vote of rejection by RCN members in August 1982.

By now services were beginning to be severely disrupted and in some places emergency cover was withdrawn against union guidelines as the action intensified. In July, for example, boiler men at Cranage Hall Hospital for the Mentally Handicapped in Crewe walked out, leaving the hospital without hot water to wash patients, many of whom were incontinent. By August the government was blaming the unions for a 10 per cent increase in hospital waiting lists since the start of the year. The unions claimed that a five-day stoppage that month had reduced 80 per cent of hospitals to an accident and emergency service only. *The Lancet* accused the government of wanting headlines that patients were dying in order to swing public opinion against the Trade Unions.

The dispute put considerable pressure on the government as many other groups of workers took solidarity action—some official and some unofficial—in support of the health workers. Miners, firemen, steel workers, water workers, were amongst those who joined in the protests, together with Fleet Street electri-

cians, whose leader was fined for secondary picketing in one of the first tests of the Employment Act of 1980.

By early September the police were being brought in to provide emergency ambulance cover in some parts of the country, such as Hartlepool, as calls began to mount for a national all-out strike.

Ministers were pursued by demonstrators wherever they went. Kenneth Clarke, who was later to describe the dispute as 'almost the biggest irrelevance of my job' was mobbed by jeering hospital demonstrators at Walton Hospital, Liverpool. The Special Branch assigned armed police guards to look after Norman Fowler. Meanwhile, Margaret Thatcher's decision to have a minor operation for varicose veins done at a private, rather than an NHS hospital riled the unions still further.

A national Trades Union Congress day of action in support of the health workers was called for 22 September. The National Union of Mineworkers and the print union, SOGAT, were amongst the unions urging their members to down tools in protest.

Behind the scenes, Norman Fowler tried to get negotiations re-started with the Unions and the Royal College of Nursing with the offer of a two year pay deal. The Royal College of Nursing responded positively to the initiative but it was rejected by the Trades Union Congress Health Service Committee, apparently against the advice of its Chairman, Albert Spanswick, the General Secretary of COHSE.

22 September dawned. *The Times* described the day as 'the biggest revolt of the decade'. 60,000 people came out onto the streets in London. Most of the pits and ports came to a halt and the morning's newspapers failed to appear.

Normal Fowler saw it as a turning point in the dispute. Claims about the day's success were probably exaggerated but more importantly the Unions' tactics turned the press and public against the health workers and drove a wedge between them and the Royal College of Nursing negotiators.

The health service union tactics then switched to a series of Regional rather than national days of action but the government held firm.

By October Government figures suggested that 110,000 operations and 106,000 out-patient appointments had been lost as a result of the action.

However, the campaign was beginning to run out of steam. What Norman Fowler described as the Vietnam War factor was coming into play. The public was becoming hardened and accustomed to the horrific scenes on television. The Trades Union Congress called a national transport solidarity day of action on 8 November to boost flagging morale amongst health workers but frustration was beginning to grow amongst the union ranks. Kenneth Clarke summed up the mood 'I am as fed up with it as everybody else in the health service and I look forward to the day when I can have it behind me'.

Nevertheless, the dispute dragged on until December, when the unions had to settle for a more modest rise over a 2 year period and one which gave differentially more pay to nurses. The Pay Review Body Award System which already covered doctors was extended to nurses in 1983 in what Norman Fowler regarded as the biggest breakthrough since the war in determining nurses' pay. Implicit in the deal was the RCN's agreement to a no strike pledge. Trevor Clay, the Secretary of the Royal College of Nursing argued for more science and less emotion in determining nurses' pay in future in an article for the *Nursing Standard.* 'Crying doesn't pay any more' he said.

All told, because of the selective targeting of the action on key groups, only around 780,000 working days were lost to the NHS, just a few more than the number of days lost by other parts of industry in solidarity action (this compares to 9m working days lost during the 13 week national steel strike of 1980) but there was a high cost in terms of human misery and suffering to NHS patients and staff.

8

FROM GRIFFITHS TO GENERAL MANAGEMENT: 'SEARCHING FOR THE PEOPLE IN CHARGE' FEBRUARY 1983–OCTOBER 1986

NORMAN FOWLER ANNOUNCES A NEW MANAGEMENT INQUIRY

THE DISPUTE, TOGETHER WITH THE SEEMINGLY ENDLESS expansion in the size of the hospital workforce which was making it hard to constrain public expenditure, convinced the Department of Health and Social Security that the management of the NHS workforce could not be allowed to continue in the same manner.

In February 1983, Norman Fowler announced a new Management Inquiry to give advice on the effective use and management of manpower and related resources in the National Health Service. The work was to be undertaken by a four-man team led by Roy Griffiths, Deputy Chairman and Managing Director of Sainsburys. Other members of the team were Michael Bett, Board Member for personnel at the still nationalised British Telecom, Jim Blyth, Group Finance Director of United Biscuits; and Sir Brian Bailey, Chairman of Television South-West and the Health Education Council. The Secretary was Cliff Graham, a civil servant with a distinctly non-civil service style.

Sir Kenneth Stowe has intimated that the idea of setting up an Inquiry into NHS manpower, once the dispute was settled, grew out of talks with senior health service union officials in 1982. Some sources say the review was determined on in early Autumn 1982.

The team's brief, however, extended far beyond manpower and it is reputed to be Griffiths himself who persuaded Norman Fowler that his remit should be broadened, initially declining to

accept the job unless the Government acceded to this request. Not that Ministers were likely to require all that much persuading about the need for change. Norman Fowler reflected in his memoirs:" 'As month after month went by, I became more and more convinced that the real problem with the health service was a lack of management'. To him, the management methods of the NHS appeared amateurish and he was especially critical of the lack of serious employee involvement in policies despite the NHS being the biggest employer in the UK. 'Managers (where they existed) did too little to involve the workforce and there were often great 'them and us' divisions between the medical staff and the rest'. This he believed, had been a contributory factor to the 1982 dispute.

Once again, but this time less than eleven months after reforms had come into effect, the NHS knew that it was in for another major shake up.

The review was to be short and sweet (no drawn out Royal Commission deliberations this time round). Everyone except perhaps Griffiths himself expected the team to report in a matter of months. But on 13 May 1983 Parliament was dissolved. Mrs Thatcher had decided to call a general election.

GRIFFITHS REPORTS

'Judging by the 'leaks' and the noises coming from the hustings, the central initiatives and enquiries and the cries of anguish from re-organisation weary staff, the health service is in one of its perennial crises and about to disintegrate completely' commented Bob Nichols, Regional Administrator of South Western Regional Health Authority, the incoming President of the Institute of Health Service Administrators. He was speaking in Newcastle on election day itself, 9 June 1983. He then paused and added perceptively 'This is not new. The health service seems to have had a crisis almost every year in the 20 plus years which I have been working in it. Not only has it survived but it has steadily developed.'

The Conservatives, riding on the crest of the Falkland's wave, won the day with the largest number of seats won by any party since the Second World War. 'The NHS is safe in our hands.' Mrs Thatcher had said and the NHS stayed in the hands of the same

Ministerial team. It was business as usual and Roy Griffiths and his team meant business. By now it was October and they were ready to present their recommendations. Their report was much praised for its simplicity, shortness (25 pages) and directness." Its findings are often summarised in the well known quotation 'In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge' but its observations went considerably further.

In the view of Griffiths and his team, the NHS lacked any real continuous evaluation of its performance against normal business criteria—levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development and the long-term viability of the undertaking. Rarely were precise management objectives set. There was little measurement of health output. Clinical evaluation of particular practices was by no means common and economic evaluation of those practices extremely rare. Nor could the NHS display a ready assessment of the effectiveness with which it was meeting the needs and expectations of the people it served.

The NHS was one of the largest undertakings in Western Europe, the team concluded: it required enormous resources; its role was very politically sensitive; it demanded top class management; but there was a lack of a clearly defined general management function from the Department of Health and Social Security downwards. Griffiths found out why the NHS aircraft carrier took so much turning—it lacked a set of effective controls.

A NEW STYLE OF MANAGEMENT

The remedies were simple but revolutionary.

> The creation of a Health Service Supervisory Board within the Department of Health and Social Security and the existing statutory framework. The Board's role would be to determine the purpose, objectives and direction for the health service, approve the overall budget and resource allocations, take strategic decisions and receive reports on

performance and other evaluations from within the health service. The Board would consist of Executive and Non-Executive Members and be chaired by the Secretary of State. (The Supervisory Board was re-shaped in 1989 into the Policy Board.)

- The setting up of a small, multiprofessional NHS Management Board, accountable to the Supervisory Board, to plan implementation of policies, give leadership to the management of the NHS, control performance and achieve consistency and drive over the long term. The Board would have members drawn from business, the NHS and civil service. Its Chairman would perform the general management function at national level and also act as Accounting Officer for Health Service expenditure. (The Management Board was the forerunner of the NHS Management Executive.)
- The appointment of General Managers (regardless of first discipline) at Regional Health Authority, District Health Authority and unit level and greater freedom to organise the management structure in the way best suited to local requirements and management potential.
- Devolution of the responsibility for all day-to-day decisions to unit level.
- Closer involvement of clinicians in the management process.
- Setting of a total budget for each unit within a clearly defined financial management framework.
- The development of management budgets which involved clinicians and which related workload and service objectives to financial and manpower allocations, so as to sharpen up the questioning of overhead costs.
- The appointment of a Personnel Director at NHS Management Board level, drawn from outside the NHS to lead the development of personnel relations.
- The development of the NHS property function to give a major commercial re-orientation to the handling of the NHS Estate, coupled with the streamlining and speeding up of procedures.

- A general review of the levels of decision-taking in the NHS to reduce the numbers and levels of staff involved in decision taking and implementation.
- The speeding up and simplification of all consultation arrangements.
- Promotion of realistic public and professional perceptions of what the NHS can and should provide as the best possible service within the resources available.
- Making how well the service is delivered central to planning and delivering services at local level by seeking out the experience and perceptions of patients and the community.

But the Griffiths report was not really about managerial structures and arrangements. It was about creating a new energetic, more thrusting and commited style of management. One in which the centre stood back from day-to-day management of the service but infused every level with its passionate concern for the quality of care and delivery of service. It envisaged a strengthened role for Regions, creating a climate in which Districts, hospitals and units were liberated to get on and manage the service but at the same time were held rigorously to proper account for performance and achievement. Griffiths was about creating a culture in which responsibility was pushed down the line as far as possible. One in which units (particularly the major hospitals) were seen as the bedrock of the whole NHS management process and where doctors were actively involved in securing the most effective use and management of all resources, especially as the service moved closer to patients. It was about creating a happier working environment and a more satisfied staff and above all a service in which management played an active, not merely a reactive role in relation to patients and the community and made them central to its activities.

But was this utopia attainable? Even Griffiths had his doubts. He foresaw it would be 'a rough ride', and later reflected that 'Once you change relationships between groups of staff, between different authorities and between various activities, you are almost bound to cause turbulence . . . the consequent uproar is part of the price you pay for reaping the advantage of liberating management to take decisions and to do their own thing'.

MR FOWLER DETERMINES ON IMPLEMENTATION

'The Management Inquiry Report' was welcomed by the government but received a gloomy reception from the professions, with the exception of the administrators who demonstrated considerable enthusiasm for the proposals. They saw themselves as the natural candidates for general management jobs because of their co-ordinating role. (A study of Area Management Teams by Schulz and Harrison in 1981 had identified Area Administrators as the most influential member of the team.) Barely two months were allowed for consultation. As Griffiths was to comment in his speech to the Audit Commission in 1991:—

> 'The nurses saw it as a challenge to a carefully established professional career structure. The medical profession saw the report correctly as questioning whether their clinical autonomy extended to immunity from being questioned as to how resources were being used. All the professions saw the report as introducing economics into the care of patients, believing this was inimical to good care.'[145]

It perhaps mattered little what consultees said; the government was determined on its implementation — the debate was described by a contemporary observer as 'vociferous, almost meaningless and because of that a bit sad'.

Norman Fowler was forced to delay formally announcing the decision until the Parliamentary Select Committee on Social Services, who were not best impressed by the proposals, completed its review and reported to the House of Commons. Behind the scenes, however, events were moving apace. By the time the Circular was published at the beginning of June 1984, the new Supervisory Board was already well established though the issue of professional representation on the Board, especially the absence of an automatic seat for the Chief Nursing Officer had been a source of annoyance to professional bodies. In response to Royal College of Nursing representations, the Chief Nursing Officer was eventually made a full member.

Changes were also well underway within the Department to prepare for the new management arrangements but it was not until January 1985 that Victor Paige took up post as Chairman of the new Management Board. Paige was an experienced general

manager with an impressive track record in managing change at the Port of London Authority and the National Freight Co-operation. These were organisations which Fowler knew well from this time as Transport Minister. He especially admired National Freight: —

'My ideal company would be organised on the lines of the National Freight Company with its emphasis on employee involvement; or like Nissan in Sunderland where the managing directors wear blue overalls like everyone else and all eat in the same (excellent) canteen.'

Victor Paige became one of the Permanent Secretaries at the Department of Health and Social Security which led to doubts amongst many in the NHS as to whether the new chairman could truly be the Secretary of State's 'right hand man as the Griffiths team had recommended. The civil service remained very closely in touch.

HEALTH SUPREMO GETS EXTRA £60 PER WEEK

By the time Victor Paige took up his post general managers had already begun to be appointed. All Regions had to identify a general manager 'to take personal and visible responsibility for carrying out the general management function' by the end of September 1984 and general managers had to be identified and associated management structures established in all Districts and Units by the end of 1985 at the latest. North West Thames Regional Health Authority announced that David Kenny, its Regional Administrator, had been appointed Regional General Manager on 9July 1984. David Kenny thus had the distinction of being the first general manager appointed in the NHS and took up post, together with a number of other new Regional General Managers, including, myself on 1 August 1984. Most were appointed after a competitive interview with other colleagues on their existing management team. Regional Administrators got most of the jobs but Catherine Hawkins (RNO) was appointed in the South Western Region, Dr Rosemary Rue (RMO) in Oxford and Gordon Greenshields (RT) in the North Western Region. Gordon Greenshields did not stay for long but reappeared in 1991 as Director of Finance for the NHS Management Executive.

The significance of these momentous changes was not lost on the media. 'This man is being appointed to do the same job for more money' Renee Short told the *Guardian.* 'Health Supremo gets Extra £60 per week' proclaimed another newspaper, referring to the fact that general managers were to receive a maximum of £3,000 on top of their existing salary.

For the first time ever in the history of the NHS, managers were appointed on short-term contracts—they had three, or at most five, years to prove their worth. As one female Unit General Manager put it. 'Perhaps you have only a little over 1,000 days to make your mark but unlike Anne Boleyn at least you know that from the outset'. Any costs incurred by appointments were to be offset by savings on other management costs. By the end of September 1985 all Regional General Managers were appointed and all but a handful of District General Managers. The Unit General Manager round was also under way, though a long way from completion. Late appearing advertisements fell foul of new restrictions on advertising introduced in the wake of the Rayner Scrutiny on Advertising. Unnecessary phrases such as 'applications are invited for' and 'an interesting and challenging post' should be omitted!

AN INVITATION FOR ENTRENCHED BUREAUCRACY TO OUTWAIT GENERAL MANAGERS

Kenneth Clarke had promised in May 1984 that in future there would be less 'i' dotting and 't' crossing, but in contrast to the liberating new spirit of Griffiths, the implementation circular was highly prescriptive. Alain Enthoven was later to comment that it read like 'an invitation for entrenched bureaucracy to outwait the general managers'. Its publication was perhaps predictable.

Sir Kenneth Stowe, was to comment in his book (*On Caring for the National Health* published in 1989 by the Nuffield Provincial Hospitals Trust[53]) that Griffiths implementation was 'nearly a disaster'. Having read the 'Griffiths Report' a considerable number of health service administrators and health authority Chairmen had got the idea into their heads that this was the 'beginning of a long awaited freedom from interference from Government; the independent body to manage the NHS on its own (the NHS Management Board) was to be realised at last'. However, as Stowe

emphasised, at the centre 'freedom for Health Authorities to cut loose and pursue their own paths at the taxpayer's expense was the last thing in any of our minds.' 'Accountability was to be more, not less rigorously imposed.' The centre could not live with the Griffiths truism that 'if you delegate and free people to take their own decisions, they will in three cases out of five not do things exactly as you would have wished.' One contemporary observer has also suggested that the circular's issue had been in part a response to panic on the part of Authorities and Managers to their new found freedoms. There had been a clamour in some quarters for detailed guidance — such was the traditional dependence on the Department of Health and Social Security that people were as yet unwilling or unable to think things through for themselves.

Some of the most disconcerting elements of implementation were the detailed 'vetting' of District Health Authority structures, and appointments by the Department of Health and Social Security, the pressure to appoint people from outside the NHS and the allegations of political interference in appointments. Each General Manager appointment needed the approval of the Department of Health. The Griffiths freedoms were yet to be earned.

RE-SHAPING MANAGEMENT TEAMS

Griffiths had stressed that the NHS was in no condition to take another major re-structuring and that much could be achieved by making the existing organisation work. But one commentator said it had gone the way of all the previous re-organisations — 'an enormous amount of managerial effort going into re-organising rather than managing the service, career uncertainty and consequent poor morale, the career hazards of the quality of competition and of an officer's relations with his current chairman and a further loss to the service through early retirement'. This is a little harsh as all in all it was a quiet revolution — hard on staff at the top perhaps but 'softer' on those in the middle.

It was rough justice for some — especially District Administrators who failed to secure General Manager posts, most of whom now found themselves out of a job, for there was no credible top management job left for them to do once they lost their co-ordinating role.

There was also in the subsequent re-shaping of the District management teams a substantial loss of status for senior nurses. The role of the District Nursing Officer was now changed to the status of adviser and there was a virtual abolition of the upper levels of their hierarchy above unit level. Some Authorities tried to do without nursing posts altogether at District level. The Royal College of Nursing leapt spiritedly to their defence, launching a £1/4m campaign 'Why is Britain's nursing being run by people who don't know their coccyx from their humerus?' 'To be effective as the patient's advocate, the clinical nurse needs to have an effective mouthpiece at the point where resource priorities are set'. On the eve of his retirement in 1989, Trevor Clay, the Secretary of the Royal College of Nursing, was to point proudly to its success. 'Now there are very few Authorities where there is not proper nurse representation and general manager and nurse relations have been enriched'.

In some places new management structures replicated the old. In others there were 'clean breaks' with the past and radical departures. Most successfully blended the old and new. There was generally a feeling that Boards worked more corporately and co-operatively than the old consensus forming teams now that they had a clear leader. All, however, had one striking characteristic; none of them looked quite the same.

MR FOWLER'S RIGHT HAND MAN RESIGNS

On 5 June 1986 speaking at the Institute of Health Services Management national conference in Buxton, Len Peach (who had been seconded from IBM to become the NHS Management Board Director of Personnel), reported that 750 general managers were now in post throughout the service.

Len Peach was positive about the future. The aim is 'to make general management stick' but his confidence hid a significant new crisis facing the NHS, for when he got up to speak on 5 June he did so as acting Chairman of the NHS Management Board for just two days earlier Victor Paige, Griffiths' 'right hand' man had resigned after only seventeen months in post.

In his resignation letter to the Secretary of State he cited the incompatibility of political and managernent objectives as the reason: —

'Ministers and the Chairman of the Management Board can approach the same issue with different perspectives, priorities, objectives and restraints. The conclusions are not always compatible. Also there are always others in the action—or trying to be! Within my remit that makes for difficulties in working to the management standards and style to which I am committed. I have brought this to your notice on several occasions. You are aware that it is not working out as I believe it should. After much careful thought and with great sadness, I have therefore decided to resign as the Chairman of the Management Board.'

Paige's departure was linked to clashes over efficiency savings and the closure of nurses' homes. There was also a culture clash between the civil service and the private sector general management that good personal relationships between the senior players had failed to cover up.

SELLING THE ROOFS OVER NURSES' HEADS

In 1985, after a Rayner Scrutiny had highlighted scope for significant savings, the Department had issued a seemingly innocuous circular requiring health authorities to establish explicit policies on residential accommodation for staff and draw up action plans for matching future requirements and stock. The Department adopted a bullish attitude to implementation and intense pressure was brought to bear on Authorities to sell off property. However, it developed into a highly emotive public issue and played a small part in the eventual resignation of Victor Paige. The Confederation of Health Service Employees said it was an attempt to sell the roofs over NHS staffs' heads. Management of NHS residential accommodation emerged as a national scandal—theft, rape, vicious assault, fires, dangerous electrical wiring seemed everyday occurrences; cockroaches roamed at will. The public grew alarmed at talk of half-starved nurses being thrown out on the street. The government was in danger of scoring a political own goal. There was no point in stirring up trouble over a comparatively marginal political issue in what could be the run up to election year and the government began to back off. The Secretary of State announced on the 25 March 1986 that no nurse was to be forced out. By the end of May 1986 the government was

promising a review of the review of the policy on residential accommodation. The programme had been effectively stopped. A week later Victor Paige had gone. He left with dignity but the problem remained for his successor and his colleagues in the civil service. It said a lot about the problems of managing the NHS when a simple common sense step of rationalising for the most part unused and empty housing caused a major political row.

Also in 1986 the National Audit Office had produced a report on 'Value for Money Developments in the NHS', questioning whether cost improvements in the NHS had really been achieved without damage to patient services, a theme which had subsequently been taken up by the Public Accounts Committee that April. This had resulted in a major political row and a good deal of adverse publicity for the government. Victor Paige's resignation did not come at a good time.

MINISTERS AND THE MANAGEMENT BOARD

Ironically, the edition of the *Health Service Journal* announcing his resignation as the publication went to press, carried an article critical of the NHS Management Board's performance in which Mr Paige scotched rumours of 'serious disquiet' at the Department of Health and Social Security over the Management Board and its Chairman.

Mr Paige was to remain silent on the turn of events until 1987 when he was asked to give evidence to the Social Services Select Committee. The introduction of general management he intimated had been a great success but was flawed in one respect—the way the service was managed at the centre.

'Because Ministers are accountable to Parliament and because of the high political pressures and sensitivity associated with virtually every central management decision then the reality is that Ministers take all the important decisions—political, strategic and managerial.'

Griffiths was later to say that 'although the Supervisory Board and the Management Board were absolutely correct in concept in the early years they were half-hearted in their implementation. Major policy issues were left uncovered and there was no attempt to establish objectives at the centre and no concentration on outcomes.'

In the light of Victor Paige's resignation, the concept of the Management Board was to be rethought. In October 1986, instead of having a combined Chairman and Chief Executive post, it was decided the Board would be chaired by the Minister of State for Health as it was not possible to divorce politics from management and have a separate Chief Executive. Tony Newton who was now Minister of State for Health in September 1986 became the first Minister to chair the Board and Len Peach, a man with 'a flair for both personnel management and multi-disciplinary working' the first Chief Executive. It was almost three years to the day that Roy Griffiths had first tendered his report.

COMPETITIVE TENDERING

For all of Paige's term of office the government was still firmly entrenched in the battle over competitive tendering for support services. The programme launched in 1983 had been going slowly. This policy had led to a torrent of bad publicity from both those who opposed the policy in principle and those who thought it was not being implemented well enough. The private sector alleged that a 'dirty tricks' campaign was being run by Health Authorities to prevent them winning contracts. Indeed, one of Victor Paige's first jobs as NHS Management Board Chairman had been to send a list of 'dos & don'ts' to Regional Chairmen but the private sector pressed for 'tougher measures'. 'Reluctant Authorities will hold up two fingers to Mr Paige!' claimed a spokesman for the Contract Cleaners Association. Fifteen Health Authorities refused outright to implement the Circular. Salford District Health Authority had its revenue monies withheld by North Western Regional Health Authority until it fell in line. There were bruising encounters between RHAs and DHAs all over the country. By September 1986 12 contracts actually won by the private sector had been terminated due to voluntary withdrawal or poor performance . . . or so claimed NUPE. In that same month the government repealed the 'Fair Wages' resolution—which have compelled private firms to employ staff on effectively the same terms and conditions of service as NHS staff. There were cries of outrage from the opposition and the Labour movement. Some private sector contractors, now worried about

'cowboy operations' entering the market, voluntarily offered NHS rates or better.

In January 1987, after the programe was supposed to be fully implemented, there were still six Health Authorities in England and Wales refusing to comply at all with the Circular, and the programme was only 75 per cent complete. Only 75 Health Authorities had put all services out to tender and there were 17 in which the annual saving remained negligible — under £50,000 a year.

Throughout the competitive tendering process the conscience and loyalty of NHS managers were heavily tested. Many felt an obligation to defend the interests of the lowest paid of their employees. Others had real doubts about quality standards and private contractors. Some found themselves trying to implement a policy against the will of their own authority. Many doubted the aggravation and disruption caused by consequential industrial action was worthwhile. The pressure from both the Department of Health and Social Security and Regional Health Authorities was tough and relentless. It was a stern test for the new general managers.

In the end competitive tendering was imposed on the NHS and it did achieve very significant savings. Norman Fowler put the figure at £100m. These savings were not usually achieved through widespread privatisation. Most contracts were awarded and continue to be awarded in-house but it had provided a spur to specialist NHS managers working in concert with NHS staff to review existing working practices and release monies for investment elsewhere in the service. It had served in Enthoven's words as 'an entering wedge for a great deal of managerial improvement'. This was accompanied by a significant re-structuring of the NHS workforce. By 1987, there were 60,000 fewer ancillary workers employed by the NHS than 10 years earlier.

9

GENERAL MANAGEMENT AND PRIMARY HEALTH CARE SERVICES

FAMILY PRACTITIONER COMMITTEES BECOME INDEPENDENT

AS GENERAL MANAGEMENT WAS INTRODUCED INTO THE HOSPITAL and community services, Ministers had been turning their attention to primary health care services in the search for effectiveness.

Upon re-organisation in 1982, professional bodies had been successful in persuading the government, and particularly Dr Gerard Vaughan, the Minister for Health, that the 90 Family Practitioner Committees should not only be retained (one option had been to merge these with District Health Authorities) but that their links with Health Authorities should also be severed. This was justified on the grounds of allowing Family Practitioner Committees to be more active in planning and organisation and development of primary health care services and to enable them to collaborate on equal terms with other agencies. Many, however, saw this pluralistic approach as a retrograde step since it widened the gap between the hospital and community and family practitioner services.

Due to legislative and other delays it was not until April 1985 (three years later) that the new free standing Family Practitioner Committees were formally established. (The proposals were first tabled in the Health and Social Services and Social Security Adjudications Bill of 1983 but the snap election of 1983 and the impending dissolution of Parliament prompted a trade off between the two main parties to get legislation through before the session ended. Labour made the removal of the clauses creating the new Family Practitioner Committees part of its price for allowing much of the Bill to go through unopposed.)

A SERVICE IN NEED OF CHANGE

Primary health care services were amongst the most popular services provided by the NHS but they were beset by problems.

The nation's cervical cytology and immunisation rates and the incidence of preventable diseases such as measles were not impressive. There was serious concern about both the quality and quantity of general practice services in inner city areas, where high numbers of elderly single-handed practitioners and lock-up surgeries were to be found.

General Practitioners continued to act as the 'gatekeepers' to hospital care but by 1985 as David Owen, by now leader of the Social Democratic Party, indicated in a speech at the Institute of Health Services Management conference, although General Practitioners were making only 155 out-patient referrals for every 1,000 patients on their list, compared to 320 in the 1960s, international comparisons showed the NHS had one of the world's most extensive systems of repeat out-patient attendances at consultant clinics.

General Practitioner services were not well integrated with community services provided by District Health Authorities and poor relationships were often to be found between senior nurse management and General Practitioners. Nurses increasingly wanted to practice in geographic patches rather than the more diffuse lists of GPs. Liaison between general practice and the hospital services was also often poor, leading to short-comings in the co-ordination and quality of care, especially for the old and chronically sick.

By 1984 only 28 per cent of GPs were practising from Health Centres. Following the de facto abandonment of the Health Centre policy in the 1970s, GPs were encouraged to raise their own capital to improve their practice premises and were given financial incentives to do so. Although general practice was held high in public esteem, there were many complaints from the public about deputising services, the physical condition of many doctors' surgeries, over-crowded waiting rooms and the lack of basic amenities such as patients' toilets. The restrictions on choice of General Practitioners and the difficulties patients experienced when making complaints, were issues of concern. Complaints

procedures in particular seemed to be stacked in favour of the professional.

Dental practice had changed beyond recognition due to improvements in dental health and the increasing emphasis on preventive care, but general dental practitioner contracts had hardly been altered since 1948.

It was becoming plain that reforms were needed, even though these would be unpopular with the professions engaged in providing primary health care, who fiercely guarded their independence from managerial intervention. The government could no longer allow things to continue in their present state without doing something.

MINISTERS INTERVENE TO CONTROL EXPENDITURE

There was also the problem of rising expenditure on Family Practitioner services. In 1949 the family practitioner services had accounted for 33 per cent of the total NHS budget. By 1980 it had fallen to under 21 per cent however.

Practitioner contracts did not provide incentives or penalties to improve performance and Family Practitioner Committees appeared powerless to influence the direction and quality of service (a view shared by the National Audit Office in 1988).

On 7 October 1982 it had been announced that a firm of Chartered Accountants (Binder Hamlyn) was to study the possibility of cash limiting Family Practitoner Committees (the results of this study were fed into the government's subsequent review of primary care but were never published).

Then, in 1982/83 the health service overspent and the bulk of this occurred on family practitioner services (£100 m).

The 1983 election strengthened the government's arm and within a few weeks of taking office events increased the financial incentives to introduce change. The DHSS was forced to go back on its already published resource assumption for 1983/84 following the Treasury's demand for an immediate cut-back in public expenditure. 'Fowler slams the brakes on NHS growth' ran the *Guardian* headline on 1 July 1983.

In September 1983 a study by the Management Consultants

Arthur Anderson and Company (initially announced in April but delayed due to the election), into the use of computers got underway.

Then in December 1983, plans were announced to place restrictions on the use of deputising services from 1984 onwards.

In October 1984 a pilot scheme was introduced for making dental care payments for children's dental treatment based on capitation fees, intended to promote prevention, but the spotlight fell most fiercely on prescribing and ophthalmic services.

In November 1984, after exploring various ways of controlling medicine costs, Kenneth Clarke, the Health Minister, announced plans to introduce generic prescribing through the creation of a 'limited list' of drugs, used in the treatment of minor illnesses (an idea first put forward by the Royal Commission but rejected by Patrick Jenkin). This led to outcries from both the pharmaceutical industry and General Practitioners. In what Norman Fowler described as 'perhaps the most intense of my health service battles' the Chairman of the British Medical Association General Medical Services Committee urged General Practitioners to write to their MPs and also to enlist the support of patients. 'Once the principle of a limited list is conceded, a two tier system of care within NHS general practice is established'. The list itself was ridiculed as being produced by either 'a Department of Health and Social Security clerk or a doctor who left medicine 30 years ago'. Kenneth Clarke stood firm on the principle but made significant concessions on the list contents. In May 1987 it was reported that savings of £75 m had been achieved, against the target of £100 m. This list was extended further in 1992 when cost, again rose beyond an acceptable limit.

In December 1984 following a report by the Office of Fair Trading the professional monopoly of opticians to sell spectacles was ended with other suppliers allowed to supply them against a recent prescription. This again provoked a national outcry but a number of high streets giants quickly moved into the market and led to a reduction of costs for the consumer. In April 1985 eligibility for NHS spectacles was reduced and from July 1986 NHS supply ceased and was replaced with a voucher scheme. (Eligibility for free eye testing was later restricted from April 1989.)

FAMILY HEALTH SERVICES REVIEWED

But this was only scratching at the surface. In April 1984 Norman Fowler had announced plans for a wide ranging review of Family Health Services . . . 'the first comprehensive review of these services for 40 years' he claimed. He wanted, he said, 'to approach the service from the point of the customer as had already been done with good effect with the opticians'. This was to result in the publication of the consultative document Primay Health *Care—an* Agenda for *Discussion*,[54] in April 1986, which set out proposals to make services more responsive to the consumer; to raise standards of care; promote health and prevent illness; give patients the widest range of choice in obtaining high quality primary health care services; improve value for money and enable clearer priorities to be set for family practitioner services in relation to the rest of the health service.

Neighbourhood Nursing: A Focus for Care (The Cumberlege Report)[55] was issued simultaneously but was to meet with a less than enthusiastic reception, as the proposals to organise nursing services around discrete geographical patches conflicted with the organisation of general medical practice based on Primary Health Care Teams with geographically over-lapping catchments.

Consultation on the proposals lasted until December 1986 and those working in the primary health care services waited for the government's decision. If the Reforms were implemented it would clearly mean a new contract for family doctors and other key professionals like the dentists, but it would also mean a new management style for Family Practitioner Committees to drive them through.

The Griffiths' reforms had not applied to Family Practitioner Committees. They continued to have administrators rather than managers. In addition, they did not report to Ministers through the Management Board though accountability to the centre had been sharpened. From 1985 onwards Family Practitioner Committees were encouraged to modernise their management structures, backed up by a programme of computerisation introduced in 1984 as a result of the Arthur Anderson study completed inJuly of that year. From 1985/6 Family Practitioner Committees were required to produce Annual Programmes and outline strategies every five years. A system of Performance Review was

introduced the same year with some 19 committees each having a Ministerially led formal review and the remainder's programmes being subject to an annual scrutiny by Department of Health and Social Security Officers.

The Family Practitioner Committee Administrator was in the main still primarily concerned with implementing nationally agreed procedures which allowed little local discretion. They also reported to Authorities that had for years been controlled by the professions themselves. Any innovation that was judged not to be in the interests of the contractors did not get very far. There were a few braver souls who saw their role as being much broader and dynamic but they were very much the exceptions to the general rule.

It was, however, becoming increasingly clear that there was a need for a managerial rather than an 'administrative' culture in this vital sector of the NHS. It would need people with somewhat extraordinary skills.

As David Taylor explained in *Re-shaping the NHS*[56] the primary health care system comprises 'thousands of separate actors and millions of individual consumers' but in hundreds of different locations. Nothing could be further removed from managing a large District General Hospital. What was needed was someone capable of securing modern community health services through a giant chain of corner shops run by independent contractors.

People working in the primary health care services were, however, still waiting for the government's decision on their future when Mrs Thatcher announced the date of the next general election . . . 11 June 1987.

THE NHS: A DIARY OF KEY EVENTS

BEFORE THE NHS

In 1919

The Ministry of Health was established—as well as health it was responsible for housing, roads, planning, national insurance, environmental health and local government.

The first Minister of Health was Dr Christopher Addison, first Secretary was Sir Robert L. Morant, Chief Medical Officer was Sir George Newman.

In 1920

In May 'The Dawson Report'[66] was published setting a blueprint for a comprehensive health service.

Sir Arthur Robinson became First Secretary at the Ministry of Health (replacing Sir Robert Morant).

In 1921

The Ministry of Health report[67] was published on the finance of voluntary hospitals (The Cave Committee).

In 1926

The Royal Commission on National Health Insurance reported[68].

'The MacKenzie Report' on the *Hospital Services of Scotland* proposed the planning of hospital services based on five regions.

In 1929

The Royal College of Obstetricians and Gynaecologists was established.

In 1935

Sir Arthur S. MacNalty became Chief Medical Officer at the Ministry of Health (replacing Sir George Newman).

In 1936

Sir George Chrystal became First Secretary at the Ministry of Health (replacing Sir Arthur Robinson).

In 1937

Political and Economic Planning *Report on the British Health Services*[99] was published advocating that medical and allied services be separated from social insurance and the Poor Law and supported from general public funds. It describes "a bewildering variety of agencies, official and unofficial, created during the past two or three generations to work for health mainly by attacking specific diseases and disabilities as they occur."

The Sankey Commission (set up by the British Hospitals Association) reported[100] recommending re-organisation of voluntary hospitals on a regional basis with co-ordinating hospital regional councils.

In 1938

The British Medical Association published *A General Medical Service for the Nation*.

A senior official at the Ministry of Health commented to the First Secretary that a 'national scheme is legislatively impracticable and administratively not worthwhile'.

In 1939

The Nuffield Provincial Hospitals Trust was founded to promote 'co-ordination on a regional basis of hospital and ancillary medical services'. It began to establish regional and divisional councils representing both voluntary and Local Authority hospitals with a view to eventual consolidation into a national hospital service.

The war-time emergency medical service was established bringing voluntary and local authority hospitals under the direction of

central government departments and in effect organising them on a regional basis.

In 1940

Sir John Maude (an experienced National Health Insurance Commission and Ministry of Health civil servant) became First Secretary and Sir Wilson Jamieson (a GP) became Chief Medical Officer (replacing Sir George Chrystal and Sir Arthur MacNalty respectively).

In 1941

In June Sir William Beveridge was appointed to chair an inter-departmental committee to look into existing national insurance schemes and allied services and make recommendations.

In 1942

In June 'The Beveridge Report'[30] was published. It identified health as one of the 3 basic services (with family allowances and full employment) which are a necessary pre-requisite to social security.

The Association of Clerks and Stewards of Mental Hospitals and the Incorporated Association of Hospital Officers amalgamated to form the Institute of Hospital Administrators.

In 1944

The White Paper *A National Health Service*[31] was published by the war-time coalition government. It proposed local bodies to administer local authority hospitals and determine 'compensation' for voluntary hospitals' participation in the system.

The Report[32] was published from a Committee, chaired by Sir William Goodenough (also Chairman of the Nuffield Provincial Hospitals Trust), which looked into the organisation of medical schools with particular regard to facilities for clinical teaching and research.

In 1945

Labour won the General Election, Clement Attlee became Prime Minister and Aneurin Bevan became Minister of Health.

In 1946

Sir William Scott Douglas became First Secretary of the Ministry of Health (replacing Sir John Maude).

Bevan published a further White Paper[93] on establishing a national health service.

In March the National Health Service Bill was published proposing nationalisation of hospitals and a tri-partite structure.

In May the Ministry of Health and the Department of Health for Scotland published the *Report of the Inter-Departmental Committee on the Remuneration of General Practitioners* (The Spens Report)[94] recommending a central pool for GP payments which would be a combination of capitation fee, fixed allowance for practice expenses and item of service payments.

On 6 November the National Health Service Act became law:–

- promoting 'the establishment in England and Wales of a comprehensive health service designed to secure improvements in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness;
- setting up the Central Health Services Council, a body of professional and public representatives to advise the Minister.

In 1947

The Secretary of State began to appoint[103] the chairmen and members of Regional Hospital Boards including members to represent the relevant university, the medical profession and the relevant local health authorities.

Regional Hospital Boards prepared, for the Minister's approval, schemes for the appointment of Hospital Management Committees responsible for the day-to-day management of a hospital or group of hospitals.[101]

The National Health Services (Scotland) Act[102]

* made no separate provision for the management of teaching hospitals so they were under the jurisdiction of regional hospital boards and grouped under boards of management.

The Ministry of Health and the Secretary of State for Scotland drew up a scheme for a central joint body covering pay and conditions of service for the whole NHS and for separate negotiating bodies for the main groups of staff - the General Whitley Council and the 9 functional Whitley Councils.

BUPA (The British United Provident Association) was founded.

THE 1940s & 50s

THE SERVICE IS ESTABLISHED

In 1948

The Ministry of Health and the Department of Health for Scotland published 'The Spens Report' *Interdepartmental Committee on the Remuneration of Consultants and Specialists*[103] recommending part-time contracts and distinction awards for consultants.

On 5 July 1948 the NHS officially began.

> Government publicity for the new service included a leaflet called *The New National Health Service* which was delivered to virtually every household in Britain, a radio speech by Clement Attlee (the Prime Minister) on Sunday 4 July and a large advert in *The Times* headed 'This Day Makes History'.

In 1949

The National Health Service (Amendment) Act[104] *inter alia*, allowed doctors to use health centre facilities for treating private patients, introduced charges for non-UK residents and gave powers for the introduction of prescription charges by regulation.

In 1950

Sir Cyril Jones was appointed by Bevan to make an independent examination of the financial administration of the NHS. His report was circulated in July making recommendations about

streamlining hospital administration and in particular that RHBs should adopt an advisory role with the Ministry of Health having more direct contact with HMCs. (In fact the report was never implemented.)

The Chancellor of Exchequer imposed a ceiling on NHS expenditure.

In January the Ministry of Health tried to stem a growing financial crisis by intervening to control HMCs' wage bills.[118]

In March the Central Health Services Committee established a committee (the Bradbeer Committee)[1] to consider the internal administration of hospitals.

In June Dr John A. Charles was promoted from Deputy to Chief Medical Officer of the Ministry of Health (replacing Sir Wilson Jamieson). He was a former Medical Officer of Health for Newcastle-on-Tyne.

In 1951

J. M. K. Hawton became First Secretary of the Ministry of Health (replacing Sir William Scott Douglas).

In January Hilary Marquand was appointed Minister of Health, Bevan having moved to the Ministry of Labour because of his opposition to emerging Government policy on NHS charges.

In the spring the Ministry of Health lost its responsibility for local government housing and consequently its cabinet seat and Whitehall offices.

In April the Hospital Administrative Staff College (established by King Edward's Hospital Fund for London in late 1949/early 1950) began its first course.

In April Aneurin Bevan resigned from the government over the imposition of NHS charges, as did Harold Wilson (future Prime Minister and then President of the Board of Trade).

In May NHS charges were introduced for the first time—£1 for spectacles and half the actual cost for a pair of dentures.

In October the Conservatives won the General Election and

Harry Crookshank was appointed Minister of Health. (Health temporarily regained its cabinet seat because Crookshank was also Leader of the House.)

In 1952

The Royal College of General Practitioners was founded.

In May Iain MacLeod was appointed Minister of Health in a Cabinet re-shuffle.

From 1 June charges were introduced for dental treatment (a flat rate fee of £1) and drugs (1s (5p)) per prescription form.

In 1953

The NHS took over hospitals run by the Ministry of Pensions for treating war pensioners.

In April Iain MacLeod announced to the House of Commons the establishment of the Guillebaud Committee. (Chaired by Claude W. Guillebaud, a Cambridge economist, and including in its membership Sir John Maude a former First Secretary to the Ministry of Health.)[4]

In 1954

The Willink Committee was established to estimate the long-term need for doctors. (The Committee reported in 1957).[10]

In February a Royal Commission was appointed (chaired by Lord Percy of Newcastle) to consider the law relating to mental illness and mental deficiency.

In October 'The Bradbeer Report'[5] was published.

In 1955

In May a General Election returned the Conservatives with an increased majority. Iain MacLeod remained as Minister of Health.

In December Robert Turton (later Baron Tranmire) was appointed Minister of Health in a major Cabinet reshuffle.

In 1956

The National Training Scheme was introduced for administrators aimed at promising young staff, graduates and others with professional qualifications.

The McNair Committee on Recruitment to the Dental Profession reported on ways of increasing the number of candidates for dental training.

In January the Guillebaud Committee reported[4] on NHS finances and defended both the costs and the structure.

In April, as recommended by Guillebaud, the Ministry of Health set up a committee (under Lord Cranbrook) to look into maternity services.[107]

In 1957

A Royal Commission was established on Doctors' and Dentists' pay chaired by Sir Harry Pilkington.[108] (It reported in 1960)

In January Dennis E. Vosper was appointed Minister of Health following the cabinet reshuffle after Anthony Eden's resignation as Prime Minister.

In May the Royal Commission on the law relating to mental illness and mental deficiency reported.

In June the Hinchcliffe Committee was established to report on the cost of prescribing.[110]

In September Derek Walker-Smith was appointed Minister of Health when Dennis Vosper resigned due to ill-health.

In December Noel Hall reported[7] to the Minister for Health on the grading structure of administrative and clerical staff.

In 1958

The Voluntary Price Regulation Scheme was negotiated between the government and the drug industry which related the prices of prescribed medicines to their prices in overseas markets.

In 1959

The Ministry responded to Noel Hall's 1957 report by revising

promotion and appointment procedures for administrative and clerical staff. Appointment committees were to include outside assessors identified by the newly established Regional Staff Advisory Committees.

The Mental Health Act 1959[8] (Mental Health (Scotland) Act 1960):

- abolished the legal distinction between psychiatric and other hospitals allowing any patient to be admitted/discharged by any hospital for psychiatric treatment without formality
- ended the need for chief officers of psychiatric hospitals to be medically qualified
- encouraged development of care in the community

In February 'The Cranbrook Report'[107] on maternity care was published criticising the divisions in service provision which were causing duplications and omissions. (A separate report 'The Montgomery Report'[109] was published on services in Scotland).

In May the Hinchcliffe Committee made its final report[110] concluding that 'while there is no evidence of widespread and irresponsible extravagance in general practitioner prescribing, there is scope for economy'.

THE 1960s

GROWTH AND DEVELOPMENT

In 1960

Enoch Powell was appointed Minister of Health (replacing Derek Walker-Smith).

The Royal Commission on Doctors' and Dentists' pay (appointed in 1957) reported[108], recommending an increase in pay and the establishment of a special review body to advise on their pay in the future. (The Pilkington Report).

In 1961

The Public Expenditure Survey Committee system was established.

A revised Voluntary Price Regulation Scheme was agreed with

the drug industry, providing for direct price negotiation based on the supplying companies' overall profitability.

Sir Bruce Fraser became Permanent Secretary at the Ministry of Health (replacing J. M. K. Hawton).

In March the Ministry of Health and the Department of Health for Scotland published a report[111] on medical staffing in the hospital service.

In 1962

'The Porritt Report'[10] (from a committee established by the medical profession and representing medical institutions such as the Royal Colleges and the BMA) was published suggesting re-organisation to create a more unified NHS—under a series of Area Health Boards but with teaching hospitals retaining their Boards of Governors and direct access to the Minister.

Sir George Godber became Chief Medical Officer at the Ministry of Health (replacing Dr John A. Charles).

The Royal College of Pathologists was founded.

In January the Minister of Health appointed a committee under the chairmanship of Sir Stephen Lycett Green Bt (Chairman of the East Anglian RHB) to 'enquire into the present arrangements for recruitment, training and promotion of administrative and clerical staffs in the hospital service, and to make recommendations'. (This report was completed in 1963).[8]

In January Enoch Powell's '*Hospital Plan for England and Wales*'[81] was published which made the first moves towards more rational planning and mooted the replacement of groups of hospitals by large DGHs. (A similar document[112] was also published for Scotland).

In September a sub-committee of the Central Health Services Council reported on the organisation of emergency services recommending, inter alia, that the term 'casualty service' be replaced with 'Accident and Emergency service' and that A&E units should not normally serve populations of less than 150,000.

In October a committee was set up under W. M. Farquharson to consider hospital administrative practices in Scotland.[10]

In 1963

Nursing homes were brought under registration and some control by Local Authorities under the Nursing Homes Act 1963.[11]

The London Government Act established local health authorities in Greater London.

The Doctors' and Dentists' Review Body was established to take over the functions of the Medical and (Hospital) Dental Whitley Council.

Health & Welfare: The Development of Community Care[14] was published—a collection of the 10 year development plans of 146 local health and welfare authorities.

Anthony Barber was appointed Minister of Health (replacing Enoch Powell).

The Committee on Safety of Drugs was established, chaired by Sir Derrick Dunlop.

The Ministry of Health published *The Field of Work of the Family Doctor* 'The Gillie Report'[15] which recommended the development of the primary health care team.

In September the Lycett Green Committee (appointed in January 1962) reported[9] recommending a national, co-ordinated approach to administrative and clerical recruitment and training to meet the long-term needs of the service.

In 1964

In October Labour won the General Election, Harold Wilson became Prime Minister and Kenneth Robinson was appointed Minister of Health (replacing Anthony Barber).

In 1965

GPs threatened mass resignation from the NHS because of 'poor material recognition'. (Around 17,800 doctors signed undated resignations forms).

Regional Staff Committees were established (not part of Regional Hospital Boards) and Regional Staff Officers were appointed. These replaced and extended the work of the Staff Advisory Committees set up in 1959.

The Committee of Inquiry into the Relationship of the Pharmaceutical Industry and the National Health Service (the Sainsbury Committee) was established.

In March *A Charter for the Family Doctor Service* was published in the *BMJ* lobbying for a revised scheme of payments to encourage better practice management (support staff) and premises, the scrapping of the pool system and an independent corporation to make loans to GPs for building or improving practice premises.

In 1966

A Committee was appointed under Sir Desmond Bonham-Carter to consider the concept of the DGH.

The National Health Service Act 1966 established and set out the functions of the General Practice Finance Corporation (suggested in the 1965 Doctors' Charter) to make loans to GPs buying, building or improving premises.

The Royal Commission on Medical Education (set up in 1965 and chaired by Lord Todd) published an interim report recommending an increase in the number of medical students.

Sir Arnold France became Permanent Secretary at the Ministry of Health (replacing Sir Bruce Fraser).

The Joint Working Party on the Organisation of Medical Work in Hospitals was set up to discuss the progress the NHS had made and in particular review the hospital service. They produced the 'Cogwheel' reports, so called for the design printed on their covers.[21,43,128]

In February the *Review of the Hospital Plan for Scotland* was published.

In February the report of the Farquharson-Lang Committee was published.[129]

In May the report of the Committee on Senior Nurse Staffing Structure[20] (the Salmon Committee) was published. The main

conclusion was that nursing officers should perform duties according to their grade. A ten graded structure was recommended as was a single head covering nursing, midwifery and nurse education.

In June the Ministry of Health published a revised *Hospital Plan*[115]—scaling down the hospital building programme and giving more reliable (higher) costings.

In September the National Board for Prices and Incomes was asked to look at pay and conditions for public sector manual workers, including NHS staff.

In 1967

The National Nursing Staff Committee was established to advise on management training for nurses and midwives. It also considered selection and appointment procedures.

The National Health Service (Family Planning) Act allowed the provision of services in connection with family planning by Local Authorities as part of the NHS. (No equivalent for Scotland).

The King's Fund report *The Shape of Hospital Management in 1980*[1] was published proposing a clearer administrative chain of command with the appointment of a general manager and a medical director and a reduction in the number of committees.

Sans Everything (a quote from *As You Like It*) compiled by Barbara Robb was published. She described it as 'an indictment of the frightening conditions endured by elderly patients in some of our Government Institutions today.'[116]

The Sainsbury Committee (established in 1965) published its report[117] recommending the creation of a medicines commission and various measures to monitor and control drug company profits.

In March the National Board for Prices and Incomes concluded its review and published its report[118] concluding that Local Authorities and the NHS had large concentrations of staff whose pay was among the lowest in the country and recommending that productivity agreements be devised as a way of improving their lot.

In August *The News of the World* published allegations of ill-treatment of patients and theft at a mental hospital which was later identified as the Ely Hospital in Cardiff.

In October the first 'Cogwheel report'[22] was published. It recommended the creation within hospitals of clinical divisions of broadly linked specialties to ensure efficient sharing of resources. The divisions would be represented on a medical executive committee which would co-ordinate their activities and provide links to nursing and administration.

On 6 November Kenneth Robinson, the Minister of Health announced to the House of Commons that he was examining the administrative structure of the NHS.

In 1968

The Health Services and Public Health Act became law, allowing:

- accommodation and treatment of private patients with fixed accommodation charges
- designation of certain hospitals as university hospitals to be managed by HMCs and Regional Hospital Boards and with a duty to provide facilities for clinical teaching and research
- health visitors to operate in locations other than the client's home thus allowing them to run clinics
- approval of expenditure of HMCs, medical education committees and boards of management by Regional Hospital Boards instead of Ministers

The Medicines Act created the Medicines Commission which in turn set up a Committee on the Safety of Medicines.

The Seebohm Committee on Local Authority and allied personal social services reported, recommending the establishment of social services departments within local authorities taking on many of the tasks of the local health authorities e.g. children's services.[19]

The Report of the Royal Commission on Medical Education 'The Todd Report'[28] was published recommending:

- teaching hospitals in England and Wales should come within the administrative framework of the regional hospital service
- the constitution of Regional Hospital Boards throughout

Great Britain should be modified to provide representation of universities concerned with medical teaching
- London teaching groups should be reduced by half through amalgamation and the post-graduate teaching hospitals should be associated with them
- systematically planned programmes for post-graduate training

In July Kenneth Robinson's Green Paper[19] on NHS re-organisation was published. (A similar paper was published in December for Scotland.) Both proposed the replacement of the tripartite division of health services by area boards (40–50 for England and Wales), combining the responsibilities of Regional Hospital Boards, Hospital Management Committees, Local Authority personal health services and the contractual arrangements made by the Executive Councils.

On 1 November the Ministries of Health and Social Security were amalgamated to form the Department of Health and Social Security. Richard Crossman became the first Secretary of State for Social Services—Health regained its cabinet seat.

In 1969

'*Put Away*' was published, a study by Pauline Morris on services for mentally handicapped people.

The National Health Service (Functions of Regional Hospital Boards etc) Regulations gave HMCs the power to appoint and dismiss their own officers other than senior medical and dental staff.

The Redcliffe Maud Commission on local government reported[20], recommending three metropolitan authorities containing 20 metropolitan district authorities outside London and 58 unitary authorities in the rest of England. They also felt that Local Authorities should take over responsibility for the NHS.

The Hospital Advisory Service was established following a series of scandals (eg Ely) about the ill-treatment of patients in long-stay hospitals.

Alan Marre became Permanent Secretary at the DHSS (replacing Sir Arnold France).

The Mayston Report[11] was published recommending structured management arrangements for the Local Authority community nursing services (similar to those recommended by Salmon for hospital nurses) and attachment of community nurses to GP practices.

In March the report was published of the *Committee of Inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital, Cardiff.*[17] (Chaired by Geoffrey Howe, later Chancellor and Foreign Secretary.)

On 1 April responsibility for the NHS in Wales transferred from the Welsh Board of Health to the Secretary of State for Wales.

In October 'The Bonham Carter Report'[15] on DGH functions was published by the Central Health Services Council. It recommended larger DGHs than first envisaged with at least two consultants in each specialty.

THE 1970s

RE-ORGANISATION, CONFLICT, RESTRAINT

In 1970

The Local Authority Social Services Act put the 1968 Seebohm Committee reforms on to the statute books.

Sir Clifford Jarrett became First Permanent Secretary at the DHSS (replacing Alan Marre).

The Noel Hall Report on Pharmaceutical Services was published.[140]

The Royal College of Nursing conducted a pay campaign under the slogan 'raise the roof' and achieved a wage rise of 22 per cent.

In February Richard Crossman's Green Paper[13] on NHS re-organisation was published. Amending Robinson's 1968 proposals by doubling the number of area boards to fit in with local government arrangements, re-introducing the idea of regional planning

boards and suggesting, within the larger area boards, local 'district' committees to involve the community and health service workers in running the NHS. However, the chain of command was to run from the Minister direct to Area Boards with Regions in an advisory role only.

In March the Briggs Committee was established under Professor Asa Briggs to consider the role of the nurse and the midwife and the training and education required.

In April a Green Paper was published on re-organisation for Wales[21] proposing seven Area Health Boards directly responsible to the Secretary of State but no regional board. There were to be district authorities within the Areas but technical and common services were to be provided on an 'all Wales basis'.

In May HMSO published *Hospital Building Maintenance*—'The Woodbine Parish Report'[22]—criticising hospital maintenance standards and a lack of any overall strategy for the development of health service estates.

In June the Conservatives won the general election. Keith Joseph replaced Richard Crossman as Secretary of State for Social Services.

In 1971

A working party was set up of local government, DHSS and NHS representatives to make recommendations on the detailed implications of the proposed re-organisation. (The Working Party's sub-committees made recommendations which were incorporated into the 1973 Re-organisation Act including JCCs).

'The Harvard Davies Report'[23] was published on GP Group Practices.

The White Paper *Better Services for the Mentally Handicapped*[24] was published containing a 20 year plan for re-patterning services on a local basis.

Flat-rate charges for spectacles and dentures were replaced by broadly cost-related charges (maximum £3.50 per lens).

The Royal College of Psychiatrists was established.

In April the report was published of the Farleigh Hospital Committee of Inquiry[13] arising out of allegations of ill-treatment which led to three nurses being convicted of cruelty.

In May the DHSS published *The National Health Service Re-organisation: Consultative Document.*[14] Two months were allowed for comment so that legislation could be brought forward in time for implementation on 1 April 1974.

In June the Welsh Office published a similar document for Wales.

In July a White Paper was published on re-organisation of the Scottish health services.

In 1972

The National Health Service Staff Commission was established to handle the arrangements for the recruitment and transfer of staff arising from the re-organisation.

'The second Cogwheel Report'[18] was published dealing with the implementation of Cogwheel systems and identifying the essential elements for their success.

DHSS published the first draft of the *Estate Management Practices Code* (Estmancode) containing advice on planning, costing and executing maintenance work on NHS premises.

Ancillary staff completely withdrew their labour in a series of strikes during a pay campaign - the dispute rumbled on into 1973.

In February the report was published of the Committee of Inquiry into Whittingham Hospital[15], arising out of allegations of ill-treatment of patients and theft.

In June 'The Hunter Report'[12] was published of the Working Party of Medical Administrators.

In August Keith Joseph's White Paper *National Health Service Reorganisation: England*[22] was published, proposing 14 Regional Health Authorities in a direct management line between the Secretary of State and AHAs, no district committees but a CHC in each district, Joint Consultative Committees with Local Authori-

ties, specialists in community medicine. A similar document was also published for Wales.

In September *Management Arrangements for the Re-organised National Health Service* (The Grey Book)[16] was published. A similar document was also published for Wales.

In October the Briggs Committee report[17] was published on nurse training and education, recommending that all students undertake the same basic course and new statutory bodies to control the nursing, midwifery and health visiting professions.

In 1973

The report was published of the professional investigation into medical and nursing practices at Napsbury Hospital near St Albans. It arose following an increased number of complaints about the hospital and the death of a patient—Mrs Sophie Green—in January 1972.

In July the report was published from the Working Party on collaboration between the NHS and Local Authorities.[18]

On 5 July the National Health Service Re-organisation Act was given Royal Assent on the 25th anniversary of the NHS being established.

In 1974

The National Staff Committee introduced the Specialist Finance National Training Scheme.

Sir Henry Yellowlees became Chief Medical Officer at the DHSS (replacing Sir George Godber).

'The third Cogwheel Report'[19] was published clarifying the role of the Cogwheel System in the re-organised NHS.

The Trade Union and Labour Relations Act became law.

The Health and Safety at Work Act obliged health authorities to establish Health and Safety committees and empowered Health and Safety Executive Inspectors to close mortuaries, laboratories and operating theatres if they considered them unsafe.

Nurses campaigning for more pay refused to safeguard patient care.

In February the General Election gave no party a clear majority. Prime Minister Heath resigned and Barbara Castle was appointed Secretary of State for Social Services with David Owen as Minister in the resulting Labour government.

In March the *Report of the Committee on Hospital Complaints Procedure* was published 'The Davies Report'.[127]

On 1 April the NHS was re-organised:

- local authority involvement in health care provision was restricted to environmental services, e.g. district nursing, vaccination and immunisation, school health services became the responsibility of health authorities
- 14 Regional Health Authorities were created to manage 90 Area Health Authorities managing 206 District Management Teams
- Executive Councils were effectively retained for GP services with the creation of Family Practitioner Committees co-terminous with and set up by Area Health Authorities
- teams of managers were introduced at District, Area, and Regional levels involving the professions as well as administrators
- consensus management was introduced
- teaching hospitals were integrated into the unified structure
- Community Health Councils were formed
- Local Authority members were appointed to Health Authorities
- a comprehensive new planning system was introduced of 10 year strategic plans and three year rolling operational plans
- the Health Service Commissioner (ombudsman) was established to investigate complaints against health authorities
- Joint Consultative Committees were established to promote better awareness and co-operation between Local Authorities and health authorities

In May Barbara Castle's consultative document *Democracy in the National Health Service*[58] was published and resulted in the inclusion of local government representatives on RHAs and an increase in

their number on AHAs and powers for CHCs regarding the approval of hospital closures.

In May the report was published from the Committee of Inquiry into South Ockendon Hospital[128] (arising from allegations of mis-treatment of patients allegedly contributing to the death of a patient—Robert Robertson—in 1969.)

In June the Halsbury Committee was established (as a result of the nurses' dispute) to investigate the pay and conditions of nurses, midwives, speech therapists and professions supplementary to medicine. (The report on nurses and midwives was issued in 1974 but that on PSMs was not published until 1975).[29,30]

In August the DHSS published *Community Hospitals—their role and development in the National Health Service*[129] proposing a future for small hospitals to serve patients not requiring the high technology of the DGH.

In September the Halsbury Committee reported[29] on nurses and midwives pay and conditions giving substantial pay rises.

In October there was a second General Election which Labour won but with a working majority of only three.

In November the doctors began an industrial dispute over pay, hours and 'pay beds'.

In 1975

The Halsbury Committee reported[30] on PSMs and speech thera-pists and gave them substantial pay rises.

In furtherance of their dispute with the government, hospital consultants began working strictly to contract.

The White Paper *Better Services for the Mentally Ill*[46] was published suggesting the establishment of local networks including DGH psychiatric units, ESMI services in community hospitals, day hos-pitals and out-patient services.

The Employment Protection Act became law.

In March the DHSS published a handbook *Guide to Planning in the National Health Service*[130], setting out the detailed tasks necessary in

each level of the structure and explaining the concepts of annual and strategic planning.

In April doctors were given pay rises averaging 30 per cent.

In August the Government published *The Separation of Private Practice from National Health Service Hospitals*[21] fuelling the 'pay beds' dispute with the doctors. NUPE joined in by asking its members to refuse to service private beds in NHS hospitals.

In October Harold Wilson announced a Royal Commission on the NHS would be established.

In 1976

The DHSS published *The NHS Planning System* implementing the 1975 *Guide to Planning in the NHS*.

The Health Services Act 1976 came into force. It was ostensibly aimed at reducing the number of private beds in NHS hospitals but it was also intended to placate the consultants by allowing and protecting some private practice.

Joint Finance funds were introduced to allow NHS funds to be used in collaborative projects with Local Authority social services.

A Committee was established to consider resource allocation in Scotland, chaired by Professor R. A. Smith.

Lord McCarthy's report *Making Whitley Work* was published.[22]

The DHSS announced its nucleus hospital design concept.

A working party on inequalities in health was established, chaired by Sir Douglas Black.

Prevention and Health: Everybody's Business[23] was published.

The National Development Team for the Mentally Handicapped was established.

The Hospital Advisory Service was restructured to form the Health Advisory Service.

Sir Patrick Nairne became Permanent Secretary at the DHSS (replacing Sir Clifford Jarrett).

The Trade Union and Labour Relations (Amendment) Act became law.

In March *Priorities for Health and Personal Social Services in England* was published[18]—a consultative document setting out a planning system for allocation of resources in England (a similar document was issued for Wales). Greater emphasis was to be placed on preventive services and community care and the scope for rationalisations in acute care were stressed. Barbara Castle wrote in the document 'choice is never easy, but choose we must'.

In April Denis Healey (Chancellor of the Exchequer) introduced the concept of cash limits into government financial planning in his Budget.

In April Harold Wilson resigned as Prime Minister and was replaced by James Callaghan.

In April David Ennals was appointed Secretary of State for Social Services (replacing Barbara Castle).

In May a strike began at Normansfield Hospital in Middlesex which was to lead to one of the most highly publicised public inquiries of the decade.

In May the Royal Commission on the National Health Service (announced by Harold Wilson the previous October) was established chaired by Sir Alec Merrison, Vice Chancellor of Bristol University.

In May the report,[16] commissioned by David Owen (then Minister of Health) from three regional chairmen, was published recommending a strengthened role for Regions and a thinned Department of Health.

In September the main report (of the Resource Allocation Working Party[35]) was published.

In 1977

The Bolton Hospital Story (a fly-on-the-wall documentary of daily hospital life) was screened on prime time TV.

The Department of Trade and Industry published the report of

the Committee of Inquiry into Industrial Democracy.[98] (The Bullock Report).

The Voluntary Price Regulation Scheme for drugs was replaced by the Pharmaceutical Regulation Scheme which placed stringent controls on the content of drug advertisements and obliged companies to submit forecasts of profits on their sales to the NHS.

The DHSS published the *Handbook on Land Transactions*.

The National Health Service Act became law. It largely consolidated previous legislation but also gave the government the power to set up Special Health Authorities.

In April the Health Services Board was established to phase out private beds in a manner agreeable to both the Labour government and the hospital consultants.

In August the Association of Community Health Councils was formed.

In September *The Way Forward*[99] was published, revising guidance on the planning system; less specific than the Priorities document about rates of increase in services and time scales but still encouraging debate about priorities.

In September *SHARE: Scottish Health Authorities Revenue Equalisation* was published.[100]

On 11 October Health Service officials 'raided' the Hounslow Hospital to remove 21 elderly patients to the West Middlesex Hospital to end a 'work-in' by nurses aimed at averting closure of the ward. (This received wide publicity at the time and became known as The Hounslow Raid).

In 1978

Sir Alan Marre completed his investigation into the connection between the drug thalidomide and congenital deformity in babies.

The WHO and United Nations Children's Fund sponsored a conference in Alma Ata which produced the *'Declaration of Alma Ata'* and *Health For All* with international targets.

In October the National Staff Committee produced a consultative

document[87] on future recruitment and career development for administrative and clerical staff.

In November *Grasping the Nettle*[87] was published – the Report of the Committee of Enquiry into Normansfield Hospital highlighting failings in local, area and regional management which seemed to encapsulate all the failings of consensus management.

In late 1978 a period of sustained industrial unrest began in Britain which came to be known as the 'winter of discontent'. The NHS faced another strong pay campaign from ancillary workers.

In 1979

Professor Roger Dyson was appointed as Special Adviser to Patrick Jenkin.

The Secretary of State tried to replace the members of Lambeth, Southwark and Lewisham AHA(T) with Crown Commissioners because of their refusal to implement spending cuts but this was ruled illegal by the Courts.

New contracts were negotiated with consultants giving them greater freedom to practice privately and leaving their employment contracts with the Regions.

The first Report of the Standing Commission on Pay Comparability was published 'The Clegg Report'.[138]

In May the Conservatives won the General Election. Margaret Thatcher became Prime Minister and Patrick Jenkin was appointed Secretary of State for Social Services (replacing David Ennals).

In July the Royal Commission on the National Health Service reported[87] but the government later published its own plans for further health service re-organisation.

In the autumn the DHSS wrote to health authorities advising them of the potential advantages of contracting out domestic work.

In December the DHSS published *Patients First*[3] in response to the Royal Commission:

- strengthening management at local level

- removing the area tier and establishing DHAs
- simplifying professional advisory machinery
- simplifying the planning system

In December a similar White Paper was published in Scotland proposing that areas be retained but usually with single districts and with no regional organisation.

THE 1980s

MANAGEMENT & MARKETS

In 1980

Inequalities in Health[25] (The Black Report) was published.

The Employment Act became law banning secondary picketing and limiting picket line numbers to six.

The Health Services Act:

- dissolved the Central Health Services Council (the Ministers' advisory body)
- dissolved the Health Services Board which had been established to phase out private beds in the NHS
- disbanded the Area Health Authorities and created 192 new District Health Authorities in their place

The DHSS published *Organisational and Management Problems of Mental Illness Hospitals* ("The Nodder Report"[136]) advocating a more structured approach with annual objectives and routine monitoring.

In February the DHSS set up a Steering Group on Health Services Information headed by Edith Körner, former vice-chair of South Western RHA.

In May the DHSS published the *Hospital Services: Future Pattern of Hospital Provision in England*[35] proposing that DGHs should not normally exceed 600 beds and that smaller hospitals should be retained where possible.

In 1981

The DHSS published *Care in Action: A Handbook of Policies and Priorities for the Health and Personal Social Services in England.*[17]

'The Harding Report'[18] was published on *Primary Health Care Teams.*

Norman Fowler was appointed Secretary of State for Social Services (replacing Patrick Jenkin), and Kenneth Clarke, Minister of Health.

During the 1981–82 financial year efficiency savings/Cost Improvement Programmes were introduced.

In 1982

Sir Kenneth Stowe became First Permanent Secretary of the DHSS (replacing Sir Patrick Nairne).

The 13 unions on the TUC Health Services Committee waged a long campaign for a 12 per cent pay rise which attracted widespread support from other workers.

In January the Secretary of State announced (in response to a Parliamentary Question) the organisation of annual review meetings with Ministers, RHA Chairmen and Regional officers following pressure from the Public Accounts Committee to strengthen NHS accountability to Parliament. He also announced that Performance Indicators would be developed.

In March the DHSS announced the experimental use of private firms to audit health authority accounts.

In March the DHSS announced an inquiry aimed at 'identifying under-used and surplus land and property and where appropriate disposing of it'—'The Ceri Davies Report'.[19]

On 1 April the NHS was re-organised again (from the 1979 White Paper and 1980 Health Services Act):

- the area tier was abolished
- districts became the main operational authorities
- the 'unit' was established as the local management tier
- professional consultation, and
- planning procedures were pruned.

In April the DHSS announced the extension of Rayner scrutinies to the NHS.

In August a review of NHS audit arrangements was announced.

In October the DHSS announced that a firm of accountants was to look into the possibility of cash-limiting FPCs (the results were fed into the review of primary care).

In November the first report[41] was published from Edith Körner's steering group (set up in 1980) on health service information.

In 1983

Health Care and Its Costs[177] was published, showing that NHS productivity had grown faster than its resources between 1976 and 1981.

The NHS Training Authority was established.

The Mental Health Act appointed 85 commissioners specifically to defend the individual rights of patients.

The Pay Review Body for Nurses and Midwives was established.

In January the DHSS announced central control of NHS manpower numbers.

In February Norman Fowler announced the establishment of Roy Griffiths' Management Inquiry.

In June the Conservatives won a landslide victory in the General Election. Margaret Thatcher was Prime Minister and Norman Fowler remained as Secretary of State for Health & Social Security.

On 1 July the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) was established under powers contained in the 1979 Nurses Act.

In August the review of NHS audit arrangements (announced in 1982) was published recommending more emphasis on 'Value for Money' (VFM).

In September the Government instructed Health Authorities to

test the efficiency of their support services (eg hospital cleaning) by putting them out to tender in the open market.

In September the first set of Performance Indicators was published.

In October 'The Griffiths Report'[illegible] on NHS management was published recommending:

- establishment at the Centre of a Health Services Supervisory Board and an NHS Management Board
- appointment of a Director of Personnel to the NHSMB (Len Peach was the first)
- regional and district chairmen to extend the accountability review process through to unit level
- identification of individual general managers for each unit of management
- introduction of management budgeting relating work-load and service objectives to the available financial and manpower resources and involving clinicians in this

In November 'The Ceri Davies Report'[illegible] on NHS land use was published.

In 1984

The process of annual accountability review was extended to Units.

In April the Government announced a wide ranging review of family health services.

In June the DHSS published the circular on implementation of the Griffiths Report. (Regions had to have general managers by the end of September 1984 and district and units by the end of 1985).

On 9 July David Kenny was appointed RGM at North West Thames RHA becoming the first general manager to be appointed.

In August there was a major outbreak of salmonella at the Stanley Royd Hospital in Yorkshire.

In November the 'limited list' of drugs was introduced, aimed at

reducing the NHS drugs bill by encouraging more generic prescribing.

In December the opticians' monopoly on selling spectacles was ended.

In December Central Manchester Health Authority published a report from management consultants on income generation and offered it for sale at £100 per copy.

In 1985

The United Kingdom Central Council established the Project 2000 Group 'to determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990s and beyond and to make recommendations'.

John Major was appointed Parliamentary Under Secretary of State for Social Security.

Donald Acheson became Chief Medical Officer at the DHSS (replacing Sir Henry Yellowlees).

The Nuffield Provincial Hospitals Trust published Professor Enthoven's *Reflections on the Management of the NHS*.

The Department issued a circular, requiring action plans for managing staff accommodation.

In January Victor Paige was appointed as Chair of the NHS Management Board.

From 1 April, under the Health and Social Security Act 1984, FPCs became employing authorities in their own right, with direct funding from the DHSS and could appoint members to JCCs. They had to produce Annual Programmes and five year strategies and became subject to accountability review.

In 1986

The report was published of the inquiry into the outbreak of salmonella poisoning at the Stanley Royd Hospital[52] – the report criticised management at all levels from the hospital to the RHA.

The Management Accountancy Framework was introduced.

In April the Green Paper *Primary Health Care: An Agenda for Discussion*[24] was published.

In April *Neighbourhood Nursing—A Focus for Care* (The Cumberlege Report)[25] was published—a review of community nursing.

In June Victor Paige resigned as Chairman of the NHS Management Board. Len Peach was appointed in his stead.

In July the supply of free NHS glasses ceased and was replaced by a voucher scheme.

In September the NHS Training Authority published *Better Management, Better Health.*[26]

In October the NHS Management Board was re-structured with Tony Newton (Minister of State for Health) in the Chair, Sir Roy Griffiths as Vice-Chair and Len Peach as Chief Executive.

In October the DHSS published *A National Strategic Framework for Information Management in the Hospital and Community Health Services* identifying and discussing issues health authorities had to resolve in order to get 'the best out of better information'.

In December the Secretary of State asked Roy Griffiths to review care in the community.

In 1987

The Health Education Authority was established—a controversial replacement of the Health Education Council.

Plans were announced for a national breast screening programme.

1 April was the deadline for implementing the first tranche of Körner data collection systems.

In April the 'Look After Your Heart' campaign was launched, aimed at reducing coronary heart disease.

In June the Conservatives won a third term of government. Margaret Thatcher remained as Prime Minister and John Moore became Secretary of State for Social Services.

In October the *'Achieving a Balance'*[74] initiative was announced, aimed at reducing the numerical imbalance between consultants and junior doctors, thus improving career opportunities for hospital doctors.

In November *Promoting Better Health*[75] was published. (The White Paper on primary health care following on from Green Paper of April 1986).

In 1988

The nurses clinical grading system was introduced (and many of the appeals against the grades awarded were still being processed in 1993).

Crown Immunity from environmental legislation was lifted.

Sir Christopher France became First Permanent Secretary of the Department of Health (replacing Sir Kenneth Stowe).

The Health and Medicines Act gave health authorities powers to raise funds from a far wider variety of sources than previously, thus opening the way for income generation projects.

In January 'The Acheson Report'[76] was published which recommended each district appoint a Director of Public Health.

In January the Prime Minister announced, during an interview on the BBC programme *'Panorama'*, a fundamental review of the NHS following a financial crisis involving the closure of services and much political flak.

In March Roy Griffiths presented his community care report (*Community Care: Agenda for Action*) to the Secretary of State.[77]

1 April was the deadline for implementing the remaining tranche of Körner data collection systems.

In July the Prime Minister decided to split the DHSS into separate departments covering health and social security respectively. Kenneth Clarke was appointed Secretary of State for Health (John Moore stayed on for a short time as Secretary of State for Social Security).

In December Junior Health Minister, Edwina Currie, resigned

following a row over her remarks about salmonella in British egg production.

In 1989

Len Peach retired as Chief Executive of the NHS Management Board and Duncan Nichol was appointed Chief Executive.

In January the *Working for Patients* White Paper[76] was published and presented to the NHS via a national tele-conference. It proposed an internal market in the NHS with NHS Trusts and GP Fundholders.

In April eligibility for free eyesight testing was restricted.

In April the Department of Health published *A Strategy for Nursing*.[75]

In May the NHS Management Board was re-organised. The NHS Policy Board was established with the Secretary of State as the Chairman and the NHS Management Executive was established with Duncan Nichol as Chairman.

In May General Management was implemented in FPCs with a Departmental circular instructing FPC Chairmen to recruit general managers through their RHA Personnel Department.

In June the Department announced 178 'expressions of interest' in NHS Trust status.

In September ambulance workers began a campaign of industrial action which eventually resulted in the army being called in to provide the 999 service in some parts of the country.

In November *Caring for People: Community Care in the Next Decade and Beyond*[78] was published.

In November The National Health Service and Community Care Bill was published to give legal effect to the *Working for Patients* and *Caring for People* reforms as well as removing the remaining Crown immunities from the NHS.

In 1990

Agreements were reached with the medical profession allowing a managerial presence on Merit Awards Committees and Appoint-

ments Committees, job plans for consultants and payment for doctors involved in management.

The MESOL programme (Management Education Scheme by Open Learning) was launched—a new NHS management qualification developed by the IHSM and the Open University.

In the spring the ambulance dispute (which started in September 1989) finally came to an end.

In June The National Health Service and Community Care Bill received Royal Assent paving the legal way for implementation of the *Working for Patients* and *Caring for People* reforms.

In July the Secretary of State announced the phased implementation of *Caring for People.*

In July Regional Health Authorities were re-constituted as part of the *Working for Patients* reforms with smaller memberships, to include for the first time the RHAs' senior executives.

In September the first National Vocational Qualification for health and social services was launched by the Minister for Health.

In September District and Special Health Authorities were re-constituted on similar lines to the RHAs as part of the *Working for Patients* reforms.

In September Family Practitioner Committees were re-constituted as Family Health Services Authorities and made accountable to Regional Health Authorities as part of the *Working for Patients* reforms.

From 1 October a new contract was implemented for General Dental Practitioners.

In October Kenneth Clarke announced his intention to devise health targets and to use them to measure health authority performance.

On 31 October the NHS staged its first national exhibition on quality at the National Exhibition Centre in Birmingham.

In November William Waldegrave was appointed Secretary of State for Health.

In November Margaret Thatcher resigned as leader of the Conservative Party and thus Prime Minister and was succeeded by John Major (a former junior minister at the DHSS).

In December the Department issued Heads of Agreement with the profession on the reduction of junior doctors' working hours.

In 1991

Kenneth Calman (formerly CMO, Scotland) became Chief Medical Officer for England, replacing Professor Sir Donald Acheson.

Graham Hart returned from Scotland to become Permanent Secretary at the Department of Health (replacing Sir Christopher France).

Professor Michael Peckham was appointed as the first Director of Research and Development at the Department of Health.

In February the NHS Management Executive published *Integrating Primary and Secondary Care* and *FHSAs: Today's and Tomorrow's Priorities*—documents aimed at encouraging innovative ways of working between primary and secondary care and managing the interface between the two.

In March, on the eve of the reform implementation, Duncan Nichol (NHS Chief Executive) wrote to each member of NHS staff, thanking them for their work on the reforms and congratulating them on their success.

On 1 April the *Working for Patients* and part of the *Caring for People* reforms came into operation:

- the NHS market began—DHAs purchased the health services required by their resident populations
- 57 first-wave NHS Trusts and 306 GP Fundholders began to operate
- Local Authority inspection units for residential homes became operational
- mental illness specific grants were introduced

In April the Department launched a comprehensive Research & Development Strategy for health.

In June the Department announced *'The New Deal'* setting limits

on junior doctors' hours of work and target dates when the limits should be implemented.

In June *The Health of the Nation* Green Paper[81] was published.

In July Prime Minister John Major launched his *Citizen's Charter*, aimed at promoting good quality services in the public sector.

In September Qa Business Services, the privatised Management Services Division of West Midlands RHA, collapsed with the loss of 70 jobs.

In September honoraria were introduced for DHA non-executive members.

In October Sir Bernard Tomlinson (a former Chair of Northern Regional Health Authority) was appointed to advise the Secretaries of State for Health and Education on London health services.

On 14 October The Children's Act 1989 came into force.

In October *The Patient's Charter*[82] was launched by the Department of Health in response to the Prime Minister's *Citizen's Charter* initiative. Abbreviated copies of the *Charter* are sent to every home in England. Brian Edwards was appointed to lead implementation team (Trent RGM).

In October 'Managers Working for Patients' was launched—a new management development strategy.

On 1 November The Health Care Records Act 1990 came into force giving patients access to their records within certain limits.

In November the Department published *Competing for Quality* a White Paper, laying the ground for widening the scope of market testing and contracting-out in the NHS—this arose out of promises in the *Citizen's Charter*.

In 1992

Yvonne Moores was appointed as Chief Nursing Officer at the Department of Health (formerly CNO, Scotland).

In January the Minister for Health (Virginia Bottomley) an-

nounced the creation of a Women's Unit and an action plan to increase opportunities for women in the NHS.

In January the NHSME announced the creation of Outposts to monitor the performance of NHS Trusts (hitherto carried out inside the ME).

In January the Department announced the extension of the GP Fundholding scheme.

On 1 April

- second-wave NHS Trusts and GP Fundholders began operation
- community care planning agreements had to be in place
- regions began to operate health information services in response to the *Patient's Charter*.

On 9 April the Conservatives won the General Election, John Major remained as Prime Minister and appointed Virginia Bottomley as Secretary of State for Health (replacing William Waldegrave), who became Chancellor of the Duchy of Lancaster with responsibility for the *Citizen's Charter*.

10

GENERAL MANAGERS MAKE THEIR MARK

NEW AND DEDICATED HEROES

VICTOR PAIGE'S RESIGNATION IN JUNE 1986 HAD ROCKED THE NHS but in the end it hardly really mattered. 'Down the tatty corridors of the NHS new and dedicated heroes were striding—the general managers'. Thus, Philip Strong and Janet Robinson had described the beginnings of '*The NHS under New Management*'.[57]

The Institute of Health Services Management and the *Health Service Journal* collaborated on a survey of Units over the period October 1986 to May 1987. These results were published shortly after the 1987 election, just a year after Victor Paige's departure. Though there were regional variations, units now appeared bigger and more powerful. Just over 69 per cent of Districts now had three or less units and over 57 per cent of units had budgets of £10 m or more. Of 687 Unit General Managers in post in England and Wales, 59·4 per cent were previously NHS administrators, 11·2 per cent were doctors and 11.2 per cent nurses. Just under 10 per cent were from outside the NHS—25 from the private sector and 16 from the armed forces. Private sector managers from industry and commerce mainly took up jobs in the large acute hospitals and were on the top two of the original five Unit General Manager grades. 17.3 per cent of Unit General Managers were women and were predominantly to be found in the lower grades.

The majority of general managers (56.3 per cent) had previously worked for the same Authority or came from another Health Authority within the same Region (12·5 per cent). Nevertheless, over 21 per cent had moved to take up posts from Health Authorities elsewhere in the country.

10.6 per cent of Unit General Managers worked part-time, most of whom were doctors.

Management of the priority care and community services was beginning to emerge out of the woodwork and command respect as a job that was challenging in its own right. It was no longer quite the poor relation of the acute sector of the past, though the acute units still commanded the highest pay. Over two-thirds of acute units had Unit General Managers on Grades one and two compared to under 20 per cent of community and 33 per cent of priority care units. As late as 1992 the Audit Commission in its report *Homeward Bound: A New Course for Community Care*,[58] was to call for health service leaders to be trained in both hospital and community settings and for community Unit General Managers to be paid on a par with their acute sector colleagues.

Griffiths was at considerable pains to emphasise the new managers would not achieve change overnight. It would take 10 years at least.

How long individual managers need to make their mark on an organisation was, and remains, a subject of considerable debate. Figures published in November 1989 based on a study by the Institute of Health Services Management showed that after at best four years only 64 per cent of Regional General Managers and District General Managers recruited from within the NHS remained in the same post and 55 per cent of those recruited from outside. Nearly 34 per cent of those from outside had left the service altogether for reasons other than retirement, compared with 17 per cent of NHS appointees.

Len Peach attributed the high drop out rate amongst outsiders to four factors: some were not good enough; others received inadequate help from Chairmen, Authorities and local managers; some were not ready for the immense culture shock of joining the NHS and others were not equipped with the skills to succeed in the 'goldfish bowl atmosphere' of an organisation operating in the public arena.

Many health service workers remained deeply suspicious of general managers' intentions, associating short term tenures with 'quick fix' mentalities and it took time to win their confidence. In 1986 contracts were altered to provide for one year 'rolling' contracts after the initial three to five year period, subject to satisfactory performance review. Improving performance was still, in the words of the Royal Commission, 'a long slogging job'.

WHAT DID GENERAL MANAGERS DO?

The first generation of general managers were the people whose job was to make general management stick. The role of the General Manager was broadly sketched out in Griffiths as:

- providing the necessary leadership to capitalise on the existing high levels of dedication and expertise amongst NHS disciplines and to stimulate initiative, urgency and vitality
- bringing about a constant search for major change and cost improvement
- securing proper motivation of staff
- ensuring that the professional functions are effectively geared into the overall objectives and responsibilities of the general management process
- making sense of the process of consultation.

The Templeton studies[59] tracked a group of District General Managers from spring 1985 to summer 1987 by means of meetings and informal telephone conversations to try and find out what this meant in practice but once again, what managers did appeared to defy description. District General Managers like the Administrators before them found it difficult to reach consensus on their role—catalyst, enabler, integrator, broker, monitor, initiator, leader, organiser, corrector—it seemed to be as broad as it was long. One could almost substitute the nursery rhyme 'Tinker, Tailor, Soldier, Sailor, Rich man, Poor man, Beggar man, Thief.

The Templeton studies found that the job offered considerable scope for individual discretion and that personality rather than the formal job description appeared to be a key determinant of the amount and pace of change initiated and the range of activities tackled. The predominant characteristic seemed to be the need to maintain the support of most, if not all, of the influential individuals and groups in the health service and that considerable political sensitivity was required to carry out the job. Often, because of this, managers found themselves in very vulnerable and lonely positions.

A smaller scale study by the University of Birmingham Health Services Management Centre found General Management styles

fell into three groups 'blunt macho', 'smart Machiavellian' and 'thoughtfully streetwise' with most falling into the latter two groups. Indeed, to judge from contemporary conference speeches, many newly appointed managers were turning to Machiavelli's 'The Prince' for inspiration rather too often.

The managers all, however, had one thing in common — they were the men or women whose job it was to 'grasp the nettle' and 'make things happen'. These were after all the people, the Permanent Secretary hinted to the Public Accounts Committee, who would sort out linen shortages for once and for all! It was a tall task. 'Some were exhilarated and rode it like surfers; others were swept away, never to surface again', but by 1987 they had begun to explode the *Myth of the NHS Bureaucrat* (the name of a booklet published by the IHSM in 1988 to defend managers against bureaucrat bashing).

MANAGEMENT BECOMES RESPECTABLE

From Griffiths onwards the term 'management' steadily began to achieve a measure of respectability within the service.

From the outset it was recognised that if the new culture was to take root within the NHS, there would need to be considerable investment in management training. The introduction of Griffiths had coincided with the establishment of the new NHS Training Authority in 1983 which proved to be a ready ally in this task.

Initially attention was focused on senior management and on succession planning within the NHS. This was influenced by Griffiths' own views who, although perceiving the need for people from the outside to act as catalysts in getting general management off the ground, saw the NHS as producing the majority of the second generation of general managers from within its own ranks. It was also influenced by the work of writers on organisations such as Kotter whose work showed in ‘top’ organisations 91 per cent of top managers had spent their time in the same industry and 81 per cent of their career with their current company. 'We have to develop our own talent internally, find our own replacements for those who leave' said Len Peach in 1987. It was during this period that every RHA formal review was started with a private review of the managerial talent within the Region. 'Who could succeed

you?' was to prove to be one of the more difficult review questions for Regional General Managers.

By then the NHS Training Authority had launched its new training strategy *Better Management—Better Health.''* 80,000 copies were distributed in September 1986 throughout the service. Central to the proposals was the creation of a new fast stream National Accelerated Development Programme. (General Management Training Scheme (GMTS) I—a Junior management training scheme for people with little or no managerial experience such as direct entry graduates; GMTS II for in-service personnel such as departmental managers and GMTS III for people with board level potential). The strategy introduced for the first time the concept of 'management development' rather than management training and education into the NHS. Entry would be open to all professions. The General Management Training scheme would, it was planned, serve as the seedbed for top and senior managers and act as the flagship of management development programmes in the NHS. Unidisciplinary schemes such as the National Administrative Training Service were phased out; they were judged to have outlived their sell-by date. Progress was, however, not all plain sailing. Over half of GMTS trainees were unplaced when the first intake completed their course, forcing the centre to put pressure on Regional General Managers to find placements for them . . . this they did.

General Managers were, however, quick to grasp (because most knew already, and if they did not, they did not remain General Managers for very long) that this initiative was not enough. They quickly realised that if they were to effect real change; if they were to stop national policies slipping down the 'black hole' and not end up as the sacrificial head on the local Chairman's or Minister's chopping board that it was middle managers who held the key to their success or failure.

General Management in the NHS was not about a community of 900 top managers or even 2,700 managers on the national accelerated development programme register but a brotherhood, or perhaps more accurately a sisterhood, 85,000 strong—'a motley crew' of nurses, doctors, physiotherapists, medical laboratory technicians, speech therapists, kitchen chefs all 'middle managing' in some way. These were people who did not want to be full-time career managers but were crucial members of the management

chain. Fortunately, as Barbara Young, the President of the Institute of Health Services Management, (the first woman since its establishment in 1902) was to say in 1987, most were 'keen as mustard, green as grass and crying out for education and development'.

The NHS Training Authority set about working with the Institute of Health Services Management and the Open University to plug this training gap through the development of the Management Education Scheme by Open Learning (MESOL) foundation course 'Managing Health Services' for middle and junior managers. This was launched in 1990 and by 1992, when the NHS Training Directorate (the NHS Training Authority had ceased to be an Authority in its own right and became an arm of the NHS Management Executive in April 1991) announced the introduction of the follow-up diploma course 'Health and Social Services Management' developed in association with the Social Services Inspectorate, almost 3,500 people had either undertaken or were studying for the foundation course. The Institute of Health Services Management was getting close to giving up its own examinations in favour of accrediting others to do it for them.

But if general management was to stick, it had to achieve results and one of the toughest challenges faced by general managers in those first testing years was getting to grips with the 'microchip'.

MANAGERS AND THE MICROCHIP

The Report of the three Chairmen in 1976 on relationships between the Department of Health and Social Security and the NHS had recommended a joint enquiry into central information requirements based upon the simple question, 'Is what you are collecting of value and who actually uses it?' This was followed up by the findings of the Royal Commission on the paucity and poor quality of NHS information and had eventually led in 1980 to the setting up of a joint NHS/Department of Health and Social Security Steering Group on Health Services Information, chaired by Edith Korner, then Vice-Chairman of the South Western RHA. Her brief was to review existing health service information and consider proposals for change. The Steering Group[6] was to publish six reports between 1982 and 1984 on different facets of information requirements, recommending radical changes. These

were to provoke considerable and often heated debate but were accepted by Ministers in 1984. As Mrs Korner was to say 'To heed the criticism is to run the danger of allowing the perfect to become the enemy of the merely good and delaying action beyond our lifetimes'.

The majority of the new data collection systems had to be in place by April 1987 and the remainder by April 1988. And so began a race against time to meet the target dates. Alongside competitive tendering it was one of the earliest tests of the Centre, using general managers to drive through change in a pugnacious way and force new ideas and initiatives onto an unreceptive and sometimes resistent service. *A National Strategic Framework For Information Management in the Hospital and Community Health Service* was published in October 1986 to aid this process and Korner clubs were established up and down the country. Regions kept up relentless pressure on Districts and units. Nearly all District Health Authorities met the April 1987 deadline, though it was often a close run thing and implementation was to pre-occupy middle managers for many years after the event. 'Mrs Korner and her team have changed the face of NHS information' wrote the editor of the *British Journal of Health Care Computing*. They have broken 'The pattern of nearly 40 years of apathy about information systems in the NHS'.

Though a significant number of Authorities had to resort to making initial returns on paper, the key to Korner implementation was information technology. A King's Fund Consultant visiting several Regions in early 1987 commented:

'The dominant impression... is that of a technical battleground with Regional officers trying to get to grips with the technological problems and bloodied, sullen but nonetheless willing troops of consultants, software houses and hardware suppliers milling around on a flavour of the month merry-go-round.'

The mid 1980s were years when managers spent considerable time and energies searching for large computer solutions for collecting and analysing clinical data. In practice the solutions never worked for they took too long to build. Soon, however, the country was divided into two camps, loosely configurated around computing systems and companies. Yorkshire, North West Thames, South East Thames, West Midlands, Northern and Ox-

ford Regions focused their investment on ICL, whereas Trent, South Western and North East Thames homed in on DEC.

In this period Regions developed large computing departments, both to process data and handle developmental work. (Most of these had been sold out by the early 1990s.) It was also during this time that DISP, the ill-fated Wessex experiment, was born, which was to come to grief so dramatically in the 1990s.) At the time Wessex was regarded by most, including the Department of Health, as a pioneer which others should follow.

Technology was beginning to transform everyday life in the office in a dramatic way. No self-respecting manager's life was complete without a personal computer proudly mounted on his desk to show visitors (even if he had no clue how to use it). His secretary now possessed a word processor rather than an electric typewriter. Instead of dashing to the mail room to catch the last post with urgent letters, the 'fax' machine buzzed merrily away with important and not so important communications between tiers. Soon these would be installed in managers' homes. Within a few short years the mobile phone was allowing Regional and District General Managers to harass middle managers with requests and messages from afar as they toured around their patches in their NHS 'lease cars'. The reality might have been different but the imagery was ever powerful.

PERFORMANCE MEASURES

All the time managers were grappling with Korner implementation, a nagging underlying suspicion existed that 'No-one had seriously addressed the question of how managers will use the information'. But they need not have worried, for the computer both coincided with and made possible the years of systematic planning and monitoring. All aspects of the performance of a Regional Health Authority/District Health Authority or unit were scanned through the review process, backed up by the painstaking and detailed analysis of each dimension using performance indicators and other comparative data. Systematic 10 years plans were developed with each year's activity, finance and manpower needs carefully charted on 'summary analysis of strategic plan' (SASP) tables. Short-term plans were presented in a more business-like and compatible way through the Manage-

ment Accountancy Framework introduced in 1986/87. Robert Maxwell, Secretary of the King's Fund speaking in July 1982 warned that:

> 'In planning, budgeting and financial control and management information, the tools badly needed sharpening. But let us remember that these are tools, not ends in themselves. We must not allow ourselves to become as obsessed with systems upheaval in the 1980s as with structures in the 1970s.'

The approach was thorough and almost clinical in its execution. The information explosion and the microchip had given the tier above the capacity to interrogate the performance of the tier below with a ferocity that had not been possible before. As he left the Department, Sir Kenneth Stowe was looking forward to the introduction of a new performance indicator set for use in Regional reviews of 2,500 items! The most commonly expressed learning needs by management of the day were information handling, numeracy skills and understanding planning systems. By 1985 jargon like DRGs (Diagnostic Related Groups) and QALYS (Quality Adjusted Life Years) were beginning to creep into the vocabulary.

These approaches were far from perfect. Though managers were to claim credit for the development of more appropriate management information systems, the quality of the information they actually contained remained pretty suspect and the process often felt uncomfortable for both monitor and monitored. The tag of 'lies, damn lies and NHS statistics' still fitted.

But whilst managers were struggling with data capturing techniques, politicians, including Mrs Thatcher, became more and more interested in the results and in comparative data; increasingly they wanted it published in the form of league tables. A Sunday *Times* feature in 1988 on a range of national performance indicators caused uproar, particularly amongst those who found themselves at the bottom of the table. There followed weeks of introspective examination of the minutiae of the data input. Pride and shame proved very powerful. League tables do unleash powerful emotions. Sheila Masters who, became Director of Finance of the NHS Management Board in 1988, was later to use league tables of performance with dramatic, if somewhat brutal'

effect in presentations to Regional Chairmen and Managers in front of Ministers.

(TANGLING WITH TIERS'

Managers not only had to deliver but also had to demonstrate that they were achieving results.

The introduction of the formal Review process in 1982/83 significantly tightened up the chain of accountability after a period of pressure on Regions not to interfere unreasonably in local management. Region to Department of Health: District Health Authorities to Regional Health Authorities (Family Health Services Authorities were destined not to join the process until 1985/86 when they were reviewed first by the Department of Health and from 1989 by Regional Health Authorities). The first national reviews of Regions were led by Ministers (nowadays they are led by the Chief Executive of the NHS Management Executive). Simple questions like 'what has happened to the billion pounds invested in your Regions?' proved to be very challenging! For some, the process was exhilarating and rewarding; others found it frustrating, intimidating or a fruitless paper chase. Reviews at the Region/District interface took many forms. In some Regions a 'challenging chat' was the order of the day, in others a relatively formal and thorough review of performance began.

The new managerial arrangements had strengthened the Regional Health Authority's role in relationship to Districts as the Centre increasingly sought to use Regions to drive through national policy (indeed so great did the power of the Regions appear that on receiving the Griffiths Report the Select Committee on Social Services had expressed fears about the demise of the Department of Health itself).

A sign of the times was the 1986 Report of the Committee of Inquiry into the Stanley Royd Incident[6] (an event which reinforced Norman Fowler's conviction about the need for more 'hands on' management in the NHS). In August 1984, as the newly appointed Regional General Managers had taken up post, on a hot and sticky day salmonella bacteria had begun to grow in the antiquated kitchens at Stanley Royd Hospital in Wakefield which had been built in 1865. The outbreak was frightening in its

scale and the rapidity of its onset; 19 elderly patients were to die and a further 353 patients and 100 staff were struck down with illness. It was an enormous tragedy and the scandal led eventually to the lifting of Crown Immunity from prosecution for breaches of environmental health regulations in 1988. The subsequent inquiry blasted the Region 'We also find it quite incredible that, apart from expressing regret and sympathy about the outbreak, the Region did not discuss the problem, the causes, or the action being planned or taken at any meeting thereafter. It was as if it had nothing to do with the Regional Health Authority. If it had not, then the usefulness and relevance of this body would seem dubious'.

In 1984 the review process extended from District to Unit. Those Regions who took the process seriously got a lot out of it. It flushed out into the open issues that had often been avoided for years and set pathways and target dates for action.

The process eventually lost some of its early impetus as Ministers found it difficult to cope with the intensive briefings and meetings. A heavy crust of bureaucracy also formed around the process, including the sets of performance indicators which were to prove so interesting to Mrs Thatcher.

As a consequence of the review process, Districts were forced to devote more time to the management of the Regional interface (as did Regional Health Authorities with the Department of Health and Social Security). The best managers worked hard on the interface and made it work well but relationships were not always easy or fruitful. Regions were sometimes accused of stifling local initiatives, of being insensitive to the local scene, showing too much single-mindedness in their pursuit of national priorities, of being too interventionist, or alternatively too timid, in supporting Districts at crucial crossroads in development. One District General Manager was to say that it was impossible 'to penetrate the treacle which permeates down all levels' of his local Region. Regions in turn were to be critical of the political naivety of some Districts in their apparent cavalier attitude to national priorities, the lack of depth of managerial performance and the absence of delegation from District to Unit level. Much of this tension was, however, constructive and helped contribute to a stronger and more consistent managerial drive in key areas.

Like managers throughout the history of the NHS, managing

the interface with the tier above was always of vital importance to success and career development. This was reinforced by the Individual Performance Review/Performance Related pay process under which general managers and chairmen became involved in judgements about the performance of managers on the tier below.

THE EMERGENCE OF THE HEALTH AUTHORITY CHAIRMAN

The role of the Chairmen of the various Health Authorities has changed significantly over the years. The role has always been shaped by the individual concerned, but as the NHS grew bigger and decision making became tougher and more visible to the public, the size and shape of the job changed fundamentally. Chairmen began to receive a financial honorarium. This was extended to DHA non-executive members as well in September 1991.

Chairmen have always been appointed by the Secretary of State. In the early years of the service appointments appear to have been handled with a very light political touch. The Department of Health had a small Regional Officer network which handled the process. By 1974 the politicians were taking a closer interest in the appointments and in recent years the appointment of Chairmen has had their very close personal attention.

The stereotype of the Chairman in the early years of the service would include characteristics like worthy, sensible, locally respected and non-political. In more recent years a commitment to deliver the Government's agenda for change has been added to the list. Being a successful business woman is probably the closest one can get to a perfect CV in 1992.

Members of Authorities have rarely been entirely satisfied with their role. Much of the day-to-day decision making lies with the officers, and members are usually left with often inconclusive debates about grand strategy or receiving reports on what has already been effectively decided. The tensions this created were particularly acute when local councillors played a decisive role in the work of Health Authorities. . . these members were accustomed to taking all decisons in local government, even the most

trivial. (Local Authority representative members were abolished in July 1990.) There were many battles for power in the wake of the 1974 re-organisation between members at Area level and their operational districts who were taking all the interesting (and sometimes controversial) decisions.

Because of the make-up of authorities in the 1970s and early 1980s they were rarely unanimous on controversial issues like competitive tendering of support services. During periods of industrial unrest members often sided publicly with the Trade Union which made life especially difficult for the Authorities' Chief Officers.

This was to change decisively in 1990 with the move to small authorities. More than one manager felt that for the first time in their career their members were with them and they were all part of the same team. The role of the chairman was particularly enhanced by their presence and involvement in the Performance Review process.

One group of Chairmen, the Regional Chairmen, emerged as a particularly powerful group in the 1980s. Successive Ministers referred to them as the 'kitchen cabinet' and they in turn responded with a firm loyalty to secure the implementation of Government policy. Increasingly this group and their Regional Managers took on the role of speaking for the NHS, particularly in areas like the handling of industrial disputes, public expenditure problems and structural change.

The relationship between Chairmen and Chief Officers was always important. In some cases firm friendships were struck; in others they complemented each other's skills. There were obviously times when the relationship did not work out. The manager usually moved on first, often to be followed a little later by his Chairman when his term of office was not renewed.

LIFE IN THE GOLDFISH BOWL

More than ever before, business was being conducted in a public 'goldfish' bowl. TV and local radio (over 11 m people a week tune into BBC local radio stations alone) were now important shapers of public opinion. Technological advances were making reporting easier and news travel faster. The media was also becoming more intrusive in its reporting methods.

Managers had to think carefully about what they now said to the media. An amateurish approach to dealing with professional journalists on the look-out for a good story was no longer acceptable, even if they were only writing for trade journals with an exclusively NHS audience. Managers were increasingly propelled into the public eye, especially if closures or service cut-backs were involved. Often these led to local clashes with Community Health Councils, invariably played out in a local media arena, hostile and unsympathetic to the Authority's case. Some managers felt uncomfortable with their higher public profiles but as Tony Newton, the Minister for Health, said in March 1987 'I am fulcrum between the NHS and Parliament so you as managers can't avoid being politicians to some extent—it is part of your job to consider public reaction to your goals'.

The rule in business circles that you do not criticise 'head office' in public began to be applied in the NHS. For some managers this took some getting used to. The temptation to blame 'them' when local problems developed was enormous. During the 1982 industrial dispute, for example, Norman Fowler, a former journalist himself, had been irritated by the passage of a motion by the National Association of Health Authorities in June 1982, condemning the latest management pay offer as divisive 'Few employers' he later wrote 'have to contend with their management arm solemnly sitting down and condemning the negotiating strategy and then publicly relating their views to the press'. The National Association of Health Authorities was never to secure the power and influence of its opposite numbers in local government although its style and presentation was to improve sharply in the 1980s. Rubbishing the NHS as a whole (under-funded, badly managed, wrong priorities) was a standard negotiating tactic for many health service professionals seeking funds for their hospital, specialty or service. But beneath the posturing and bluster lay a hidden tension as to whether Health Authorities were still a series of small to medium sized semi-independent bodies or part of a corporate conglomerate—the NHS PLC with a single corporate identity. As one contemporary observer put it . . . up to that time the NHS had really been little more than 'a series of small employers loosely linked by computer print-outs of pay slips'. The elusive search for an NHS corporate spirit and approach that could match its public corporate identity continued.

THE REPORT THAT REFUSED TO GO AWAY—HEALTH JOINS THE AGENDA

By the mid-1980s the NHS managerial agenda was beginning to change. Quality, community care, the interface between primary and secondary health care, were all emerging as key issues. These presented new challenges to tax even the most resourceful manager, but many were keen to get in at the leading edge of developments and play a proactive role in determining local responses.

It was in 1985 that Ken Jarrold, speaking at the Institute of Health Services Management Annual Conference, brought managerial concerns about health out into the open by referring again to the Black Report, which had been commissioned some years before by David Ennals. *Inequalities in Health*,[63] had been published in 1980 in a manner which suggested that those in power hoped it would soon be forgotten. Only 260 copies were made available; the report was published in the week of August Bank Holiday without any commitment or support from the Government. And yet, despite this inauspicious start, the report had refused to go away. The central message of the 'Black Report' is too serious and too challenging to be ignored. Poverty and ill health are linked. Despite 35 years of the welfare state, inequalities in health and health care are still a major feature of British society.

Managers did not stand alone on this issue. They had powerful allies within the caring professions who understood from their day to day professional experience the linkage between poor health and poverty. This was also the period when the international 'Health for All' movement was gathering pace. Managers began to talk seriously about the core of the business they were charged with managing, Managerial agendas were typically centred on resource (input) control issues . . . cash limits, cost improvements, spending plans, capital programmes, staff appointments. Gradually, matters of health began to intrude.

The mid to late 1980s saw a stream of national government initiatives targeted on specific diseases or conditions, starting with drug misuse in 1984. HIV Infection and AIDS emerged as major threats to the health of the population that demanded a political and management response. Donald Acheson the Chief Medical Officer persuaded Norman Fowler to take a personal interest in

the problem of AIDS. Indeed, so much of his time began to be spent on the 'AIDS — Don't die of ignorance' campaign that Mrs Thatcher jokingly reminded him that he was more than the Minister for AIDS. Sexual diseases were also on the increase and there was a renewed interest in preventative health issues championed by Edwina Currie, who became Junior Health Minister in 1986. Improvements to cervical cytology screening programmes was made a service development priority for all Health Authorities in January 1986 and plans for the introduction of a national breast cancer screening programme were announced in 1987. The first tentative steps were made to target the reduction of coronary heart disease through the Look After Your Heart! campaign in April 1987. The management agenda really was beginning to change.

A strong body of opinion began to emerge that what one needed was to revive the office of the Medical Officer of Health to wield 'power in the commonwealth' in the manner of the nineteenth century in tackling preventable diseases. (The Medical Officer of Health who had been a powerful figure in Local Government had disappeared in the 1974 re-organisation and had been replaced within Health Authorities by Community Physicians).

In the wake of the Stanley Royd Enquiry of 1986, a Committee of Inquiry, chaired by Sir Donald Acheson, the Chief Medical Officer, was set up to look at the future development of the public health function where in the words of one observer 'spurned by both their clinical and academic colleagues, community physicians inhabited a half world'. The Acheson Enquiry[64] did not report until January 1988 but was to spell the renaissance of public health defined as 'the science and art of preventing disease, prolonging life and promoting health through organised society'. In future there were to be Directors of Public Health at both District Health Authority and Regional Health Authority level to provide epidemiological advice, prepare an annual report on the health of the population, develop and evaluate policy on prevention, health promotion and health education and co-ordinate control of communicable diseases.

Even before Acheson had reported, however, the more enterprising Districts led by their Community Physicians and District General Managers had programmes in hand for reviewing the

health needs of the population and targeting resources on the client groups and localities most in need.

The debate on health was also important because it began to engender a new concern with long-term strategy and focus General Managers' minds on developing a vision of health care in the twentieth century rather than achieving short-term goals. NHS management was beginning to mature and move from administering a system to managing a service.

Griffiths had been struck by how little overt interest NHS managers displayed in the quality of the service provided to patients compared to the pre-occupation of leading organisations in the private sector with customer care and relations. As he was to say in 1991, if a manager or chairman 'once passes a hospital out-patient department which has long queues and an air of neglect; if he passes this without questioning as to why it is happening and seeking an understanding of what is being done to correct it, then he will show he is not really interested in a quality service.' This too was beginning to change as pioneering Regions like Trent began to focus managers' energies into Personal Service.

CARE IN THE COMMUNITY

In the 1970s, joint care planning had essentially been a two way dialogue between the Health Authority and the Local Authority. Some modest, but nevertheless real, progress had been made in working together. But now the scene had shifted; Local Authorities were subject to increasingly tight financial controls. Joint finance became a source of tension rather than co-operation as hard-up social service departments pressed for the extension of financial support for schemes beyond their expiry date and refused to consider new starts. Soon a growing proportion of joint finance was being used to pump prime NHS developments. Health Authorities began to forge new partnerships, especially in the priority care services with voluntary agencies and housing associations.

In 1983, the government followed up proposals outlined in its consultative document *Care in the Community* by revising joint finance arrangements. The changes also enabled Health Authorities to offer lump sums or continuing grants from mainstream funding

to Local Authorities or voluntary organisations for as long as necessary in respect of people to be cared for in the community, instead of in hospital. In addition, Ministers decided that the maximum period for joint financing of schemes allowing people to move out of hospital could be extended to 10 years at 100 per cent funding and 13 years in total with tapering off.

By the close of the decade the private sector had also grown into a major supplier of long-term medical/nursing care for elderly people. By 1989 there were 153,000 registered private residential and private nursing homes compared to 35,000 in 1979. This impacted upon health authorities' roles as registering authorities of nursing homes, as providers of long-term care, and as employers and training authorities as the private sector emerged as a major employer of nurses.

Much of this growth had been made possible by the open-ended nature of social security payments—a situation which a government committed to tight controls on public expenditure found increasingly exasperating. Moreover, it was leading to inappropriate placements. National concern was growing that community care was not being turned into reality and that implementation was falling between agencies. As Griffiths later put it 'Everybody's distant relative but nobody's baby'.

Various proposals were put forward for making 'progress in partnership' including some by the Audit Commission in their report *Making a Reality of Community Care.* Eventually Roy Griffiths was asked by the Secretary of State in December 1986 'to review the way in which public funds are used to support community care policy and to advise on the options for action that would improve the use of these funds as a contribution to more effective community care'. In the meantime, managers battled on to find innovative solutions to the delivery of uniquely tailored packages of care, especially those managers who had to re-settle people currently living in large mental hospitals which were now seriously close to closure.

FUNDING MECHANISMS: THE DEBATE RE-OPENS

There was, however, one item high on the manager's agenda that never changed. This was finance.

In 1985 a book was published by the Nuffield Provincial Hospitals Trust expounding ideas that were to have far-reaching effects on the NHS. It was called *'Reflections on the Management of the NHS: An American Look at Incentives to Efficiency in Health Service Management in the UK'* by Alain Enthoven, Marriner S. Eccles Professor of Public and Private Management at the Graduate School of Business at Stamford University.[65] General Management was all well and good, said Enthoven, but the NHS was caught in a 'grid lock' of forces that made change exceedingly difficult to bring about. Unless these structures and incentives were reformed more fundamentally then change was likely to be cosmetic. What was needed within the NHS was to get the incentives right; what was needed within the NHS was a 'health care market'.

Contemporary research was to show that a funding crisis was building in the NHS which was ultimately to bring about the adoption of some of Enthoven's ideas. International comparisons suggested that Britain spent a lower proportion of Gross Domestic Product on health than its European neighbours. There was also evidence that resources had not kept pace with the growing demands of an ageing population and a burgeoning health technology that was expanding the range of diagnostic and treatment options. The elastic tension between what could be provided and what could be afforded was growing tighter and tighter. The British Medical Association, the Royal College of Nursing and the Institute of Health Services Management were very concerned and jointly tried to engage in a sensible dialogue with the government over funding levels for several years. They commissioned a series of joint reports on trends and future problems in funding health care. These reports were not wholly negative or self seeking but displayed a sense of realism about national economic policies. They had little impact.

In 1988 the Select Committee on Social Services concluded that between 1980–81 and 1986–87 expenditure on hospital and community health services had been 'under-funded' by £1,325 billion at 1985–86 prices. This figure had been calculated by adding up the 'shortfall' in each year, defined as the difference between target expenditure for that year and total resources actually available to District Health Authorities for spending, including cash released by cost improvement programmes. Target expenditure was calculated as 'the maximum required to main

tain services at their present level plus two per cent per annum increase in service to reflect demograpic change such as the ageing population, technological advances and new policy initiatives such as HIV and AIDS'. There was some dispute as to whether the 2 per cent per annum growth might be an over-estimate but all figures pointed to a sizeable gap that needed to be plugged.

Later work by the National Audit Office revealed that during this period many Authorities were actually living beyond their means. They were providing services and pursuing developments costing more than their annual recurrent income. They were doing this through a variety of measures, including postponing payments to their suppliers and by utilising funds not available on a recurrent basis.

The study also exposed serious weaknesses in NHS budgeting, planning and monitoring control systems and a shortage of qualified financial staff.

Health Authorities were living dangerously close to a knife edge and it was increasingly clear that they could not go on this way for much longer. They were in danger of falling over the edge. But in the early days of May 1987, as the country prepared to go to the polls, it was all too easy to pretend the problem was not there. It was just the NHS moaning on as usual about lack of cash.

11

GRIFFITHS: THE PROVISIONAL VERDICT

IT WAS NOW THREE YEARS SINCE THE FIRST REGIONAL GENERAL Managers had taken up post. What difference had this much fought over managerial change made to the NHS? In 1987 some began to make judgements about its effects so we shall pause our history here and do the same, though with a longer perspective.

Some argued then, and perhaps still would, that the jury is still out. Many commentators, including Griffiths himself, felt that general management could not realistically be evaluated until it had been in place for ten years. Many of the first general managers were not appointed until late 1985 or early 1986. Nevertheless, the IHSM cautiously commented in 1987 that 'the early stages of the implementation of general management show promise' and NAHA described it as 'working out well and bringing considerable benefits to the NHS'. Victor Paige commented 'Much has been achieved; but the task was and is formidable.'

In evidence to the House of Commons Select Committee on Social Services in February 1984 Steve Harrison, from the Nuffield Centre for Health Services Studies in Leeds, captured some of the cynicism that was still around 'What is seen as being a good manager in the National Health Service is a manager who can solve problems, pour oil on troubled waters, avoid conflict and keep things quiet'. In its report on the Griffiths Management Enquiry, the Select Committee warned 'the NHS may suffer more in side-effects from the wonder drug of general managers than it gains in better management'.[66]

Some would claim that general management had failed because of the significant problems the organisation still faced. General Management was introduced in a climate of financial restraint and this, together with clearer management objectives, tended to cast managers in the role of hatchet men and women. Harrison *et al*[67] commented 'managers faced overwhelming pres-

sures to conform to and accept a narrow, finance-driven agenda.' David Hunter and Peter Williamson commented in *Health Services Management* in 1991 'general management has tightened up financial management and created a clearer and more direct system of line management'.

Some might argue that one of the critical criteria for judgement must be the ability to successfully deliver quality initiatives. Harrison *et al* commented 'No general managers had been sacked for lack of success on the quality front'. This was difficult territory anyway because many staff, and particularly doctors, viewed some of the quality initiatives as 'frills' when they perceived basic service standards to be under threat from financial restraint. For the first few years the top priority was financial control, and economic viability remains the driving force behind the managerial agenda in the NHS in the 1990s. But in some parts of the NHS, notably Trent and Wessex, General Managers did develop successful quality initiatives which were patient-focused and concerned with service and environment.

It is, of course, unrealistic to expect a single change, however fundamental, to solve all the service's problems. In 1988 Len Peach commented 'general management in the National Health Service in its infancy is already demonstrating its achievements and is moving rapidly towards a maturity which promises much.'

One thing general management did achieve was a very welcome clarity of purpose and accountability. David Hunter and Peter Williamson have commented that 'there has undoubtedly been a greater emphasis on management responsibility and authority and more relevant agendas and quicker decision-making'. At last a clearly identifiable individual was in charge at Unit, District and Regional level. The best General Managers quickly built alliances and created space for colleagues to become part of general management. Some faced conflict as colleagues fought to retain the old world . . . this was usually short-lived; within a very short time people wondered how the service had coped in any other way. General Management was clearly here to stay but was still evolving and developing.

Calum Paton and Stephen Bach from the Centre for Health Planning and Management at the University of Keele commented in 1990 that 'The implementation of general management with the aim of shifting from a professional ethos to a management

ethos had an uneven impact across the NHS.'[68] General management has not imposed a uniform management style—that remains totally individual—and has not led to the tightly controlled 'NHS plc' that many feared. It has, however, brought new skills and attitudes to the organisation as the culture of general management has spread throughout the organisation. The Nuffield Institute concluded in 1989 that general managers had succeeded in acquiring the authority Griffiths envisaged for them 'nowhere have we found them to be a laughing stock or a spent force'.

The same piece of research went on to conclude that 'The deepest shadows... cloak the relations between general managers and the medical profession'. Although on a personal basis relations were often good 'the consultants emerge as the most pessimistic, critical or even dismissive group.' Many felt that Griffiths had under-estimated the power of clinicians. In practice this pessimism was unwarranted. Most clinicians like the clarity that general management creates and many have embraced its culture with enthusiasm through the mechanism of clinical directorates.

Suddenly there was a need to measure performance against objectives, which meant everybody had to know about what was going on within the organisation. The Resource Management Initiative, designed to help doctors participate more directly in management was to attract growing support. It is now firmly embedded in the majority of larger hospitals as an integral part of the general management process.

Another positive spin-off has been the need to develop what some have called 'foreign policy'. Developing relationships and alliances outside the health authority or unit with local authorities, voluntary organisations, the media and pressure groups, both to progress the organisation's business and to ensure effective public relations. It would be an exaggeration to say that some general managers have become celebrities but most have to accept daily contact with the media as part of the job. The down-side is that managers become personally identified with unpopular decisions and some have faced not only threats of dismissal, should there be a change of government, but threats of violence to themselves and their families.

From the very beginning managers were appointed on short-

term contracts (usually three year rolling contracts). They were also entitled to Individual Performance Review leading (or not) to the renewal of their contracts and Performance Related Pay. The development of Performance Review has been seen by many as a positive process, especially as a way of helping to clarify individual responsibilities and targets. However, the Nuffield research reveals less enthusiasm for Performance Related Pay, even from those who have benefitted from it. The decision to cap, within a Region, the number of awards created much tension. The awards themselves were also too small to affect performance dramatically (the range was between nothing at all, even cost of living, and 8 per cent, with a maximum over time of 20 per cent).

There is little doubt that without the development of general management it would have been difficult, if not impossible, to deliver later reforms, especially those introduced by *Working for Patients*–the clear lines of accountability helped drive them through. Sir Roy Griffiths commented to the Audit Commission 'One of the great achievements of general management in the health service is that sensible and realistic policy stands a good chance of being implemented. The management process has taken root'.

Manager bashing is still great fun—in a letter to *The Independent* Newspaper in the summer of 1992 a consultant commented that no qualifications are needed to become a general manager. However, the fact that this kind of outburst is now rare enough to be worthy of comment shows that general management has settled and become an integral part of NHS culture. Gordon Best, writing in 1987,[69] commented that the NHS had been transformed into an organisation 'that increasingly is exhibiting the qualities that reflect positive, purposeful management'. Andrew Wall has commented 'those who thought Griffiths might be a passing fad will have been surprised at the significant change it has brought about in the NHS in a comparatively short period.' Wall himself later lost his job as a General Manager in the reconfiguration of purchasing in Wessex in 1992.

Since the White Paper *Working for Patients* was published, debates about general management have taken second place to the creation of the internal market. However, the politicians retain their penchant for manager bashing in moments of crisis. During a BBC interview in 1991 William Waldegrave described the NHS

as an 'administrative slum', which was unusual because he had got on well with managers during his term of office. Bring back the hospital secretary3 No, general management had stuck in the system and looked set to stay.

12

THE GREAT STORM

THE STORM CLOUDS GATHER

IT WAS JUNE 1987. THE GENERAL ELECTION HAD BEEN CALLED FOR 11June 1987. For the first time for many years the NHS was a key election issue. Labour had targeted the government's policies on health, unemployment and education as the 'uncaring face' of Thatcherism. The Social Democratic Party/Liberal Alliance Manifesto had described the NHS as being in a 'state of fundamental crisis and malaise'. The worsening waiting lists came in for strong attack. Labour claimed they had risen by 15 per cent since Mrs Thatcher took office. The Alliance produced an eight foot high stack of computer print-out, representing the 768,000 people on the lists. Nobody even tried to explain it was not how many people were on the list that mattered but how long they waited. The Conservatives promised action if they won the election.

However, away from the hurly burly of the hustings new events were beginning to unfold. The British Medical Association Annual Hospital Conferences were being held in London. Scrutator, the columnist of the *British Medical Journal*, sensed the hospital doctors were in an unhappy mood. The doctors, together with the nurses had just had a big pay rise but more money was not everything.

As Scrutator put it, Consultants were fed up with the 'unremitting pressure on beds and the confrontational tactics of many managers. Junior doctors are reaching the end of their tether because of the pressures on them to work long hours by penny searching management refusing to supply adequate locum cover.'

The doctors were trying to do their best for patients within what seemed to them to be ever decreasing resources, 'prescribing regimen for the good of my patients according to my ability and judgement and never doing harm to anyone' in line with the Hippocratic Oath and yet all politicians, academics and managers

seemed to do those days was to point their fingers at them and say they were idle good-for-nothings and the root of all the inefficiency in the NHS. It was a far cry from the halcyon early days of the NHS. The doctors' leaders could derive a certain smug satisfaction from the fact that as yet none of these Griffiths' super-heroes had so far managed to uncover 'the wasted millions that lay buried in the NHS'; but it was pretty cold comfort.

The managers' journals were increasingly expounding radical new ideas that made Consultants' hair stand on end . . . no more jobs for life, General Managers sitting on Consultant Appointment Committees, Districts holding Consultant contracts and, worst of all, performance-related pay. Tales also abounded of health authorities trying to gag doctors who spoke out in what they regarded as being the patient's interest. Speaking on election day itself, Paddy Ross, the Chairman of the British Medical Association Central Committee for Hospital Medical Services, starkly outlined the choice 'General Management would not go away if Consultants acted like ostriches. The choice was simple—get involved as a profession or be overtaken by the process!' He went on to issue a stern warning to managers to 'stop tampering with our nationally agreed terms and conditions of service; stop trying to modify the nationally agreed model form of contract; stop playing games with the statutory instrument that governs advisory appointment committees for consultants; and, stop trying to move our contract to District by stealth'. The British Medical Association Senior Staff Conference backed a strongly worded statement that Consultants were contractually accountable to their employing health authority—professionally accountable to the General Medical Council and not managerially accountable to the general manager. Paddy Ross's message to managers was clear 'You are alienating the most senior staff group in the hospital service, and you are seeking a battle that you will not win'. The doctors were beginning to smoulder arid they were spoiling for a fight.

THE STORM BREAKS

The Conservatives won the election in June 1987 though its majority was trimmed to 101. Norman Fowler—Teflon man—the longest serving Secretary of State of all time: moved on. The doctors were not reassured by the appointment of his successor,

John Moore. All kinds of talk was circulating about radical new approaches to funding the NHS. A book by John Peet, the health correspondent of *The Economist*, entitled *Healthy Competition: How to Improve the NHS*[70] was attracting wide scale interest as was the announcement by both the King's Fund and the IHSM that they were studying alternative funding mechanisms. John Moore was a known supporter of private medicine and it was not clear where he stood on the NHS. Some recalled the 'Think Tank Report' of 1982 and its ideas about health insurance and wondered whether it was about to re-emerge from a dusty shelf in Conservative Party HQ.

'Moore pledges reform of the health service' ran the headline in *The Times* after his first major speech at the Conservative Party Conference in October 1987. 'If we are to have a health service that works for us now and into the twenty first century, we have to sweep away myths and dispense with sacred cows.'

Doctors were beginning to wonder if they themselves might be the sacrifice he had in mind. Managers were not sure what he had in mind either.

The family doctors were also fed up. They were tired of waiting to hear the government's response to the Green Paper *Primary Health Care: an Agenda for discussion* published in 1986.[54] It was now nearly three years since the Secretary of State had promised the Society of Family Practitioner Committees proposals on the future of primary health care yet it had not even been thought worth a mention in the Queen's Speech for the new session. Three years was a long time to wait.

On 16 October 1987 a great storm wreaked havoc across the south of England. 'Is the Almighty on the side of the administrators?' *The British Medical Journal* was to ask as the great gale badly damaged a surgical ward just reprieved from threat of closure, saving the health authority the job of shutting it down. The violent weather even stopped John Moore travelling north to announce to the Society of Family Practitioner Committees the news they were eagerly awaiting that 'Medicine's own big bang'—the Primary Health Care White Paper—would be published within the next month. The storm left a trail of debris and destruction in its wake; when it abated the National Association of Health Authorities estimated that health authorities in the south were looking at a repair bill of at least £15 m.

But the great storm was but nothing to the storm now gathering on the NHS horizon. Reports were beginning to trickle in of hospitals forced to make cuts in service, of junior doctors collapsing on the job from fatigue, of freezes on staff vacancies and of patients facing long waits for treatment. Soon everywhere, it seemed, doctors were at loggerheads with local management. The reports flowed in: bed closures in Doncaster to save £700,000; wards shut in Central Birmingham to save £750,00; Darlington yet to decide measures to halt a £900,000 overspend; South East Thames Region short of £9·3 m despite ward closures and cuts already having taken place—family doctors urged to restrict referrals to emergency and urgent cases; North West Thames projecting a similar £9 m deficit—Districts actively drawing up plans to cut spending.

'Your NHS is falling apart', said an advertisement placed in the paper by hospital consultants in West Berkshire in September, protesting at plans to save £1·3 m by closing down wards. (The hospital manager, recruited from the private sector was later to resign in protest at the measures he was being forced to take to balance the budget). No-one took much notice at first—health authorities were always crying wolf—but it very soon became apparent that it was not the usual run of the mill 'shroud waving' which had become almost a ritualistic feature of NHS life. 'Every winter we had the same rows about cuts—we were pouring more and more money into a sort of bottomless pit', Kenneth Clarke was to say of his first spell at Health as No 2 to Norman Fowler.

Amidst reports that the Thames Regions were heading for a massive overspend it emerged that the NHS Management Board had requested an urgent report from Regions, requesting details of what the *Health Service Journal* described as 'budget juggling tactics' taken by District Health Authorities to 'window dress' their books.

The National Association of Health Authorities' Autumn Survey[71] to which 106 out of 192 District Health Authorities responded, suggested around 53 per cent of Districts were in serious financial trouble. The Health Authorities blamed underfunding of pay and prices, amounting to around 1·55 per cent of the total cash limit, and reported that they were deferring service developments, transferring capital to revenue, freezing recruitment and taking other measures that might in the words of the

report 'adversely affect the liquidity of the health authority'. Ian Mills, the Director of Finance of the NHS Management Board, was to advise Ministers more bluntly that 'The NHS was technically bankrupt'. 'Why should we pay for mistakes at the top?' asked the doctors. The list of Authorities with financial problems continued to grow.

The announcement of long-awaited plans for future medical staffing in hospitals 'Achieving a *Balance*'[72] designed to cut junior doctors' hours and end the situation of too many patients treated by doctors who were inadequately trained or supervised came and went on 27 October with barely an audible murmur. Mind you, it had been issued as a consultative document over a year earlier after a protracted series of negotiations with the profession.

Meanwhile, family doctors began to brace themselves for the promised announcement on the Primary Health Care White Paper expected on 19 November—Moore's 'personal NHS initiative'. It would mean a new contract and the British Medical Journal did not under-estimate the challenge facing the profession. 'For family doctors, it will bring their first experience of a major negotiation with the Thatcher administration, which has not only never shirked taking on vested interests from the miners to the City, but has seldom lost the argument'. Then fate intervened—John Moore went down with influenza which quickly turned to pneumonia. The announcement was postponed. He was still ill on 25 November and it was left to Tony Newton to announce the new policy initiative and the associated Health and Medicines Bill on that day. By then the 'big bang' had turned into a whimper. One of the most far reaching pieces of social reform in the history of the NHS destined to transform the face of primary health care attracted only passing notice, for what had started as a trickle of bad news about cuts in health services had turned into a torrent and from a torrent into a flood.

THE SPIRAL OF DESPAIR

Cuts in London made daily headline news. Consultants at St Thomas' Hospital offered to donate 5 per cent of their salary to keep a ward open. Nurses there talked of pushing beds—one for every bed closed—to the doors of Westminster. The West Mid-

lands Region was also hard hit — Birmingham, Bromsgrove and Redditch, Cheltenham — the list seemed to grow by the day.

The scale of the crisis was unprecedented. A British Medical Association survey in the Spring of 1988 suggested that across the country as many as 3,100 beds could have been closed during 1987–88 for financial reasons. A survey in December by *The Independent* also put the figure at well over 3,000. These closures were to put considerable strains on the relationship between District Health Authorities and Community Health Councils. Substantial shortages of medical and nursing staff were also reported.

The NHS was in danger of entering a 'spiral of despair', the Regional General Managers advised the NHS Management Board.

The government announced that the NHS was to receive £700 m extra resources in 1988–89 and £800 m in 1989–90 but it cut little ice. Who cared about tomorrow? The crisis was about today.

Then the crisis began to show its human face — most poignantly in the case of a small baby, barely a few weeks old, waiting for 'hole in the heart' surgery in Birmingham whose operation had been cancelled no less than five times due, it was said, to shortages of skilled nursing staff.

Following the lead set by a patient waiting for dialysis treatment, the desperate parents took the Health Authority to court.

The baby was finally admitted for surgery on the very day the Court of Appeal turned down his parents' application for a judicial review, only to die 10 days later. He was just eight weeks old. The Consultant claimed that he had been told by his local Health Authority Chairman to stop speaking out about the plight of patients. Was this genuine or shroud waving? It depended where you sat.The media had a field day.

On 18 November, the Regional Chairmen expressed their concern to Ministers about the deepening crisis. The NHS could not keep going. 'We cannot have Dunkirk after Dunkirk after Dunkirk' said one elder statesman. Ministers were impressed but held out little prospect of more cash.

A major debate on the health service was scheduled for 26 November 1987—it was the day after the introduction of the Health and Medicines Bill and could not have been worst timing.

The Bill itself was controversial as it contained proposals for phasing out free dental and eye checks. With a twist of irony it also set out provisions permitting health authorities to generate income through profit making enterprises, such as leasing space to shops, providing health clubs and hiring out services. It was estimated this move could raise £20 m in 1988–89 and possibly £70 m in three years' time.

Tory backbenchers made plain their displeasure at the government's current health policy, seizing on the income generation plans. 'You can't buy billions by selling buns!!', cried Dame Jill Knight, Chairman of the Conservative Backbench Health Committee — '\lie don't need a modest increase. We need hundreds of millions of pounds'. So serious had the crisis now become, that behind the scenes Tory backbenchers were reputed to be pressing for the Prime Minister to take personal charge of the situation.

The crisis continued unabated. In December, as the *British Medical Journal* put it 'decibels were rising about untreated patients, closed beds, absent nurses, and impecunious Health Authorities.' MPs received a stream of letters from Consultant medical staff. In Manchester, 15 intensive care cots closed. Nurses from St Thomas' Hospital spent a week picketing Parliament in their uniforms. The British Medical Association petitioned the government. Then on 7 December 1987, the Presidents of the Royal Colleges of Physicians, Surgeons and Obstetricians and Gynaecologists, in a rare public expression of unity, issued a Joint Statement:—

'Every day we learn of new problems in the NHS — beds are shut, operating theatres are not available, emergency wards are closed, essential services are shut down in order to make financial savings. In spite of the efforts of doctors, nurses and other hospital staff, patient care is deteriorating. Acute hospital services have almost reached breaking point. Morale is depressingly low.

It is not only patient care that is suffering. Financial stringencies have hit academic aspects of medicine in particular, because of the additional burden of reduced University Grants Committee funding. Yet the future of medicine depends on the quality of our clinical teachers and research workers.

Face saving initiatives such as the allocation of £30m for waiting lists are not the answer. An immediate overall review of acute

hospital services is mandatory. Additional and alternative funding must be found. We call on the government to do something now to save our health service, once the envy of the world'.

PANORAMA

The battle was now firmly joined. *The Health Service Journal* put it less eloquently, 'The Prime Minister and the highest echelons of the medical establishment are having a slanging match'.

On 16 December 1987, a beleaguered Tony Newton (John Moore was still laid low with illness—the press sharply attacking him for choosing to be treated privately rather than on the NHS) reported that the Department of Health and Social Security's own monitoring returns had shown a shortfall in District Health Authority income and over £100 m extra funds were to be allocated in the current financial year as a one-off payment.

This emergency injection of funding was welcome but the professions howled with derision. The National Association of Health Authorities' survey had shown a shortfall of £228 m. The Institute of Health Services Management demanded to meet the Prime Minister, criticising the lack of leadership from the Department. The House of Commons Select Committee for Social Services announced its own enquiry into the resourcing of the NHS. The government, it was rumoured, was determined to bring the 'doctors to heel'.

Christmas intervened but the respite was only temporary. *The British Medical Journal* launched a scorching attack on the government in its first editorial of the New Year. Doctors accompanied by Tory MPs presented a petition to Downing Street. 100 Consultants in Birmingham launched a campaign to save the NHS.

Then the nurses joined the fray. The Royal College of Nursing, National Union of Public Employees and the Confederation of Health Service Employees launched a renewed campaign for better pay in December 1987 to stem the 'haemorrhage of nurses' leaving the NHS and to protest at government plans to offset the cost of the proposed new clinical grading structure by a reduction in unsocial hours payments. The Royal College of Nursing stuck to its anti-strike stance but in Manchester nurses from the National Union of Public Employees went on strike over the plans of the 'hard-hearted' health authority to cut unsocial hours al-

lowances for looking after elderly people. This was followed by spontaneous action in other parts of the country. A national Day of Action was called for 3 February 1988.

In Yorkshire Region blood transfusion services were disrupted by a strike over new subsistence allowances which had reduced workers' take home pay. The action looked poised to spread and operations were threatened across the country. Uncharacteristically the government gave way.

As doctors and nurses spoke of shabby rundown hospitals with paint peeling from the walls, John Moore returned to work to the Department of Health and Social Security's new 'palatial headquarters' at Richmond House.

The Presidents of the three Royal Colleges met with him on 13 January and came away in an optimistic mood, encouraged by what they thought was a promise of more resources and a fundamental review of the NHS. But their hopes were promptly knocked on the head by an emphatic denial from the Treasury that there would be any more new tax payers' money for the NHS. The Royal Colleges felt they had been duped—fuelled by reports that the Prime Minister had referred to them as 'upmarket trade unions'. Sir Raymond Hoffenberg, President of the Royal College of Physicians, giving evidence to the Select Committee, likened the government's health policy to applying 'elastoplasts to erupting sores until the whole body was covered in plasters'.

On 18 January 1988 Sir John Harvey Jones observed—'The NHS has fallen over the edge, throwing money at it will not help . . . it needs a radical change'.

Everyone began to look to the Prime Minister. Surely there would be a statement in the House? There was a debate in the Commons on 19 January which produced nothing new but which did secure a comfortable government majority. Then on 25 January Margaret Thatcher appeared on 'Panorama'. She deftly dismissed any idea of a Royal Commission—one could not afford to wait that long. She was now personally taking an interest in the NHS and with the Cabinet would be making a thorough examination. 'We will hold our own inquiries and our own consultations . . . We are looking at all possibilities. It is our bounden duty to do so'. A no holds barred Review of the NHS was under way as the service entered its fortieth anniversary celebration year.

Suddenly, almost abruptly, it was over—the squall subsided;

health service workers kept up the pressure on the government with demonstrations and torch lit processions for some months but the storm had blown itself out.

The Review was expected to take six months though no firm timetable was ever announced—indeed it is a curious fact that very little information was ever made available to the Parliament or the public about the review—who was involved, what was being considered and how long it would take. In the end it took a whole year with the publication of the White Paper *Working for Patients*[76] in January 1989. 'It is so long since the Prime Minister announced an enquiry into the NHS that by the time the result was published at the end of January it was difficult to remember why it had been set up', commented the Editor of the journal of the Institute of Health Services Management.

CASH: THE PERENNIAL PROBLEM

The financial crisis had in reality been building for some time, with problems over funding levels compounded by the way in which the NHS was managing its resources.

In 1987–88 the service had gone over the edge. There were several reasons for this. First, cash releasing cost improvements in the non-direct patient care services were beginning to dry up. Increasingly managers were having to look at constraining or cutting back patient care services which was bringing them into confrontation with clinicians. Second, 1987–88 pay awards had been seriously under-funded. In April 1987 (in the run-up to the general election) for the first time since 1980 the government had accepted in full the Pay Body Review recommendations on doctors' and nurses' pay. Other larger than expected pay rises for key frontline staff had followed.

Non-pay costs had also escalated, especially for medical supplies and British Telecom charges.

In London the situation was aggravated by the Resource Allocation Working Party policy which had depressed growth rates in the London regions for years and forced major resource shifts within individual Regions.

Ten years of the Resource Allocation Working Party (RAWP) policy had substantially achieved its objectives and was increasingly difficult to sustain politically. Money had moved but not

hospital doctors, who were still trying to practice medicine at a level that London Authorities could no longer afford. It was consequently hardly surprising that the public was mistaking resource re-distribution for cuts.

It was against this background that the NHS Management Board undertook a review of the RAWP formula in 1985–86 and concluded it had largely served its purpose. By 1988–89 the gap between Regions had indeed been reduced sharply. At its widest point the gap was still 11.28 per cent (East Anglia minus 3.99 and North East Thames plus 7.29) but by now 11 of the 14 Regions were within three per cent either side of the target. RAWP had been a success.

In the eyes of the government the problem of the NHS lay not in under-funding but in the absence of incentives or the will to improve efficiency.

However, efficiency was a double-edged sword. Many acute hospitals were caught up in the so-called 'efficiency trap' i.e. treating more patients at a cheaper cost did not necessarily pay, as it still cost more money in overall terms and this was cash which the NHS did not have. This dilemma was summarised by the Acting General Manager of the East Anglia Regional Health Authority in evidence to the Select Committee:

'Health Authorities are being subjected to two conflicting pressures. On the one hand, we are being urged to treat more patients by speeding throughput and using resources more intensively—improving productivity at marginal costs which in any other sector of the economy would result in increased profits. On the other hand funds needed to meet those marginal costs and achieve this improvement may not be available. The result is frustration all around and increasing financial pressures'.

What the government needed was to find a way of creating a climate for getting the incentives right; for giving rewards to high performing units, enabling them to escape the efficiency trap; for providing the levers and opportunities for improving health and in particular, reducing the growing numbers of patients waiting a long time for treatment; and for shifting the focus of public attention away from government policy to the performance of the NHS itself and particularly its managers.

Increasingly the government was taken by the ideas of Alain

Enthoven.[65] Even before the fateful announcement on 'Panorama', the Prime Minister was known from a press interview in October to be warming to the idea of a health care market.

WINNERS AND LOSERS

So the crisis was over but what did it mean? There were no clear 'winners' or 'losers' except as usual for those patients caught up in the fray. The Prime Minister had held firm on the question of resources. There was to be no more cash for the NHS but she had been forced to concede a 'no holds barred' review of the NHS—a major policy review which had not formed any part of the government's legislative plans for the current Parliament. Although Sir Kenneth Stowe had indicated that it was 'no secret that a very few of us concerned with the future of the NHS had concluded before the General Election of 1987, that we could not go on as we were' the 'efficiency trap' looked as if it may have led the government into a potential 'heffalump trap'. (The Guardian Political Correspondent, Alan Travis, claimed Mrs Thatcher once likened the NHS in discussions with cabinet colleagues to the 'heffalump' trap in Winnie The Pooh 'a hole in the ground that was only to be tampered with at your peril'.)

The doctors had secured the government's commitment to the NHS but had been denied their 'crock of gold'. As Sir Bryan Thwaites, the Chairman of Wessex Regional Health Authority, commented in October 1988 'There was an obstinate refusal to admit that the overwhelmingly huge proportion of the service to patients was carrying on business as usual... The three Presidents of the Royal Colleges were imprudent and did their cause no good to skate onto Lake Crisis when it was covered by such wafer thin ice'. As he had earlier pointed out in his aptly named lecture in May 1987 'The NHS—the End of the Rainbow?'[73] 'It is foolish to think that the NHS can persist by trying to do everything that is medically possible—it follows that bounds and limits need to be set'. The Presidents may have been imprudent and may have precipitated changes beyond their worst fears, but events so propelled them that they probably had little choice. Their sincerity of purpose and belief in the NHS should not be questioned.

The managers had been shaken by doctors' claims that 'virtu-

ally everywhere the clinicians are disenchanted with management which seems unsympathetic and often incompetent'. For many doctors it seemed that in the build-up to the crisis, managers had either like Nero played beautiful music on the violin—with talk of winning the 'hearts and minds' of staff, raising quality standards and improving health, while Rome or Birmingham or London burned. Or, as others might put it, they had become so blinkered in their pursuit of financial goals that they had forgotten what the NHS was here for. Balancing the books often seemed to doctors to be a higher managerial priority than providing patients with good quality care.

But attitudes were beginning to shift. Out of the crisis grew a new awareness of the need for hospital doctors and managers to work more closely together, and with it a new sense of realism. Most doctors were beginning to understand that 'shroud waving' would not persuade central government to conjure up more cash. Hard choices could not be avoided. Both sides had to decide in the words of an Institute of Health Services Management Day Seminar held in early 1988 whether 'Management and Medicine' wanted to be on a course for collision or collaboration.

13

MANAGEMENT AND THE HEALTH PROFESSIONS

MANAGING CLINICAL PRACTICE: THE NEW FRONTIER?

'MANAGING CLINICAL PRACTICE REPRESENTS THE NEW FRONTIER' said Cyril Chantler, Professor of Paediatric Nephrology and former Unit General Manager of Guy's Hospital and a member of the NHS Policy Board. He perhaps should have said a crucial point of change and balance in the organisation of the NHS. Until the introduction of general management, the NHS was in Strong and Robinson's words 'a giant state organisation which was controlled simultaneously both by Whitehall and by 30,000 doctors'.[57] The King's Fund, in its futuristic book written in 1967 *The Shape of Hospital Management in 1980?*,[11] had foreseen the need for a general manager who would manage in every area, including that area where the 'elements of anarchy lie most thick' the clinical services.

By the time of the 'Griffiths' Report' in 1983, the need to involve clinicians more closely in the management of hospitals, especially large units with 200 or more Consultants and numerous specialties and sub-specialties, was widely acknowledged amongst managers, particularly in decisions about the use of resources. How to achieve this was a major dilemma. Iden Wickings, first at the Westminster Hospital and later in Brent, took the idea of planning agreements with clinical teams and clinical budgets quite a long way.

It was an uphill task. As Unit General Managers had found, most Consultants were not keen to participate because of time constraints and the fear that it would involve them 'in a financially driven workload insensitive budgetary system'. It required at least a few enthusiasts amongst senior Consultants and determined leadership. Managers met with mixed success. Those with a clin-

ical background such as Professor Chantler at Guy's had a certain edge, although they were not the only ones to make progress. To do so, managers needed to demonstrate a sound intellectual grasp of the issues at stake with some scientific and clinical insights; establish personal and professional credibility and trust; deliver on promises and plans and develop a network of winning alliances.

To help, pilot schemes of 'management budgets' for doctors got off the ground in late 1983 but were not initially judged to be wildly successful because of the concentration on the technical rather than the human dimensions of change. These were re-launched under the 'Resource Management Initiative' banner in 1986 by Ian Mills. the NHS Management Board Director of Finance, but only after he had conducted extensive private negotiations with the professions. He launched it with the style and energy that was characteristic of the man. Whilst there were many examples of doctors and managers pulling together, there were others (perhaps better reported) where the attempt had resulted in stony silence or outright confrontation. 'The glorious Griffiths' image of the District General Manager cutting through the bureaucratic undergrowth is just hogwash. You can cut through it as much as you like, but when you've done it, you're just left up there against the Consultants who are saying 'no'' said one battle scarred manager. But from 1987 onwards there was a new realisation that it was in the mutual interests of doctors and managers to make it work. *Working for Patients* was to imply greater managerial participation in clinical practice but as Patricia Day and Rudolf Klein were to point out, it also implied greater clinical participation in managerial practice.[142] Cyril Chantler put it more succinctly — 'Doctors must play a bigger part in managing the health service to protect their clinical freedom'.

THE CLINICAL DIRECTORATES

There was still, however, no satisfactory blueprint or model as to how this was to be achieved.

Working for Patients recognised that the Resource Management Initiative must be rolled out to encompass all major acute hospitals if the reforms were to work successfully. In June 1989 the Resource Management Division of the NHS Management Executive commissioned the Institute of Health Services Management

to carry out a rapid survey and analysis of clinical management models around the United Kingdom.

Most interest focused on the so-called 'Clinical Directorate' model developed in the United States at the Johns Hopkins Hospital in Baltimore and championed in the United Kingdom by Professor Cyril Chantler. In this model, clinical services are organised into a series of Directorates. For each Directorate a clinical director or lead Consultant is 'appointed' by the Unit General Manager but more normally in practice chosen by other consultants to act on their behalf. He/she assumes responsibility for managerial leadership and representing overall specialty interests as the 'first amongst equals', including initiating change, agreeing planned workloads and associated resource commitments with the Unit General Manager, and acting as prime budget holder.

As such he/she has more akin to a 'contractual' rather than a 'managerial' relationship with fellow Consultants and the Hospital General Manager. The clinical director cannot tell his colleagues what to do—only negotiate and persuade — and similarly the Unit General Manager cannot tell the clinical director what to do... that at least is the theory. The Consultants are invariably part-time managers and continue to spend most of their working week on clinical practice. Most Directorates operate with the support of 'business managers' and try to involve the emerging breed of Unit Accountant who is paid to be 'nosey' and 'think laterally'. Getting the Senior Nurse Management input right has been more problematic because of the potential conflict with professional line loyalties to the Cnit Director of Nursing Services (nurses indeed have commented that comparatively little attention was paid to involving nurses in resource management in its formulative stages).

The clinical directorate model has since evolved as the most common model of organisation although it has not yet reached maturity. The relationships are still not easy. To many managers 'Leading doctors is still like herding cats. It is unclear where the power lies' whilst many doctors consider 'many managers are still of dubious competence and adopt the macho bull in the china shop image'. The Institute of Health Services Management study, however, emphasised that whatever the model chosen — 'the most important pre-requisite for effective clinical management is for

doctors and managers to know more about and better understand each other's roles and responsibilities'. The normal clinical role increasingly demanded sophistication in managing people, using financial and clinical information, managing time and communicating well. Equally managers needed to be more understanding of the nature of clinical work and the motivations that influence clinicians.

It was a polite way of saying despite 40 years of working together, NHS managers and doctors still did not speak the same language. The NHS reforms were to quickly alter that.

PRIMARY HEALTH CARE: THE NEW REVOLUTION

1988 rattled by, but if it did not have the explosive quality of 1987 it certainly did not lack its own fireworks. December saw the resignation of Edwina Currie, the Junior Health Minister over remarks suggesting a linkage between salmonella and British egg production. Whatever her faults, she had brought energy, ideas and a flair for publicity to her ministerial brief as well as her experience in a former life as the Chairman of a Health Authority in the West Midlands.

Family Practitioner Committees were grappling with the implications of *Promoting Better Health*[74] which had introduced a far reaching programme of reforms for improving primary health care.

- Linking the remuneration of practitioners more directly to the level of performance to provide incentives to achieve health promotion/disease prevention targets in areas such as vaccination and immunisation and cervical cytology. 'Grab 'em and jab 'em is our attitude now' explained one General Practitioner later for the benefit of an American audience.
- Making contracts more sensitive to the range of services provided to encourage doctors to provide more comprehensive services such as regular care for elderly people and child health surveillance.
- Developing primary health care teams through the removal of restrictions on the types and numbers of staff General

Practitioners can employ under the direct reimbursement scheme.

- Achieving a better distribution of doctors and increasing financial support to improve premises, especially in deprived areas.
- Making more information available about local medical practices to enable the public to make informed choices about the selection of doctors.
- Simplifying and streamlining arrangements for handling complaints.

Primary Health Care stood on the verge of its own revolution. The White Paper also introduced important changes in the organisation of dental and pharmaceutical services. The government assumed a flexible position on the implementation of neighbourhood nursing, but in November 1987 it invited health authorities to review the way in which community nursing services were managed. The government also promised to look further at the possibility of employing nurse practitioners and giving nurses more freedoms to prescribe.

As predicted, for Family Practitioner Committees, *Promoting Better Health* meant a new management style. The Committees strived to respond to this challenge but it was becoming increasingly clear to people working in the service and to those at the centre working on the Prime Minister's review of the NHS that to lead the transformation from an 'administered' to a 'managed' service what each Family Practitioner Committee needed was a general manager.

Promoting Better Health also meant a new contract for family doctors. Somewhat ominously, General Practitioners were still in the throes of negotiating this contract as the turn of the year approached and with hindsight one could see the signs of a crisis building, but 1988 was dominated by a problem of a different kind—a crisis within the nursing profession.

NURSING: GLOOM AND DESPONDENCY

Nursing had been in a state of low level crisis for some time by the mid-1980s. The profession did not feel it had emerged very well

from the introduction of general management and its leaders were warning about being marginalised in the decision-making process. But the problem for nurses went deeper than this; the profession was still searching for a distinctive professional identity of its own. Doctors still regarded nurses as assistants and yet other professionals, such as psychologists and physiotherapists, were growing up alongside them and taking a more autonomous professional role.

This was also the period when the so called 'black hole' in the recruitment market was identified as a consequence of a projected fall in the number of school leavers. Gloom and despondency seemed to pervade the profession.

Nursing, and more particularly its authoritarian hierarchy and tradition, was increasingly out of tune with the rest of society and the expectations of the modern woman. There were nurses who wanted to develop and expand their professional role but by and large the system smothered them. Health Visiting was an exception to this rule and had by this time developed an independent professional role which was itself sometimes a cause of friction with General Practice.

Midwives, who had always had some measure of independence from doctors, were chaffing at the bit for more and groups of 'radical' midwives began to emerge, arguing for women's rights to choose an exclusive midwife led obstetric service.

This was also the heyday of the nursing formulae which told you how many staff you needed on duty for any given patient dependency. The National Health Service Manpower Planning Advisory Group identified a wide range of different formulae producing radically different answers, each with their own set of devotees and advocates. Aberdeen, Telford, Trent and Senior were the names on the lips of nurse managers.

But nursing on the ground was beginning to change. Ideas about holistic approaches to care were developing into practical professional practices. The 'nursing process' began moving away from a task orientated ('you do all the temperatures and I'll do the drugs') to a more patient centred approach leading to personalised care plans for patients (primary nursing). Progress was, however, patchy and much of nursing stuck to its old traditional ways of working. The middle management of nursing was just as resistant to change as their colleagues in any other large and long estab-

lished manufacturing industry. But whatever was wrong within the profession nurses retained their high public esteem.

1986 saw major changes proposed in nursing training with the announcement of the introduction of Project 2000 which moved away from the traditional apprentice based system of training to a college based education with learners becoming supernumerary to establishment. This was phased in from 1988 onwards. At about the same time the concept of NCVQ (National Council for Vocational Qualifications) training for unqualified health service support workers emerged (though the first NVQ was not launched until 1990).

In the same year (1986) Anne Poole, the Chief Nursing Officer, called the leaders of the profession together for a serious look into the future. Their joint report 'A *Strategy for Nursing*' in 1989[75] produced 44 action points which concentrated on developing professional leadership, primary nursing, a more extended clinical role, and better training.

The leaders of the profession were by now talking openly about the emergence of a highly skilled 'nurse practitioner' and the disappearance of enrolled nurses. Not everybody was happy. The doctors made clear their opinion that practical skills were more important than academic training. Managers began to worry about who would do the day-to-day work at the bedside. At the same time the Department of Health was trying to re-jig the nursing career structure in order to give greater weight to clinical skills and responsibility.

Inevitably, the creation of this new career structure was inextricably linked to pay.

'THE BIGGEST CON THAT EVER WAS'

Pay was a very sore point with nurses, whom by 1987 numbered nearly 404,000. It was estimated that 3p in every pound of public spending went on nurses' pay. The nurses felt, however, with some justification, that their pay was beginning to lag behind other occupational groups. In 1985 4 out of every 10 nurses were said by the National Union of Public Employees to be living below the poverty line.

The growing arguments over nurses' pay prompted the Chairmen of Regional Health Authorities to commission a study by

Price Waterhouse in 1987. The results published in 1988 showed that 67 per cent of NHS nurses, especially those in the younger age groups, felt their pay was poor and 85 per cent compared it unfavourably with jobs outside, particularly the police force. Equally as worrying, the Price Waterhouse study confirmed that nurses appeared disenchanted with local management. 'A lot of nurses feel you are just a number; you are just a pair of hands, a pair of feet,—get on with it'.

In 1987 the government accepted the Pay Body Review Board recommendations in full for nursing and, in the light of the financial crisis of 1987–88, impressed by the anti-strike stance taken by the Royal College of Nursing, agreed that the cost of the clinical grading structure should not be offset by savings in unsocial hours payments. As one commentator put it 'It was not the time to be beastly to nurses'. A ballot of RCN members in the spring had produced a 4:1 vote in favour of its no strike policy.

Everything on the surface at least looked set fair for the successful implementation of the grading structure. In April 1988 the government again agreed to fund the Pay Body Award in full. 'It is good news for the staff, good news for the patients and good news for the country,' said John Moore. Yet by July 1988 the Royal College of Nursing was calling the deal 'the biggest con that ever was'. Implementation had turned out to be an elephant trap.

Nurses alleged that quota systems were being imposed by management to prevent costly grade drift. In some parts of the NHS they clearly were. At first it appeared that the Treasury would not fund the increased costs in full but then in October 1988, the Department of Health announced an extra £110 m on top of the £803 m already provided.

The local interpretation of grading definitions emerged as a major bone of contention. The process set nurse against nurse, left a bitter legacy of disharmony between nurses and local management and clogged up the administrative machinery of Authorities for years to come as the Trade Unions encouraged appeal after appeal against local grading decisions. By March 1989 over 100,000 appeals had been lodged and in April 1992 the Royal College of Nursing claimed 30,000 still had to be heard.

Managers blamed 'the duff wording' of the centrally negotiated agreement drafted 'with all the consistency of shaking a bag full of Scrabble letters' but Ministers were not impressed with either the

performance of general management or senior nurses. Kenneth Clarke made plain his view 'No other organisation could have made such a Horlicks of such a change.'

Mr Clarke had become Secretary of State for Health in July 1988 following the decision of the Prime Minister to split the Department into two independent Ministries: John Moore stayed with Social Security. Clarke had inherited the NHS Review mid-way through and immediately set about re-shaping its direction. In the words of Tony Kember (formerly with the NHS Management Executive and the South-West Thames RHA) 'Kenneth Clarke did not want to kick the NHS because it would only bruise and heal. To him, it needed a heart attack—the kiss of life and a new start'. Clarke's most radical idea, GP Fundholding, is said to have developed and grown on a beach in Spain, far away from the restraints of those who might have counselled caution and impracticability. With Clarke in the driving seat the NHS review reached its conclusion, although by all accounts Mrs Thatcher played a very strong personal role in shaping the final result.

14

THE NHS REFORMS

HURRAY FOR HOLLYWOOD: THE LIMEHOUSE LAUNCH

IT WAS BY NOW JANUARY 1989. THE NHS REVIEW WAS COMPLETE AND Mrs Thatcher was putting the final stamp of approval on the programme of change. The NHS Reforms were about to be unveiled.

On 31 January 1989, Kenneth Clarke sailed up from Westminster to the Limehouse Studios in London's Docklands to launch the White Paper *Working for Patients*" in the manner of 'a grand medieval monarch'. 'A bit of big brother and a hunk of Hollywood' helped introduce the White Paper *Working for Patients* to Regional Managers wrote the *Health Service Journal.* It was the dawning of the age of the teleconference. Kenneth Clarke's speech was beamed simultaneously live to 2,500 NHS doctors, managers and chairmen tuning in from Regional centres up and down the country. The well known TV presenter Nick Ross of '*Crimewatch UK*' acted as linkman, but only after, so it was said, some personal agonising about the political nature of the event. One journalist likened it to the Eurovision Song contest. The launch was to be quickly followed up with a series of Regional roadshows.

The NHS had never known anything like it but behind all the 'glitz' and the Hollywood razzamatazz lay a serious purpose. It was the first attempt at a controlled mass communications exercise throughout the NHS. Managers were to return armed with videos and briefing packs to spread the news throughout the service. No longer would staff be left to read about major changes to be introduced into the NHS in the national and local press. There were complaints in Parliament about the cost, estimated at £1.25 m, but as some health service managers pointed out with 1 million employees that worked out at only £1.25p per head. If

the cascade worked and the message got through, it was money well spent.

The teleconference also introduced to the NHS its new Chief Executive, Duncan Nichol, who was to succeed Len Peach on 1 February 1989. The former Regional General Manager of Mersey Regional Health Authority and a product of the National Administrative Training Scheme, he was the first practising health service manager to become Chief Executive of the NHS.

'WORKING FOR PATIENTS'

Most of the contents of *Working for Patients* had already been leaked in the press but the breadth of the reforms still took many people's breath away. What had started as a review of funding arrangements had changed tack mid-stream into a full scale review of the service. Nevertheless, on the White Paper's publication, many were immensely relieved to see that it re-affirmed the commitment to the 'basic principles of the NHS—an overwhelmingly tax financed service universal in its scope and free at point of use'.

The aims of the reforms were simple and straightforward:

- to give patients, wherever they live, better health care and greater choice of the services available; and
- to produce greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.

The White Paper said nothing about more cash but plenty about efficiency. 'In 1986–87 the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even after allowing for the complexity and mix of cases. In the same way, waiting times vary sharply and there are great differences in the referral rates and prescribing habits of GPs.'

Injecting more money by itself was not seen as the answer. What was needed was a new framework to raise the performance of all hospitals and general practices to that of the best.

- More delegation of responsibility to local level. District Health Authorities would be given more freedom from Regional Health Authorities and hospitals would be given much

more control over the running of their affairs through the creation of a purchaser: provider split at local level.

- The creation of NHS Trusts, independent of District Health Authorities, giving units which successfully applied for this status more freedom to manage their own affairs such as employing and determining the pay of their staff and raising capital within clearly defined limits.
- The introduction of the new health care contracting system known as the 'internal market'. Money would in future follow patients and go more directly to where work was done and done best. This would allow purchasers to make better use of their funds to secure a comprehensive range of services, especially in arranging treatment of people requiring surgery as they could be referred to hospitals outside the local area with shorter waiting lists. The system would also offer a way out of the efficiency trap by creating incentives for providers to improve their performance and attract more 'business'.
- The establishment of 100 additional new permanent consultant posts over and above existing plans to reduce waiting times, improve the quality of service, and help reduce the long hours worked by some junior doctors.
- The introduction of the General Practitioner Fundholding Initiative to allow large general practices to hold 'budgets' to purchase a defined range of services direct for patients on their list. Patients would also find it easier to change their General Practitioner.
- The reformation of Regional Health Authorities, District Health Authorities and Family Practitioner Committees (now to be known as Family Health Services Authorities). These would have a slimmed down membership with no Local Authority representation and be organised on business lines. They would have both Executive and Non-Executive Directors. The Family Health Services Authorities would in future have general managers and account directly to Regional Health Authorities. Community Health Councils would continue to act as a channel for consumer views.
- At national level, the Supervisory Board, which had not met

for almost a year, would be replaced by a Policy Board in May 1989 with a dynamic new approach and the Management Board re-modelled into the NHS Management Executive.

Better audit arrangements. The Audit Commission would in future be responsible for the audit of health authority financial accounts. Arrangements for medical audit by peer review would also be extended throughout the NHS.

THE NEW VISION OF HEALTH CARE

The real significance of the reforms, however, lay in their potential to:–

To create a consumer driven service in which choices over 'rationing' health care would increasingly be taken by 'consumers' or more commonly General Practitioners acting on their behalf.

To shift the balance of power away from hospitals and Consultants towards primary health care and General Practitioners. From now on, General Practitioners would find themselves feted by purchasers and providers alike, who would beat a path to surgery doors with the determination and tenacity of double glazing salesmen.

- To develop a pluralistic, and increasingly federalist system of health care organisation through the fragmentation of the purchaser/provider base. In 1989 it was calculated this new health care community could theoretically consist of nearly 320 independent member providers, 190 District Health Authority purchasers, 90 Family Health Services Authorities and thousands of General Practitioner Fundholders revolving like satellites around a central core of the NHS Management Executive and its intermediate tier.
- To give individual members within the organisational community considerable power and autonomy, thereby developing a health care system which would increasingly self-regulate its affairs and activities rather than be subject to central control and intervention.

- To achieve a subtle but conscious shift of emphasis away from 'efficiency' towards 'effectiveness' where quality and health outcomes would increasingly be ranked against quantity and cost.
- To bring the professions, especially doctors, into the management domain.
- To make the management of the NHS a 'professional' business (i.e. the NHS would no longer be managed through voluntary committees but through professional boards) and with it transform the role of the traditional public servant. The National Health Service Management Executive would also increasingly operate at 'arms length' from Westminster and Whitehall, signalled by the announcement in November 1989 of its planned physical separation and symbolic move to Leeds in 1992. The Chief Executive would also in future chair the Management Executive rather than a Minister, restoring the distinction between policy making and management originally envisaged by Griffiths.

THE 'LIMEHOUSE BLUES'

'Limehouse Blues' quickly set in, not least because *Working For Patients* was published as a White Paper rather than a Green Paper without the customary opportunity for consultation. It was a high risk strategy.

The programme of change was so wide-ranging that almost everyone found something in it both to like and dislike.

Fears were expressed about the radical nature of some of the proposals, whether they would all work in combination, the lack of clarity of certain aspects and the absence of experimentation. The NHS was used to change by detailed guidance and circulars spelling out exactly what must happen. This time the service was presented with powerful ideas (competition, purchaser/provider split, General Practice Fundholding) and invited to get on and implement them. For some, this was an invigorating and exciting way to change a large organisation. For others it was threatening and even frightening. A general concern was that too much change was being attempted in too short a time-scale. Everything

had to be in place by 1 April 1991. In February 1989, the first of eleven working papers was published to guide implementation.[96]

There was disappointment in some quarters that *Working For Patients* did not address community care. In March 1988, Sir Roy Griffiths had presented his report *Community Care: Agenda for Action*" but consideration of his recommendations had been put on ice pending the completion of the NHS Review, and in the event the government did not publish its response until November 1989.[78]

The doctors were most outspoken in their criticism. Many interpreted the lack of consultation both before and after publication as a deliberate snub to the medical profession. Mrs Thatcher had appeared to promise in the *'Panorama'* interview that proposals would be brought forward for consultation. 'The profession was being treated like slaves!' pronounced the *British Medical Journal.*

In April 1989, not to be outdone in the mass communication stakes, the British Medical Association launched its own publicity campaign opposing the reforms—'An S O S for the NHS'. 40,000 posters and 11 million leaflets were distributed through doctors' surgeries. The President of the BMA called the reforms an 'exercise in cost cutting' which would do 'serious damage to patient care and the doctor: patient relationship'. Patients were urged to write to their MPs, asking the government to reconsider 'so we can make the NHS into the kind of health service we all want to see'. The government, against a background of growing backbench concern, moderated its tone slightly. There was to be no going back on the direction or time-table for the reforms but it was a 'White Paper with green edges'. Future changes were not set in 'tablets of stone' and 'much dialogue with managers and clinicians' was needed. But the professions were not to be placated; another battle was in the wind.

KENNETH CLARKE TAKES ON THE GENERAL PRACTITIONERS

By this time the government was locked in conflict with family doctors over the terms of their new contract, which did not predispose the latter to the introduction of new ideas such as General Practice Fundholding 'the real joker in the re-structuring pack'

and Indicative Prescribing Budgets. The negotiations seemed to be interminable, and General Practitioner frustrations had been increased when *Working For Patients* unexpectedly impacted on general practice. (The British Medical Association negotiators claimed to have received assurances previously that the new set of NHS Reforms would not affect General Practitioners.) 'We have lost our existing contract, together with the independent contractor status; our charter has been torn up; our freedom of referral has gone; the partnership with Family Practitioner Committees has been destroyed and Local Medical Committees have been emasculated', lamented the Chairman of the Birmingham Local Medical Committee when the British Medical Association General Medical Services Committee met in February 1989. Mr Clarke made clear he did not intend to back down, indicating that he wished the 'more suspicious of our GPs would stop feeling nervously for their wallets every time I mention the word reform'. General Practitioners were enraged. 'No matter how much Mr Clarke bullies and stampedes and rushes—we will not bind the professions without consultation' retorted one of the chief negotiators.

In late April—early May, Kenneth Clarke thrashed out a deal with the negotiators, who recommended acceptance to General Practitioners 'We firmly believe the choice is between the implementation of an agreed package or the imposition of contractual changes unilaterally by the Secretary of State'. The General Practitioners, however, remained incensed by the proposed extension of capitation based payments, financial penalties on the use of deputising services, loss of group practice allowances and the setting of targets for preventative activities; they demanded a ballot. The results were announced in July. The vote was an overwhelming 3 to 1 against acceptance. Clarke threatened to impose the new contract and despite last ditch behind the scenes efforts to reach a negotiated settlement, eventually announced he would be bringing a Bill before Parliament which was passed on 1 November 1989. 'I have quite a reputation with doctors for being extremely and belligerently inflexible' he reflected in Autumn 1990 in an interview for the *British Medical Journal* published just after his departure from the Department of Health, entitled 'Hatchet Man or Remoulder?':—

'My defence is that I am actually doing something and that some of the things I am doing are not always with the consent of the community of doctors. . . The British Medical Association is accustomed to telling the government what its opinion is and the government doing what it is told. What they actually want is no new General Practitioner contract, no reforms'.

'A THOROUGHLY SALACIOUS AND DISGRACEFUL ADVERTISEMENT CAMPAIGN'

However, this lay in the future. In the meantime the British Medical Association's campaign was gathering pace. Self-governing hospitals emerged as the focus of the anti-reform lobbies despite these being dismissed by many informed observers such as Gordon Best, the Director of the King's Fund, as simply 'the ideological icing on the cake'. They will take the 'National out of the National Health Service' claimed critics. In June 1989 the government announced that 178 expressions of interest had been received in self-governing status. 'If Bevan stuffed Consultants' mouths with the gold of merit awards, Clarke seems intent on ingratiating the managers with the silver of opting out' the editor of the *British Medical Journal* had proclaimed a few months earlier.

A video was produced by the British Medical Association to show at public meetings. More leaflets were showered on patients through doctors' surgeries. In August giant posters began to be pasted up on 1,000 bill-boards a week up and down the country. The most infamous of these carried the slogan 'What do you call a man who ignores medical advice?—Mr Clarke'. In North London doctors collected 100,000 signatures on a petition against the reforms. Polls suggested that 67 per cent of the public believed the NHS was 'not safe in the government's hands'; that hospital consultants were 3:1 against the proposals and that only 1 in 8 favoured General Practice Fundholding.

In the House of Commons, a Tory MP was to condemn the British Medical Association's action as 'a thoroughly salacious and disgraceful advertisement campaign'. Hippocrates had been a thoroughly good chap, learned, humane, calm, pure of mind, grave and also reticent. 'I do not think any of these adjectives could be applied to the British Medical Association today' he roared.

The British Medical Association quickly proved that many doctors could have lucrative second careers as advertising executives. Hard-nosed public relations men marvelled at their new found prowess. In opposing the Reforms they found themselves with some unlikely bed fellows—the Royal College of Nursing, the Labour Party, Trade Unions, Community Health Councils and a cornucopia of consumer organisations. In August the House of Commons Select Committee on Social Services recommended the slowing down of implementation of the NHS Reforms. It might have been termed an 'unholy alliance' if this group had not also included the General Synod of the Church of England and the Methodist Congress.

It had become a mass communications battle to win the support of the public and the NHS professionals fought in twentieth century public relations terms—TV interviews, press conferences, newspapers, mailshots, advertisements, videos, teleconferences, public opinion surveys—all the latest in public relations techniques and technology were enlisted by both sides. The NHS had never experienced anything like this in its history. A 'wall of protest' was sent to Mrs Thatcher with 1 million signatures. In the confusion, alarm began to spread amongst the general public.

'MARKETSPEAK'

The use of commercial language such as markets and contracts gave rise to anxiety that the NHS was about to be turned into a 'business' (General Managers began to be called Chief Executives about this time). The government moved swiftly to clarify their intentions, reiterating earlier assurances. The NHS would never be a business but it did need to be more 'business-like' in the management of both financial and manpower resources. 'Medicine is more important than baked beans but most baked bean companies run better than most hospitals' explained Kenneth Clarke.

Opponents of the reforms changed the term 'Self-governing Trust' to 'opted-out hospital' and convinced many members of the public that hospitals were going to 'opt-out' of the NHS altogether and would no longer treat NHS patients free of charge. Fears developed that it would lead to a two tier service of first and second class hospitals.

Giving General Practitioners budgets to purchase hospital and certain other services also aroused considerable suspicion. Many members of the public, especially elderly people, became frightened that General Practitioners would not take them on their books if they required expensive forms of treatment or high cost drugs. They grew scared that once their 'credit' was exhausted, their treatment would be stopped.

People became worried that they would have to pay at Accident and Emergency departments; that rather than having more choice, they would be made to travel long distances away from their homes to get treatment where it was cheapest, or that hospitals would cut corners on their care to save money.

General Practitioners also became alarmed that District Health Authorities as purchasers would dictate where patients would go.

It was a case of information, misinformation and disinformation.

Managers were urged to clean up their 'market speak'. As Griffiths was later to say 'we have to explain in simpler terms the intent of the reforms for the man in the street and the general body of staff. . . in *Coronation Street* and 'Albert Square' one can imagine they talk of little else, except the internal market or the purchaser/provider relationship.'

Top Managers, as the local spokesmen for the NHS, soon found themselves playing a key role in defusing public concerns, often leading to criticism by opponents of the reforms that they had breached their traditional 'neutrality' as public servants. (Managers themselves were privately known to be divided like all professional groups about the merits of the Reforms. In September 1989 it was revealed that a sample survey by the Institute of Health Services Management had shown 62 per cent of rank and file managers were against General Practice Fundholding and that 54 per cent opposed self-governing Trusts.)

AMBULANCE WORKERS TAKE TO THE STREETS

By now the government was also locked in to another industrial relations dispute. Ambulance crews voted 4 to 1 in favour of industrial action after rejecting a 6.5 per cent final pay offer. As usual, pay comparability lay at the root of the ambulance staffs' discontent. British Rail and the BBC had received pay awards of

8·8 per cent and the Police 9.25 per cent. A ban on overtime and rest day working commenced in September 1989. Ambulance controllers and officers later joined the dispute. Soon ambulance services in London were crippled. Response times for emergencies were almost double the recommended time. The police, the St John's Ambulance brigade and the Red Cross were called in to provide cover. As the industrial action escalated troops were brought in. Appearances explaining the government's case made Duncan Nichol a familiar face on TV sets in homes up and down the country. The dispute was to drag on until March 1990 when a settlement was eventually reached. Both sides were to claim victories — The National Union of Public Employees saying it had secured a 17.6 per cent increase for qualified staff over two years. In practice, victory (if that is what it could be called), was for the Government, who had held pretty firm throughout the dispute. While the ambulance dispute raged, the public grew even more concerned about the state of the NHS.

The doctors undoubtedly were making a major impact on public opinion. By October 1989 the Secretary of State was openly admitting that the government had not followed up the success of the launch of the reforms strongly enough in explaining the programme to health care professionals, and a new communications strategy was quickly developed by the NHS Management Executive. 'People will put up with the most extraordinary things and changes in the most extraordinary ways if they own your vision' advised Sir John Harvey Jones.

Indeed, despite concerted efforts by the government and managers in the field to explain the NHS Reforms, a series of five tracking surveys conducted by MORI for the Trent Region over the period September 1989 to November 1990 showed that between 70–72 per cent of residents remained of the view that the main aim of the government's re-organisation was to reduce spending rather than improve care.

Winning the propaganda battle did not, however, mean a victory in the war. It was a battle the government could not afford to lose if it was to transform the NHS into a consumer rather than a professionally driven organisation, and move from an 'administered' to a managed service. It had to break the professional hold on the NHS and indeed the shift in the balance of power was a natural progression of the direction in which the NHS had been

moving in the 1980s. What is more, the government possessed the political, the managerial and the monetary clout to drive through its programme. The preparations for change continued.

THE DOCTORS BECOME RESIGNED TO IMPLEMENTATION

As the legislation began to be brought before Parliament — the first major piece of legislation affecting the NHS to be debated in televised session — the furore began to subside — though both professionals and the public might continue to have reservations, they became resigned to implementation.

Indeed, behind the scenes the British Medical Association and the Royal Colleges, realising that the government was determined to press ahead, had been striving to hammer out the best possible deal for doctors. In so doing, they managed to secure a good pay settlement for family doctors in 1990/91. The government also offered considerable financial incentives to family doctors to participate in General Practice Fundholding schemes — £16,000 per practice. Despite British Medical Association polls suggesting General Practitioners were opposed to participation in the scheme — one of the most controversial elements of the NHS Reforms — in the Autumn of 1989 Regional enquiries already suggested the government could be confident of securing nearly 300 expressions of interest. In the end 850 formal enquiries were forthcoming from General Practitioners.

Private negotiations also continued between officials at the Department of Health and the profession on Consultant contracts. Probably for the first time, a senior NHS manager, Brian Edwards, was drawn into the negotiations. It was in these private negotiations that agreements on a managerial presence on Merit Awards Committees, general manager representation on Appointments Committees, Job Plans for Consultants and payment for doctors involved in management were hammered out. In separate meetings (although with many of the same players) consultation moved forward on reforming postgraduate medical education and the introduction of medical audit. All these negotiations reached a conclusion acceptable, if reluctantly, to both parties. By April 1990 British Medical Association negotiators believed they had struck a better deal on Consultant contracts

than they could have anticipated at the outset, especially in persuading the government to retain the contractual flexibility offered by the notional half-day session. However, they did not under-estimate the changes implied by the devolution of day-to-day management of contracts to local level. 'Greater accountability is being introduced which may well affect consultant autonomy' wrote John Harvard, former Secretary of the British Medical Association on 12 May 1990. 'This change will be the nub of future relations between Consultants and the NHS. Insensitive handling of Consultants' accountability or a defensive reaction from Consultants will not augur well for patient care.'

A Cardiologist summed up the Consultants' general mood, 'We'll just keep our heads down and keep working and taking care of patients. Then we'll look around in a year to see how things work' he confided to an American journalist writing in the *British Medical Journal*.

'KEEPING OUR HEADS DOWN AND WORKING'

'Keeping our Heads Down and Working' was in fact what managers had been seeking to do since January 1989.

While the public debate raged about the NHS Reforms, managers had squared up to the task of implementation. It was a formidable challenge which Griffiths said would have made 'strenuous demands on a well established management, let alone the still fledgling management process' of the NHS. Regional Health Authorities were given the lead role in preparing for the new world.

The programme meant an enormous amount of hard work for staff at all levels within a 'pressure cooker' timetable. 'The NHS is an inert great juggernaut in which, if you are not careful, nothing ever happens,' reflected Kenneth Clarke. 'We are working like slaves,' retorted one District General Manager.

It was an enormous culture shock. The NHS was being turned upside down. There was a whole new set of concepts to be grasped — pricing, contracting for clinical services, capital charges, marketing, business planning, constructing GP Fundholding budgets and market rules were but a few of them.

The change in agenda was huge and seemed to grow bigger as people began to understand the practical importance of these

powerful ideas. It proved again that people and organisations can achieve objectives way beyond their own assessment, but there were few who did not experience some self-doubts as to whether it could ever be achieved on time.

FAMILY HEALTH SERVICES MANAGERS JOIN THE RANKS

General Manager ranks had by now been swollen by the General Managers for Family Health Services. The government had given the go-ahead for their recruitment in May 1989 in advance of the creation of the new Family Health Services Authorities.

A Health Service Journal survey in the late Autumn of 1989 showed that 91 of the 97 available posts in England and Wales had been filled. Of these, 43 General Manager jobs had gone to the previous administrator and seven to administrators from elsewhere. In total, therefore, over 50 per cent of General Manager posts had gone to Family Practitioner Committee Administrators. Of the other posts, roughly half went to other NHS applicants and half to external candidates. (50 per cent of whom came from a military background.) Around 25 former Family Practitioner Committee administrators — roughly one quarter – are estimated to have found themselves out of a job, though precise figures are not available. A number decided to retire or not put themselves forward for appointment for other reasons.

Such was the mix of emotions at these great changes that 'mourners drank champagne around the coffin' at the final meeting of the Society of Family Practitioner Committee Administrators in Autumn 1989.

'CARING FOR PEOPLE'

To managers' workload was added the job of working with Local Authorities on preparations for the implementation of a 'seamless service' between Health and Local Authorities with the publication of the White Paper *Caring for People—Community Care in the Next Decade and Beyond* in November 1989.[78] The idea of uniquely tailored packages of care for individual citizens, clients and patients had arrived.

These far reaching reforms were designed to establish a new financial and managerial framework to secure the delivery of good quality local services in line with national objectives.

- Local Authorities were to be responsible in collaboration with medical, nursing and other interests for assessing individual need, designing care arrangements and securing their delivery within agreed resources.
- Local Authorities were to publish clear plans for the development of community care services, consistent with the plans of health authorities and other interested agencies.
- A new funding structure was to be established for those seeking public support for residential and nursing home care. Local Authorities were to be responsible for the financial support of people in private and voluntary homes over and above any general social security arrangements. Applicants with few or no resources of their own were to be eligible for the same levels of income support and housing benefit whether they were living in their own homes or in independent residential or nursing homes.
- Local Authorities were to establish 'arms length' inspection and registration units, responsible for checking on standards in both their own homes and independent residential care homes.
- A new specific grant was to be introduced to promote the development of social care for severely mentally ill people.

The original implementation date was set for 1 April 1991 to coincide with the introduction of the NHS Reforms but was later slowed down with full implementation delayed until April 1993.

Local Authorities were given 'lead' responsibility for implementation but the programme still entailed considerable work for Health Authorities, who were told very firmly to let Local Government keep the lead role and offer support only.

DEVELOPING THE PURCHASER/PROVIDER SPLIT

For District General Managers, *Working For Patients* posed considerable challenges in terms of creating and building a new

purchasing arm of the health authority separated by a so-called 'Chinese Wall' from a strengthened and semi-autonomous provider side of the organisation. In 1989 nobody was sure what purchasing meant—what it involved, how to set about the task. Considerable concern existed about the potential down-grading of the role of DHAs as a focus for local community participation until the concept of the role of the champion of the people began to emerge.[79]

Organisational relationships had to be re-shaped to give provider units more space and freedom to manage their own affairs and make their own mistakes. Decisions also had to be made about staffing to make sure both purchasers and providers had the right numbers of staff with the right skills to deliver the reforms on time, especially in the shortage areas of finance, information and personnel management. New skills had to be quickly acquired or brought in. To take finance, both the Healthcare Financial Management Association and Sheila Masters, NHS Management Executive Director of Finance, estimated that 1,000 new accountants would be necessary to run the new contracting service, fulfilling Brendan Devlin's worst nightmare of 'Consultant carparks full of yuppie accountants' Porsches'. By November 1990 an estimated 800 more accountancy staff were in post than a year previously.

For many District General Managers it also meant hard career choices. For some the attraction of operational management was too great and soon a number of experienced District General Managers began to retrace their steps to unit level with the intention of leading these units to NHS Trust status. Others chose to bow out of NHS Management altogether––the most prominent resignation being that of the former President of the Institute of Health Services Management, Barbara Young, to become Chief Executive of the Royal Society for the Protection of Birds.

Many were keen to try their hand at purchasing in the words of Chris Ham 'something new and hardly management in the conventional sense at all'. 'It is a big job, pivotal in influencing the health of the population' wrote one contemporary observer. It will remain to be seen how well general managers adapt to being at the centre of a web of networking relationships and alliances rather than at the top of a provider pyramid. Tracking surveys by

the National Association of Health Authorities and Trusts showed that in October 1990 only 30 per cent of District General Managers were describing their role as solely 'hands-on in purchasing'. By December 1991, a quarter of District General Managers were, however, describing themselves as spending more than 70 per cent of their time and just under half (48 per cent) were spending more than 50 per cent of their time on leading the commissioning function.

'SMOOTH TAKE OFF WITH NO SURPRISES'

Both the Department of Health and managers were determined that the NHS Reforms would be implemented without disruption to patient services.

Candidates for self-governing Trust and General Practitioner Fundholder status were carefully selected. There was a subtle change in emphasis away from free market forces towards a 'managed market' to counter concerns about public accountability, together with the placement of 'fetters' on Trust Freedoms such as capital borrowing, to protect the public interest.

More money was made available to implement the reforms, including cash for demonstration projects. Nearly £85 m was provided in 1989–90 and £305 m in 1990–91.

By April 1990, Regional General Managers were warning that there was a need to avoid radical changes in contracting patterns in the first year. The NHS Management Executive's own stocktakes of progress through Regional tours and discussions with managers and professionals in the field highlighted the risks of moving too fast, too quickly, too soon. East Anglian Regional Health Authority's Rubber Windmill simulation exercise[a0] — 'playing war games in Norfolk' — dramatically illustrated the risks of a market collapse. Although the direction of the reforms remained non-negotiable, ('I am not in the business of playing the role of the Grand Old Duke of York marching the NHS up the hill in preparing for the new system only to march it down again' said Kenneth Clarke), the aim in the first year of the reforms increasingly became to achieve 'steady state' to provide a platform on which to build for the future. Contracts were to be kept simple;

refinements were to come later. It was to be 'smooth take off with no surprises'.

The NHS Reforms perhaps presented providers with the greatest challenges. For many Unit General Managers the initial experience was exhilarating, almost intoxicating but, after the first taste of freedom, and some early devil-may-care macho talk, an air of more sobriety set in as Unit General Managers realised that with more power also went more responsibility. Soon they were taking on tasks which were traditionally the preserve of District. In these circumstances the Unit General Manager just had to be a leader; to command the support and respect of staff, to explain concepts and ideas which he was just beginning to understand himself and inspire staff to work towards the goal of determining their own future. 'A disgruntled workforce passes on bad messages to the patients and bad vibes to the public' Duncan Nichol was later to say.

In April 1990 Peter Griffiths, the Deputy Chief Executive of the NHS Management Executive (and later Chief Executive of the Guy's Trust) emphasised that 'Local communication strategies mean talking, talking, talking and involving, involving, involving. These are the key to the next 52 weeks.'

The NHS was entering countdown.

PREPARING FOR TRUST STATUS

If the unit was aspiring towards first wave Trust Status, the challenges for the Unit General Manager were tremendous; for as soon as he/she put their name on the expression of interest, they stuck their heads above the parapet to meet a barrage of local opposition. For the first time ever NHS Managers were encouraged, if necessary, to act without the authority of their parent corporate body (indeed several health authorities tried to reprimand officers who backed Trust applications). In so doing, they emerged from the shadows and anonymity of being a public servant and became legitimate media game. One commentator dubbed them the 'Rottweilers of the NHS'. In some places managers were threatened with the sack by local anti-Reform lobbies if the Conservatives did not win the next election (though Opposition leaders were swift to stamp on such suggestions) and there

were also threats of a much more personal nature. Leading a first wave Trust application required a good deal of courage—for many it was a horrid experience.

The passage of the NHS and Community Care Act was slow and it was not until June 1990 that the bill received Royal Assent. As Griffiths once said, 'The Almighty would not have brought order from chaos . . . in even six years, let alone six days, had the House of Commons been sitting at the time contesting every painful inch.'

'With less than 200 working days to go, the real action starts now', declared Kenneth Clarke. In the meantime the 79 of the 178 units given the go ahead to draw up applications for NHS Trust status had been continuing with preparations for formal consultation—despite a legal challenge in January 1990 led by a Consultant from Guy's Hospital—a unit at the centre of the Trust controversy. The challenge had alleged that it was unlawful for the Secretary of State to invest government resources in the reforms before they were approved by Parliament but this was rejected by the courts.

Applicants had to demonstrate that the Unit was in fit financial and organisational shape to hold its own in the new health care market (only 12 of the successful 57 applications were widely reported to be considered financially watertight by the Management Consultants, Coopers and Lybrand Deliotte, who had been engaged by the Department to advise on viability); that the unit management had the necessary standards and skills; that doctors and nurses were involved in management and that the unit had effective information systems—for it was recognised early on that the contracting system would succeed or fail on the strength of NHS information services.

The calibre of Unit General Managers themselves came in for close scrutiny. Some prime movers behind first wave applications did not succeed in securing the post to which they aspired, that of Chief Executive of the new Trust. For the first time salaries were on a par with District General Managers and possibly more generous, prompting the Secretary of State to write to Trust Chairmen in January 1991 to remind them that the NHS was a public service and that the salaries of Chief Executives must be financially defensible. Salaries for Chief Officers in Trusts were to emerge as the highest in the system.

NHS TRUST APPLICATIONS GO OUT FOR CONSULTATION

With the Act now law the implementation of the Reforms proceedcd apace. The new Regional Health Authorities came into being on 26July 1990 followed by District Health Authorities and Family Health Services Authorities on 17 September 1990. These had a new purpose and a whole new management style. It was not 'back to business' as usual under a new name. In addition, for the first time in the history of the NHS, other than when they had served as professional representatives, paid NHS employees were appointed Executive Directors and sat on Health Authorities as the equals of lay members. For lay members and managers alike this took some getting used to.

Both the government and the opponents of the reforms led by the doctors steeled themselves for a new confrontation as those Units aspiring for first wave Trust status submitted formal applications to the Secretary of State in July. A Department of Health mailshot delivered the booklet *The Reforms* and *You* to every household in the United Kingdom. The doctors began to gather evidence of Consultant opposition to the proposals.

Individual Trust applications met spirited local campaigns of opposition in some parts of the country. In Doncaster, for example, 23,000 signatures were collected against the establishment of the Doncaster Royal Infirmary and Mexborough Montagu Hospital Trust. But the national consultation exercise turned out to be largely a damp squib. The dye was already cast—the protest was largely ritual.

On 2 August 1990, slap bang at the start of the consultation exercise on NHS Trusts, Saddam Hussein, the President of Iraq, had rolled his tanks into Kuwait. It was the beginning of a new oil crisis, the build up to the Gulf War which was to cast a long shadow over the NHS as it prepared for its own 'Operation Desertshield'.

Besides world events the politics of the NHS paled into insignificance. The preparation for change continued apace.

COMMUNITY CARE—IMPLEMENTATION DELAYED

Within a few weeks of the NHS and Community Care Act receiving Royal Assent in June 1990, the government announced

a slowing down in the pace of implementation of 'Caring for People' due to the 'unacceptable burden on poll tax payers.'

Although the introduction of inspection units and mental illness specific grants was still time-tabled for 1 April 1991, planning agreements were stepped back to April 1992 and the transfer of funding support from Social Security to Local Authorities to April 1993. This decision provided NHS managers with much needed breathing space in the time table for implementing the reforms. In the event, Local Authorities spent a good deal of the extended time-scale arguing about the politics and the funding. Many hoped for a different result in the General Election, which certainly took the steam out of the process of preparation for change. NHS managers began to chaff at the bit as they worked out the implications for their services of a poor process of implementation. A national task group was eventually created, led by Andrew Foster, the then Deputy Chief Executive of the NHS Management Executive (and appointed Chief Executive of the Audit Commission in 1992), to support and speed up the process of change. It all looked pretty hairy to those close to the action but the Government had allocated extra funds in a very tough public expenditure round and the race to the tape was on. It just started a year later than planned.

CHANGES AT THE TOP

International affairs then began to intervene in another form. The growing political crisis in the United Kingdom, linked to policy on Europe, was eventually to lead to the resignation of Margaret Thatcher and the election of John Major as the new leader of the Conservative Party, and thus the new Prime Minister in November 1990.

Just a few weeks earlier, on 2 November 1990, Kenneth Clarke moved to education in Mrs Thatcher's last cabinet re-shuffle. His departure was marked by Scrutator, the columnist of the *British Medical* Journal with a grudging respect and admiration of the type only normally found between opposing armies on the field of war. It remains to be seen if in Kenneth Clarke the doctors met their Waterloo, for, as they say, 'he who fights and runs away lives to fight another day'. Scrutator perhaps paid him the ultimate accolade 'For all the noise and fury of battle between doctors and the

government since January 1989, when the NHS review was unveiled, I do believe that we shall come to appreciate Kenneth Clarke's legacy to make the NHS more efficient.' As for the public, Mr Clarke predicted on the eve of his departure 'Public opinion will come around as the doctors do.'

He was certainly right as far as the doctors were concerned. Their attitudes to both GP Fundholding and NHS Trusts was to change sharply as they got used to the idea. One is left only with the question whether the changes could have been secured without a bruising public battle. Would an extended, if challenging, dialogue have succeeded? Probably not must be the answer, but that should not dissuade both parties from reviewing the arcane, and formalised mechanism for discussing change with the leaders of the professions. Far more challenging dialogues are certain to be on a future agenda for some Government in the next 10 years and the opportunity to start at least with challenging conversations should not be lost. The NHS always wins when the Government, the health professions and the managers drive forward together.

THE NEW FUNDING CRISIS

William Waldegrave was appointed as Kenneth Clarke's successor. Almost immediately the doctors sought to establish an *entente cordiale.* 'The Health Service needs balm not further bloodshed' proclaimed the *British Medical Journal* leader. (The British Medical Association had in fact been 'publicly talking tough about the reforms whilst pragmatically building bridges with Whitehall' even before Clarke's departure.) The doctors' leaders had not shifted their emotional opposition to the reforms but they also wanted to make him aware of their continuing anxieties about other issues, including, in particular, what they regarded as the under-funding of the NHS.

Health Authorities had been charged with ensuring that, unlike in 1974, strict financial control was maintained as the reforms were implemented. Every District had to enter the new contracting system with a clean balance sheet. This was no mean feat as in 1989–90, Sheila Masters, the NHS Management Executive Director of Finance, 'the scourge of underlying deficits' estimated that two thirds of Districts had deficits of varying scales and sizes

to eliminate before that date. The Centre had to eventually provide a £81 m 'bail out' to help authorities with high creditor levels. Most went to the Thames Regions.

In 1990–91 many Authorities decided to close beds temporarily to achieve income and expenditure balance. *The British* Medical Journal described it as 'Death by 1,000 cuts'. Just 16 Districts were reported to be still in deficit at the start of 1991–92 though none were judged to be serious. One survey estimated that between 3,500 to 4,400 beds were temporarily out of use, leading to complaints from doctors that patients were being placed at risk.

Mr Waldegrave may have lent a more sympathetic ear to the doctors' complaints but he remained unmoved on the principal planks of the reform programme. Achievement of 'the level playing field' was essential if a smooth transition to the new contracting system was to be achieved.

Speaking on BBC Radio on the eve of reforms he prophesised 'We are laying the foundations for a better, more securely funded, more efficiently managed health service which will last for generations.'

15

THE REFORMS ROLL ON . . . INTO THE MARKET

'THE MOST DIFFICULT MANAGEMENTJOB IN BRITAIN'

ON 1 APRIL 1991 (EASTER MONDAY) THE NHS REFORMS WENT LIVE. The new contracting system came into operation. 57 provider units became NHS Trusts (out of 178 original expressions of interest) and 306 general practices became first wave Fundholders (out of 850 initial expressions of interest). Looking back to the Limehouse launch of 1989 only one of the *Working For Patients* main original sponsors remained — Duncan Nichol.

Managers up and down the country breathed a sigh of relief; most hoped it was also the return to sanity.

After the heady, almost surreal, existence of 1989-90–1990-91 most managers were ready for a rest and the resumption of something close to normal service. Not that the NHS had ever closed its doors. Unlike great aircraft carriers or giant juggernauts, the NHS cannot go into dock or garage each time it needs a major refit. Many felt weary and in the summer of that year concern was beginning to grow about 'management burnout'. 'In some organisations working late has become a fetish and people who go home on time are seen to be slacking', said one expert.

International visitors and more than one management 'guru' marvelled at the changes the NHS had managed to effect in so short a space of time. Managers were surprised themselves — how indeed had tney managed to do all this in under 800 days? William Waldegrave later paid tribute to their work. Never before had such 'creative and enthusiastic commitment to necessary change been shown by managers in a large organisation, public or private than that shown by NHS management in the last 10 years'.

Managers had no time to bask in the glory. 151 Executive

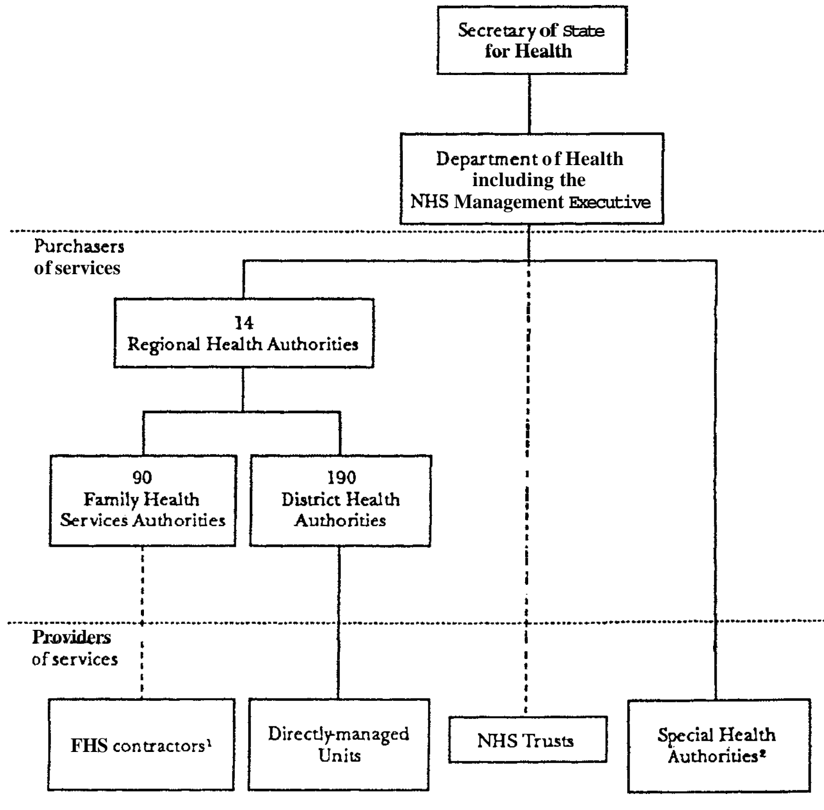

FIGURE 3

letters to action in 1991 alone and, in what would inevitably be election year, managers found themselves increasingly having to walk an even tighter tightrope than normal between politics and public service, between medicine and management, and between professionals and patients. It was after all, as one newly arrived NHS Trust Chairman described it, 'the wonderful and wacky world of the NHS'.

Little wonder one prominent industrialist was to describe health service management as the 'most difficult management job in Britain'.

THE NHS REFORMS ROLL OUT

The performance of the NHS Trusts in their first year of operation inevitably attracted close public scrutiny. In May 1991, Guy's Hospital announced 600 job losses and cuts of £6·8 m in an example of what its Chief Executive later described as 'the captain setting fire to the gunpowder on board'. (The Finance Director was later to resign in July.) In practice Peter Griffiths, the Chief Executive, had done no more than face up to a problem that had been staring everybody in the face for years. The Bradford Hospital Trust also announced 300 jobs were to go at Bradford Royal Infirmary and St Luke's Hospital.

The Select Committee on Health (a separate Select Committee on Health was established in the Autumn of 1990 reflecting the Department of Health and Social Security split into two Ministries) decided to hold a special enquiry.

An 'off the ball' incident developed over the NHS Management Executive's refusal to disclose Trust business plans on the grounds that these came within the 'managerial' rather than the parliamentary domain. Then in May 1991, for the first time ever, Chief Executives of NHS Trusts were called to give evidence to the Select Committee and its combative Chairman, Nicholas Winterton. The event attracted widespread media interest. The Chief Executives put up a spirited defense of their actions. Their performance dazzled even the doctors, but the latter's admiration was tempered, for it seemed to prove beyond doubt in the words of the *British Medical Journal* headline that 'The Manager is King!'.

The NHS rose up and down on a see-saw of good news—bad news all the year through. A survey in October 1991 by *The Times* suggested one in three NHS Trusts were overspent—an allegation which was roundly re-buffed by the NHS Management Executive. The truth was nobody was entirely sure exactly how the business plans were holding up.

General Practice Fundholding also came in for criticism amidst allegations of queue-jumping by fund holder patients, leading to calls for rules on clinical priority to ensure equal access for patients. In January 1992 the government announced an expansion of the General Practice Fundholding scheme with a lowering of the minimum list requirements to 7,000 patients from April 1993. A report by the King's Fund *A Foothold for Fundholding*

in February concluded that the scheme had produced clear benefits.

'The case for bottom-up funding in which General Practitioners are responsible for purchasing health care on behalf of their patients is more powerful than a top-down system in which District Health Authorities take on this responsibility'.

The support for GP Fundholding amongst GPs was growing apace, leaving the BMA rather one footed in its opposition to the principle.

THE HEALTH OF THE NATION

Now that the new contractual framework was in place, health re-emerged as a major issue on the NHS Agenda.

In October 1990, Kenneth Clarke had announced his intention to devise health targets and measure performance by them. William Waldegrave had worked this up into a bigger idea—a full scale health strategy, setting clear priorities, targets and goals for the NHS. Griffiths described this as a 'brave but correct step', referring to the 'worry politically in that to set targets which could be monitored might be giving hostages to fortune, a feeling, as someone once said, that the air might eventually become dark with chickens coming home to roost'.

The Prime Minister invited the leaders of the NHS to Chequers to discuss the planned policy. The meeting went well despite some tough talking by the doctors about the tobacco industry. In June 1991, the government published the consultative document Health *of the Nation*,[81] setting out its strategy on preventable disease. Mr Waldegrave warned in advance in an interview given to the British *Medical* Journal 'At this point every lobby in the country will descend on my head. so I will need the help of serious senior health professionals to maintain some discipline. If priority setting is going to mean anything we can't include everything'. The subsequent White Paper of the same name issued on 8 July 1992 by William Waldegrave's successor Virginia Bottomley, targeted five key areas for health improvement:

Coronary Heart Disease

Cancers

- HIV/AIDS and Sexual Health
- Mental Health
- Accidents

The NHS was required to develop implementation plans for addressing these priorities by January 1993. *The Times Health Service Supplement* described the Strategy's launch as a 'landmark in taking the Department of Health and the NHS beyond a health care service to health itself. The management agenda was at last getting closer to the core of the business.

THE PATIENT'S CHARTER

Management interest and concern for Quality had been growing for some time. In May 1991 the Select Committee on Health criticised the government's four-year initiative to cut waiting lists as poor use of the £119 m so far spent. Figures published by the College of Health suggested there were 40,000 more patients waiting for hospital treatment in September 1990 than September 1989. A concerted drive by Districts and Units succeeded in reducing the numbers of people waiting over two years for treatment, with provisional figures published on 2 April 1992 showing a massive fall from 50,423 in March 1991 to 1,117 in March 1992. 'We're talking of pigs flying. What they are asking for has never happened in the history of the NHS' commented one Waiting List Manager on the NHS Management Executive's request for information within 24 hours of the year end. He was wrong, as was the waiting list guru John Yates who resigned in a huff in 1991. By the autumn of 1992 all over 24 month waiters had disappeared and NHS management knew exactly where it stood on this issue. This issue of managing waiting lists was a major turning point for NHS managers. Suddenly they were interested and concerned about specific patients . . . offering them alternatives . . . checking their progress. Doctors were distinctly uncomfortable but the mutterings about clinical freedom were low key.

In October 1991 the 'Patient's *Charter*' was launched.[82] Linked to the *'Citizen's Charter'* initiative, it set out 10 rights and nine national standards of service which every citizen should expect from the

NHS. The Director of the Patient's Association dismissed it as 'a rather flabby gelatinous object than even I ever thought it would be' but it marked an important new opportunity for the NHS to show just what good public sector management can achieve. Making explicit public promises about service levels and even tough guarantees in some areas was challenging but invigorating.

Since then the NHS has emerged as the pace-setter amongst public service organisations seeking to implement the Citizen's Charter. Suddenly excellence in the public service could be talked about with real determination.

HEALTH CARE IN THE YEAR 2000

Thoughts too began to turn to what might be the vision of health care in the future. In November 1991 the government announced that spending on health would rise by £2·7 b in 1992–93. A major task for purchasers was to ensure it was spent wisely and efficiently.

February 1991 had seen the publication by the NHSME of *Integrating Primary and Secondary Care* and *Family Health Services Authorities: Today's and Tomorrow's Priorities*, prompting the service to begin to give renewed thought as to how best to achieve an effective balance between prevention and treatment services, between primary, community and hospital care and deliver seamless care across health interfaces.

In late 1991 Baroness Cumberlege predicted that the next 25 years would see far fewer hospital beds, an increase in patients being cared for in the community and a power shift from Consultants to General Practitioners. In January 1992, a report from the Audit Commission, *Lying in Wait: The Use of Medical Beds in Acute Hospitals*, suggested that up to a third of hospital medical beds could be cut if all health authorities used their beds as efficiently as the top 25 per cent.

Meanwhile, health authorities continued to work closely with Local Authorities on preparations for the implementation of 'Caring for People' and how to deliver a seamless service and uniquely tailored packages of care across health and Local Authority boundaries. This was against a background of concern that individuals might still fall between stools, likened by the Prince of

Wales to 'throwing the dead cat over the garden fence. Only in this case it is not a dead cat but a vulnerable human being.'[144] Concerns also emerged that funding arrangements might not be in place on time. As one commentator put it—'the money side will be left too late, tackled in a rush and rely on hard-pressed finance staff again to take on Hollywood's role of the US Cavalry'.

The problem of securing a proper range of health services for the nation's capital continued to pre-occupy many people's minds. 'What the new system will do will force some decisions out of us cowardly politicians, who for 20 years have put them off, said William Waldegrave. In October 1991 the Secretary of State announced an inquiry into London's health services to be chaired by Professor Sir Bernard Tomlinson.[83] (This was to report a year later and recommend a radical shake up of London's health services.)

GETTING THE MOST OUT OF STAFF

Improving human resource management also began to loom large on managers' agendas. The NHS is 'a man made cat's cradle that stops dedicated, committed and keen staff from doing things', Sir John Harvey Jones once commented. Surveys pointed to low morale amongst NHS workers and its employment practices were likened to that of Victorian mill owners by Stuart Fletcher, the IHSM President in 1991. First Wave Trusts began to experiment with the introduction of local pay bargaining, triggering some local disputes as the professions grew alarmed about the possible phasing out of the pay body review system. In the event, the Trusts used their new pay freedom very sparingly indeed in their first year or two.

In June 1991 the government struck 'The New Deal' with the medical professions designed to ensure that junior doctors' hours were cut to 83 a week as fast as possible and 72 hours by 1994. The junior doctors were not ecstatic about the time-scale and their leaders warned that it would mean juniors working long and dangerous hours 'tomorrow and a year tomorrow and a year after that'. Throughout 1991–92 the doctors kept up a determined campaign to expose hospitals advertising posts of up to 136 hours a week which had been banned nine years earlier. This time a Ministerial Working Party which included NHS management

meant business. The complex web of competing interests had to be broken if a solution was to be found. A solution of sorts was found eventually but it was left to general management (including many Directors of Public Health) to deliver on the ground.

'NHS Managers in Sex Scandal' doubtless caused many a Chairman's heart to miss a beat but the headline was misleading. In August 1991, a report from the Equal Opportunities Commission said that the NHS could be wasting £1b worth of talent. The government responded in January 1992 with the establishment of a Women's Unit and an action plan to increase opportunities for women in the NHS. One of its key objectives is to increase the number of women in general management posts from 18 per cent in 1991 to 30 per cent in 1994.

In October 1991 a new management development strategy 'Managers Working for Patients' was launched, targeted on 250,000 staff. 'We cannot afford another false dawn' said Duncan Nichol. The Institute of Health Services Management redoubled its efforts to extend its membership and educational system to professional staff involved in management.

THE SEVENTIES REVISITED — STRUCTURE AGAIN

The closing months of 1991–92 saw the beginnings of a revival of the NHS's preoccupation with one of its favourite topics—structure. How should purchasing be organised in future? Views were divided. One school favoured the creation of large scale purchasing organisations to give power to the purchasers' elbow to match the strength of providers. Some Regions built up large consortia as a means of conserving scarce skills. A spate of planned District Health Authority mergers began to be announced. The second school favoured a closer working relationship between District Health Authorities and Family Health Services Authorities through the formation of joint purchasing executives to preserve local community links and identities. In either model the issue of co-ordinating District Health Authority and General Practice Fundholder purchasing strategies represented unfinished business.

The other main area of debate revolved around future arrangements for market regulation and management. Should purchasers and providers report direct to the centre or through an intermedi-

ate tier? If the latter, should the same intermediate tier cover both purchasers and providers and be an arm of the NHS Management Executive or a corporate body in its own right? This debate was fuelled by the NHS Management Executive's announcement in January 1992 that outposts were being set up to monitor NHS Trusts, though it was emphasised this would not necessarily be the pattern for the future. The early Trusts were vehement in their opposition to losing their newly acquired right of direct access to the Department of Health. They did not wish to report through the Regions, which is why outposts of the NHSME were created. The argument about Regions (the Intermediate Tier debate) rumbled on into 1993 with spasmodic reports of Cabinet disagreements occasionally surfacing.

As the *Institute of Health Services Management Journal* was to warn in May 1992, 'It will be all too easy in the coming months to become obsessed with structure and organisation as District Health Authorities vie with Family Health Services Authorities and Regions and purchasing consortia. The important thing to remember is not the structure but the outcome'. But all the talk about structural change was proving to be a drag on the development of purchasing and to prove a difficult time for Regions as their role and future came under the microscope. Some Regions began the process of downsizing and re-shaping, others sat in their comfortable castles and waited on events.

'MACHO MANAGEMENT'

It was ironic that the service's obsession with structure — almost a throwback to the pre-Griffiths' day of public service administration should re-surface at the time when the NHS was beginning to worry about the need to define new standards of public sector management.

This concern surfaced against the background of fears that the taint of corruption might creep through the NHS as a consequence of the introduction of the new contracting system. 'It is up to managers as never before to ensure the invisible hand is kept scrupulously clean.' Chinese walls to separate purchasing and providing began to be constructed within District Health Authorities.

This was coupled with concerns that 'gagging' clauses were

becoming too common a feature of NHS contracts of employment to prevent professionals 'blowing the whistle' on poor standards of care; that too much 'public' business was being conducted behind 'closed doors'; that too few Chief Executive posts were subject to open competition and that some managers were flirting dangerously close to the boundaries between politics and public service.

Then, a wave of 'sackings'—instant dismissals of managers, especially in NHS Trusts ran through the service. The Institute of Health Services Management Legal Helpline reported an upsurge in calls from managers facing contractual difficulties.

Duncan Nichol felt compelled to make a public statement at the Institute's Conference in June 1992. 'In my book there's no place for the 'clear your desk tomorrow' syndrome . . . don't confuse timely and firm action with that brand of macho management which is spreading fear and despondency in too many places.' He was backed up by Roger Stokoe, the President of the Institute, who called for a code of ethics for managers. In the meantime, the wholesale dispersal of managers at District level was underway, in some Regions as consortia were created. Notable casualties included the President of the IHSM, Roger Stokoe, Margaret Goose, a past President, and Andrew Wall from Bath. All three were to find new posts and opportunities. Peter Griffiths later lost his place at the helm of the NHS Trust flagship when Guy's merged with St Thomas's in 1993.

THE WAR OF JENNIFER'S EAR

For all of 1991–92 there remained one supreme unknown. What would the election year of 1992 hold for the NHS? Managers lived in a state of suspended animation. The Conservatives staunchly defended their policy on health against allegations of creeping privatisation. 'Our NHS is not for profit and not for sale' said Virginia Bottomley, who succeeded David Mellor as Minister for Health in October 1989. Labour was pledged to reverse the reforms within 100 days of taking office (later revised to 18 months;. The Liberals had also promised to phase out General Practice Fundholding and cut the powers of NHS Trusts. Even amongst managers who believed this was the right way forward, there was an almost unspoken fear of the task of dismantling what by election day itself had taken over 1,000 days of blood, sweat and toil

to put in place. Those who passionately supported the reforms expressed few fears — the changes of culture and attitudes were by now irreversible in their view.

Speculation mounted throughout 1991–92 as to John Major's choice of election date — possibly June, surely October, maybe December, could it be February? Almost certainly March–it had to be June. Then the date was fixed–Thursday, 9 April 1992. Just eight days before a further 99 providers had become second wave Trusts and 280 more practices joined Fundholder ranks.

The media headlights of the political campaign trains glared at the NHS with a ferocity most people found distasteful in the infamous episode of 'Jennifer's ear'. Newshounds fell over each other in their efforts, firstly to track down the real life identity of the little girl waiting for a grommet operation featured in a Labour Party political broadcast and then to discover the identity of the person who had revealed Jennifer's identity. All sides condemned it as sleazy gutter journalism.

Yet, the incident did not develop, as some commentators predicted, into the NHS's 'grommetgate'.

The Health Service Journal almost unwittingly fingered the nation's election mood:

'The War of Jennifer's ear looks destined to be a curious footnote in British political history. It flared up, obsessed the nation for three days (or did it?) and has already faded fast. It was the point at which the NHS at last dominated the election campaign and somehow did not'.

Perhaps the electorate got tired of the politicians rubbishing something they valued, whatever the reasons.

9 April saw the Conservative Government return to power with a majority of 21. William Waldegrave moved on to head the implementation of the *Citizen's Chaster* initiative and Virginia Bottomley became the new Secretary of State for Health. Kenneth Clarke, the architect of the reforms, became Home Secretary.

'All those months of speculation, rumour, anxiety and expectation are over and the result of the General Election is now clear. The NHS Reforms are here to stay and it is now up to managers to move forward and consolidate the benefits' wrote the *Institute of Health Services Management Journal.*

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ISSUES, IDEAS AND THE FUTURE

NHS POLITICS AND ECONOMICS

IF YOU ASK THE ORDI ARY CITIZEN WHAT THEY THINK ABOUT THE NHS, they almost always respond positively . . . thus the high satisfaction scores that are regularly reported. More discerning and more persistent questioners can, however, quickly elicit criticism about the impersonal nature of the service provided, its queues, its inefficiency, its drabness, its perceived under-funding.

A Marplan poll commissioned by Trent Health in 1987 showed that 50 per cent of patients felt they had been treated as just another person on the ward or in the clinic with no special or personal treatment. The Audit Commission reported in 1992 (Making *Time For Patients*)[84] that one in four patients felt their care had been impersonal and felt like a production line. Despite the massive investment by successive Governments over the years, the service still has a utilitarian feel to it . . . khaki rather than silk. Queues are expected . . . after all it is free.

A more accurate interpretation of high overall satisfaction polls is probably that the people of the United Kingdom are still deeply wedded to the 'ideal' of the NHS . . . free, comprehensive, national . . . but increasingly dissatisfied with the service they receive when they need it. The gratitude factor that is strong amongst those who remember what the world was like before the NHS has steadily declined, as a new generation emerges who take its existence for granted. . . but want it to be better.

The basic ideals of the NHS look to be here to stay. But the system is going to have to be re-shaped as society itself changes and becomes more demanding of its public services. Excellence must be a public service standard. Ideas about the central role of quality in successful service industries and organisations have

moved forward with general management. Competition has provided a further stimulus as understanding grows about the association between quality and marketing and quality and productivity.

Medical science looks set to continue to expand at least at its present rate. Traditional thinking suggests it will always be so, but even this needs constant challenge. Public expectations for access to these new technologies will of course grow in direct response to their availability. The pressure to hike up the overall level of government investment in the NHS will increase. The internal market will force the pace because of the more explicit nature of the choices that now have to be made. Before they invest more, Governments will seek first to increase efficiency... and this avenue does indeed still present a major opportunity for re-investment and growth in new services. Pre-occupation with small percentage efficiency gains is hardly challenging. Creating a fault-free environment in providers who are commited to continuous quality improvement offers dramatically better gains—20 per cent or more. New investment will of course be possible if the economy expands, but at the end of the day an increased share of the country's GNP for health looks to be both inevitable and desirable in the next decade.

At some point the idea of co-payment at time of use will re-emerge as a means of taking the pressure off the Treasury and inhibiting demand. Private health insurance will also play a part in the future development of the NHS, particularly if links grow between the private insurance market and the NHS Authorities charged with purchasing comprehensive care within a cash limit on the one hand, and entrepreneurial NHS Trusts on the other, seeking private business. The idea of competition between purchasers might be the next philosophical hurdle for NHS management . . . it already exists of course with GP Fundholding. Enthoven suggested District Health Authorities taking on the form of Health Maintenance Organisations as being a long term option for the NHS.[65] Conversations between Fundholding Practices and the private insurance sector offer an alternative route.

In the United Kingdom, politics and economics are going to play a dominant role in shaping the NHS and therefore the management agenda.

POLITICS AND MANAGEMENT

But if politics and health are inseparable, do the politicians have to manage the NHS?

Bevan's quip that 'when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster' has returned to haunt many Ministers.

William Waldegrave commented in March 1991 that the role of the Secretary of State is a 'strange and vulnerable job for a politician because you are presiding over an enormous management structure... the semi-managerial role makes it unlike a normal political job'. He was echoing the views of many of his predecessors.

Politicians have consistently complained the balance at the centre is not right. Central government is too involved in the minutiae of operational detail at the expense of policy-making and direction. Patrick Jenkin observed in 1978, 'No one man can conceivably be accountable for all the detailed day-to-day decisions'.

Management is not the job of Ministers. With one or two exceptions, they do not especially relish the task and few are good at it. As Sir Roy Griffiths told the Audit Commission in 1991:

> 'Politicians are not excited by the management process. As with top civil servants, the adrenalin flows in bringing out new policy documents, getting them through No 10 and through the Houses of Parliament, whereas the process of implementation is very long and laborious.'

The Patient's Charter was well conceived and competently launched. If it fails it will be because the Department of Health gets bored with the long managerial process of implementation.

But in any case, as the Royal Commission realised in 1979, 'detailed Ministerial accountability for the NHS is largely a constitutional fiction'. Ministers cannot become personally involved in every individual operational matter or personal case.

Yet, despite, all best efforts to deflect this flow of decision-making to a local level through the devolution of responsibilities, Ministers still spend a considerable amount of their time and energies on detailed operational matters . . . often at the behest of their parliamentary colleagues.

Similarly, top civil servants persistently complain about the burden this involvement in detailed operational matters places upon civil service resources. Stowe writing in 1989 said:

'the combined effect of the ever expanding Parliamentary requirement and the oppressive central obligation to secure 'efficiency' at the operating level is to squeeze out the essential role—which must belong to government—of thinking, assessing the present policies and prospecting for better and more relevant policies for the future.'

As a consequence, the civil service is still forced to maintain large intelligence gathering capabilities within the Department of Health and the NHS Management Executive to amass detailed information about the workings of the NHS.

Likewise, managers continuously make noises about the volume of the upwards information flow, the centre's pre-occupation with the minutiae of operational detail and the constant intervention by the tier above in day-to-day management matters. Sometimes it feels that the main *raison d'etre* of general management is not to manage local services but to make detailed ministerial accountability a constitutional reality. Outside observers such as Sir John HarveyJones have commented 'in many cases there is in the NHS a feeling that you are swimming through treacle and have to spend an awful lot of time managing the system'.

All sides are clearly dissatisfied with the current relationship but what can be done about it?

John Major, in a speech to the Adam Smith Institute in 1992, talked about the privatisation of choice by the citizen. 'For many people lack of choice in public services is merely a minor irritant in their lives. But for those who depend on those services, it can be a source of bitterness and even despair.' He went on to argue that the role of the Government has to be limited. 'For an increasing number of public services, the State should be an enabler and facilitator.'

In an earlier speech to the Audit Commission in 1989 during his days as Chief Secretary to the Treasury, John Major predicted:

'we shall increasingly find the big battalions—the service providers, those who execute policy—in Units that are more distinct, more autonomous and more clearly separated from the

central policy areas . . . this separation will not damage the prestige or importance of any part of these services.'

This, of course, opens up again the possibility of an independent NHS Board or Corporation. This would represent a natural extension of John Major's policy lead and extend the purchaser:provider split. . . that simple but powerful idea that is at the heart of the present changes in the organisation of the NHS itself.

The idea of an independent Board or Corporation is not new. In a BMA review of the future in 1967 the idea was mooted but dismissed in the same short paragraph that also dismissed the idea of a National Sweep stake.[85] The Fulton Committee of 1968[143] had suggested the 'hiving off' of activities, including those in the social fields to autonomous public bodies. The Royal Commission of 1979 considered the idea for the NHS but thought there was more to be gained at that time from trying to make improvements within the existing statutory framework, though it left the option on the table for the future.

Norman Fowler commented in his memoirs 'Ministers Decide' that:

'By the end of my stay in Health, I had become convinced that it would be possible to create a health commission with its own Chief Executive or Chairman. . . nothing will now take Health out of politics, but a commission could produce a more efficient service with the potential for advances in training, employee involvement and swifter decision-making. The advantage would be that Ministers and civil servants would not be involved in day-today management'.

This represents a major step in political thinking. Enoch Powell thought the idea of an NHS Corporation was simply not possible . . . the public would not stand for a move that would enable politicians to avoid accountability for the NHS.[86] Perhaps service results are now a higher priority with the electorate than political accountability.

The creation of the NHS Management Executive 'lean and rigorous and living in Leeds' but still very firmly part of the Department of Health, may be seen as but one stepping stone down this path. Rudolf Klein, writing for the British *Medical Journal*

in September 1990 in an article 'What Future for the Department of Health?' (based on research funded by the Nuffield Provincial Hospitals Trust), has described its role as 'a flagship of what might turn out to be a revolution in government' — the realisation of the *Next Steps* manifesto. The *Next Steps*[a7] was a report published in 1988 by the then Prime Minister's (Margaret Thatcher's) efficiency unit and recommended fundamental changes in the Whitehall machinery. It proposed limiting the functions of central government, as far as possible, to devising the framework of policy, monitoring performance and transferring to agencies the executive functions with maximum freedom to determine how centrally determined objectives should be met. 'The presumption must be that, provided management is operating within the strategic direction set by Ministers, it must be left as free as possible to manage within that framework'.

An independent NHS Board would manage the service to a policy contract determined by Ministers. This would, however, need to be a high level contract, concentrating on the essentials. The production of a voluminous document, with detailed specification after detailed specification, requiring the upwards flow of a huge volume of monitoring information would mitigate against the very creation of the NHS Board.

An even more radical option would be to contract purchasing and management to a series of local or regional bodies rather like the television company franchises. The decision to invite the Norwich Union Insurance Company to bid to run the NHS in Guernsey may be a short straw in the wind. In either option, NHS Trusts and GP Fundholding would remain, provided they sustained their early energy and enthusiasm and genuinely extended choice for GPs and their patients and the ordinary citizen.

Some ideas are around for a long time and suddenly happen . . . the time was ripe. Now is the time to re-open the debate about an NHS Board operating outside the Department of Health, but to a contract negotiated and awarded by them.

It would be wrong to pretend this would be a straightforward or easy debate. There would be many issues to be worked through. The NHS is a huge segment of the public sector. The relationship with Parliament and its Select Committees would require clear definition. The link to the Department of Health would probably be easier to sort out than the links to other

Ministries over matters like pay policies, Europe or public sector borrowing.

The creation of an independent Corporation would also require a considerable adjustment in attitudes and skills on the part of managers working in the NHS. The new Corporation would need to stand on its own feet and create its own identity and network of relationships, independent of the centre but never in conflict with it.

An NHS Corporation would never have tolerated the steady and inexorable decline in the health services in London. It would have acted decisively to sort out the over-manning and over-provision in the hospital sector... much as other public sector Boards have done as they moved away from the centre of politics. Tough decisions, even when they are right, are a hundred times more difficult if they become politicised.

But, whatever the organisational framework in which they find themselves, managers in the NHS must expect to develop their talents in a service that is going to continue to go through a period of rapid transition with no clear final destination. Those who are excited by this prospect will succeed. Those who are comfortable with today's certainties will fall by the wayside.

MANAGERS AND PLURALISM: MARKETS

As the monolithic structures of the NHS shift in the face of competition and a managed market, so managerial styles and skills will have to change. Highly developed leadership and marketing skills will be at a premium in NHS Trusts. Making things happen in future at District and FHSA level will depend more on networking, negotiation and facilitation and the skill of using incentives rather than command. Market shaping and management will be the crucial link between competition and planning, and represents an entirely new challenge for NHS managers operating at a Regional level.

Even managed markets have a life and energy of their own. Providers intent on their own future will undoubtedly become more efficient, more customer focused and probably better employers, as managers recognise that their success is almost entirely dependent on the skills of their fellow workers. However, in pur-

suit of their own place in the sun they will seek to diminish the place of other units.

David Starkweather[88] describes how American hospitals adjusted to de-regulation and market forces in three distinct phases.

- **Phase 1:** Each hospital sees itself as an individual competitor and views all other hospitals likewise. A proliferation of services leads to extensive duplication. Vertical diversification into community services and ambulances, for example, increases.

- **Phase 2:** The market forces mergers amongst competing hospitals . . . horizontal integration in order to secure market dominance becomes a strong desideratum.

- **Phase 3:** An accelerated vertical integration between primary and secondary care and a move into purchasing via health insurance. A move away from open competition amongst many toward domination by a few.

The managed health care market in the UK is a very different context indeed from the American scene, particularly because of the unique strength of general practice and primary care. However, some of the changes described by Starkweather can be found in today's NHS. NHS Trust Hospitals looking to extend into community outreach on the one hand; and, on the other the Department of Health setting their face firmly against combined hospital: community Trusts. GPs creating limited companies to supply consultant out-patient services to their patients is another example, (though the creation of limited companies was banned in 1993 in a direct market intervention by the Department of Health). The historical trend of GP mergers will no doubt continue. GP Fundholding consortia were already well established by the end of 1992.

Mergers amongst Trust Hospitals and services are now on the agenda in many cities. One hospital providing services from a base in another is emerging as a new configuration (the shop in a

shop principle). The market is forcing re-configuration of the provider side of the NHS with a speed that is breathtaking.

The Rubber Windmill market simulation undertaken by the East Anglian RHA and the Office of Public Management also foreshadows some of these changes but predicts that the market will eventually 'freeze' as the acute hospital sector runs into financial trouble and the powerful 'system maintenance' forces come into play. London may well turn out to be the crucial test as to the relative weight given to planning a path to a different Health Service in the capital on the one hand and letting it be forged by competitive forces on the other. Planning has always failed in the past, but perhaps this time the threat of the market will give planned change a better chance of success.

Many of these sort of structural changes in the hospital service are long overdue and have been held back for years by self-interested conservatism. Handling the process of change will be very challenging indeed. The market will need managing.

We also need to be clear that the market will not always work naturally in the interests of the consumer. Far from extending choice, it will, left unchecked, sometimes seek to restrict it. The market managers of the future will need to become the guardians of sensible competition and extended choice. They will need to create a strategic planning framework, gossamer thin but strong, visible and recognised by all as sensible.

Managing the new market may turn out to be a far greater challenge for politicians and managers than anybody thought it would be.

PATIENTS: MARKETS: CHOICES

Patients have become more demanding and competition should both extend their range of choices and make those that have always existed, but rarely been offered, more explicit. Managers will have to be more sensitive to their needs; increasingly looking to them to shape services. The handling of complaints is but one area that needs radical overhaul. Complaints are not something to be feared or handled by lawyers. They need to be seen as suggestions, as jewels to be sought with vigour and enthusiasm . . . they tell us how to serve a patient better next time.

Whilst Health Authorities which are purchasing will share a

strong national and regional corporate culture and discipline, the provider side will be more independent and locally focused. They will create corporate loyalty and identity at the level of professional practice or hospital. That in itself represents a powerful change for the good.

We have always had pluralism in general practice. We now need to adjust to its existence in the secondary care systems.

There are many who remain sceptical and apprehensive about the new NHS. They remind those who listen that this country spent many years searching for a unified system of healthcare. They abhor the fragmentation that they observe now. They want to rely on planning to take the service forward in an incremental manner.

But the long search for unification between the two World Wars led eventually to a monolith that spent too much of its energy preserving powerful professional empires. In the fight for more cash the NHS rubbished itself and its standards in front of the community it served. The system hated Clarke and Thatcher, who were determined to force change. Many of their changes (but not all) are now being acknowledged by senior health professionals as good for the NHS. The history of 1946 and the battles between Bevan and the BMA may well have repeated itself. There is, however, the chance to learn from the past. The service now recognises the energy and stimulus of competition and the value of local management control. But the new NHS also needs a strong, resilient strategic framework which channels and sustains these powerful forces into a stronger and better National Health Service. Without this framework the wheel might well turn back to the fragmented and near bankrupt circumstances of the 1930s and the search for a unified system might have to start again.

MANAGING A PUBLIC SERVICE

Managing a public service demands many of the same skills found in successful managers in the private sector–vision, leadership, energy, the ability to delegate and develop subordinates, making things happen. But the public service manager does operate in a distinctly different culture. Party politics are very intrusive, producing many, often conflicting, objectives and ambiguities. Social and political objectives are at least as important as economic

efficiency. As a result, the bottom lines are not as clear cut and performance is judged as much on 'handling' as it is on achievement. Sir Kenneth Stowe, paying tribute to the achievements of Victor Paige in his short period of time as Chairman of the NHS Management Board commented, 'By comparison with what could have been done by a Chief Executive in a commercial environment it may have appeared and evidently was perceived as too little (by Victor Paige)... But Government never was and never will be like commercial business'.[53] It could have been Bagehot speaking one hundred years earlier. The word management is now very fashionable in the public sector, but it has to be accommodated within a long and honourable tradition of public service and public administration. For many talented managers, the idea of using their skills in the wider interests of the community fills the same powerful vocation as it does for their clinical colleagues.

But working in the public service carries with it other restraints. Business, wherever possible, is to be conducted in public with all the pressures that generates. The public service has very demanding standards of propriety which in the health service at least has produced a system astonishingly free of corruption. But the boundaries of the traditional culture and controls that have underpinned this behaviour are inevitably under challenge in a more competitive environment.

Supplies Officers hit the barrier first as they tried to move into negotiated tenders—eventually they succeeded. Purchasers and providers on the other hand have little to guide them in developing their relationships except their innate honesty of purpose and a rather naive view of the rules of negotiation. The problem is not so much one of guarding against improper personal gain (although that could emerge with Fundholding and private practice deals) but more the conduct of parties negotiating with each other with public money. When will contractual incentives go too far . . . beyond the bounds of propriety? Is insider trading going to be a real issue for the NHS as Health Authorities contract both within and without the public sector? Are the rules about declaration of interest robust enough to cope with a new world of contracting? How are they to be enforced in General Practice? Some of the same tensions will emerge as the NHS contracts for professional training (Working Paper 10) with an increasingly

competitive higher education sector. When does a gift or a dinner from a provider to a purchaser become improper? What happens when quite against the rules, providers offer loss leaders to retain the market share . . . until the market rises in their favour! The NHS (and perhaps the whole of the public sector) needs a clear set of rules to guide behaviour in a public sector market place—perhaps the Audit Commission should suggest what they might be.

FINANCIAL MECHANISMS

Financial mechanisms assume a new order of importance in an internal market and are likely to be a decisive influence on the day-to-day life of the NHS. Purchasers are already developing financial incentives and penalties to secure provider adherence to patient outcomes they conclude are appropriate. Financial incentives have always worked in general practice, although not always with the anticipated result. Many of the paths providers will be guided down by contract will be entirely legitimate, like *Health of the Nation* targets. Increased day surgery will also be acceptable, provided the purchasers do not get too far ahead of broad professional opinions about safety. Whilst the financial mechanisms are broadly based, they will almost certainly succeed. However, as they get more and more specific and begin to intrude into the heartland of clinical practice, there will be an adverse reaction from the clinicians concerned. The irony is that in order to move the service in the direction of *Health of the Nation*, greater control over clinical practice is vital, particularly in the expensive hospital sector. Tomorrow's managers in both purchasing and providing organisations will need to be much more knowledgeable about medicine and clinical practice. For a good deal of the history of the NHS, administrators, and later managers, were primarily concerned with the corporate outer layer of the business, its support services, its human resources, its systems and its funding. In the new world they will have to engage closely and directly with professional staff about the content of their clinical practice. The line between a supportive and knowledgeable partnership between doctors and managers and unwarranted interference in clinical practice will be more tightly drawn than ever before.

No successful manager in the NHS has ever been able to manage without financial knowledge and skills. In the future they

will have to be of an altogether higher order. The complexities of budgeting, price setting, external financial limits and capital charges will have to be core knowledge, not something that only the Treasurer needs to comprehend. They will also have to be able to make a connection between price and clinical practice.

At the IHSM Annual Conference in 1990, Sir Jimmy Saville warned that the day of the accountant was fast approaching—he was right. The service has to hope that his other prediction about this having the seeds of destruction in it are wrong. The future managers of the service do need a high level of financial acumen, they do need trained accountants working within them as colleagues in the organisation—they do not necessarily have to be accountants themselves.

They do have to retain the confidence and support of the clinical professions and the doctors in particular. Without them a manager has nothing worthwhile to manage.

MANAGERS AND COMMUNITY SERVICES

The management system of the NHS has not always been quick to respond and react to changes in service delivery and clinical practice. More treatment and care than ever before is being delivered in a community setting and this trend looks set to continue. The management task in the community is different from the large chunks of managerial business found in the hospital service. General Practice is highly localised and fiercely independent. Direct control mechanisms are sparse. Facilitation, persuasion, negotiation, are the traditional tools in the community or primary care manager's tool kit. Managing the contractual interface between GPs and FHSAs is a new and challenging task. The introduction of *Caring For People'* on 1 April 1993 will add to the complexity. In recent years the private sector has come to play a major role in the nursing home market place. Add to that the development of hospital outreach programmes and we find a very rich brew indeed.

So what is the management task in the community? Firstly, it is about overall market management and creating a strategic framework that secures each of the component parts of the service and helps them grow and thrive. It makes sure services remain accessible to local people and, where appropriate, are targeted

and located in areas of greatest need. It is perhaps a sad reflection on the NHS of the last 40 years that resources have not naturally flowed to the areas of greatest need in the community. The economically deprived communities also seem to attract less health investment; this, despite our certainty of the connection between poor health and poor economic and social circumstances.

The management role will continue to be about facilitating change and improvement in professional services . . . encouraging clinical audit; patient focus and practice development.

It will also be about connecting all these services to individual citizens. Developing uniquely tailored packages of social and health care is a marvellous vision of service. To achieve, it will demand a very sophisticated managerial process indeed and management talents of a high order. The new community managers are few and far between at present. Their development must be an urgent priority.

MANAGEMENT : DOCTORS

As the history of the NHS has progressed, the relationship between doctors and managers has changed. In the early years of the NHS, doctors were very powerful indeed. Indeed, until very recently general practitioners were so dominant in FHSAs that they largely managed their own contracts. One should not assume of course that this dominance was always bad for either the organisation or for patients. Many doctors approached their managerial and representational duties with a very real and conscientious concern for patients. However, as the years went by they began to represent one of the most entrenched barriers to change.

In the hospital world of the 1960s and 1970s, a powerful Chairman of the Medical Committee was an enormous asset to his administrative and nursing colleagues.

Things began to change in the mid-seventies as the power of the profession reached its zenith with the 1974 re-organisation. There were more and more hospital consultants and the powerful clinical leaders were not so apparent. Power had also shifted upwards in the organisation away from the then hospital to District and Area level. 'Buggins turn', the usual way of advancing though the complex machinery of the Cogwheel system (the medical advisory committee structures) produced too many poor performers. It

must also be acknowledged that demands on the individuals concerned had grown enormously. Membership of full blown management teams was often added to the representation role, which itself was usually on top of a demanding clinical practice. For GP members of DMTs that was a very heavy 'add on' indeed, particularly for those GPs who took their new role very seriously and began to challenge the big battalions of the hospital service in the management meetings. The whole organisation was also at that time extraordinarily complex, with a myriad of committees and specialist officers at Region, Area and District.

As funding became tighter, the role of the managers (and their management teams) increased and many consultants found themselves under challenge. Often the challenge was entirely legitimate and overdue but it was resented nevertheless. This was part of the reason why Administrator bashing became so strident in the late 1970s. But the closely drawn organisational design of 1974 also had within it a vital strategic flaw. These managers who had over many years developed a relationship with their senior clinical colleagues, and in many cases earned their respect, had moved up the organisation and they went to Regions, to Areas and to Districts. Senior consultants at hospital level found themselves being challenged by very junior administrators and this added to their resentment. The lesson for the future, and for once it has been learned, with the emergence of the Trust movement is the NHS needs most of its best and most experienced managerial talent at the same level as the powerful clinical leaders.

In the new market of the NHS the balance between doctors and managers is moving again as managers seek to deliver contracts that impose on clinical practice. Doctors do have to practice medicine in the NHS within an organisational framework and a clinical community that will at times inhibit their personal freedom in pursuit of a bigger goal. It is no good extending expensive care to a few patients if as a consequence, the hospital or practice is totally de-stabilised financially and many other patients suffer as a result. We, however, need to take care that clinical freedom at the level of the individual patient is not unreasonably compromised. . . for that would be directly against both the wishes and the interests of the patient. As usual in the NHS the really important bottom lines have an elasticity in them which allows impossible choices to be made.[141]

DOCTORS AS MANAGERS

As we move forward, one of the questions that keeps arising is the role that the senior professionals and particularly doctors, should play as Managers in their own right. Most of those Doctors who took up the challenge of becoming District or Unit General Managers did not survive for very long. Some found the task too demanding when combined with clinical practice, others resigned on what they regarded as matters of principle — usually associated with financial problems and difficult managerial choices. All experienced a problem with the inevitable tension between a doctor and a Manager. It is unlikely that the system will look to the doctors as the prime source of recruitment for future General Managers, either within Trusts or purchasing agencies, although there will be a few talented doctors who would want to aspire to those jobs and they should be given every encouragement to do so. Those who do will make a conscious decision to shift their careers. It is the combination of management and daily clinical practice in the same person at the same time that seems to be generally unworkable in our health care system. However, in a different part of the organisation doctors are emerging as very real and very powerful Managers. You see it at its strongest in the burgeoning development of clinical directors. Doctors are beginning to play a decisive role in the management of their own and their colleagues' day-to-day clinical practice. Searching for efficiency, searching for quality, managing the budgets, increasingly appointing the staff, these are decisive roles for the future and it is very exciting to see these changes in action. At last the inner core of the NHS, the point where the service meets the patient is being managed.

The NHS is not providing very much structured support for this very important new managerial tier and one of the most urgent priorities is to build a skilled support mechanism to enable doctors who want to become clinical directors to move and survive in that territory. Offering some personal financial rewards would be wholly beneficial at present. The new breed of business manager operating at the level of the clinical directorate is a positive and welcome development.

General Practitioners, of course, have been independent businessmen from the beginning and as they move into General

Practitioner Fundholding, their role as managers of a large slice of the NHS resource becomes increasingly important. They too need help in developing their maturing skills in this territory.

Helping doctors to become better Managers of clinical practice must be a prime target for priority and investment over the corn- ing years.

NURSING

Nurses fared less well in the competition to become General Managers although there were a few notable success stories... Christine Hancock, now General Secretary of the RCN amongst them. This was particularly galling for the leaders of the profes- sion who felt they had at last achieved real parity with medical and administrative colleagues in 1974 with their full membership of management teams at every level. The good General Manager at Unit level quickly learnt how vital a strong and effective nursing colleague was. One expression of the re-emergence of the strong nursing leader in the hospital service was the return in some to the title Matron, although the profession itself did not much like the title. At District and Regional levels the explicit and special nurs- ing role was harder to define and as a consequence, the personal qualities of the individual shaped their role and influence.

As clinical directorates have developed the question of who man- ages the nursing resource within them has been the source of much heated debate. The most common pattern that is emerging is that they do indeed become part of the directorate but with a professional link to the Matron or Senior Professional Nurse. However, this is but a side show compared to the really long-term challenge facing both nursing and the organisation. We now train nurses who expect to emerge as independent professionals in their own right in both a hospital and a community setting. They do not want to practice in a tight hierarchy—they will want their profes- sional freedom. The development of primary nursing and the Patient's Charter requirement for a 'named nurse' is building this momentum as is the advent of nurse prescribing. Those Managers who are having problems with a few independent professionals called Consultants or GPs will find dealing with a somewhat large group of independent professionals called nurses far more challenging.

MANAGEMENT TECHNOLOGIES AND SKILLS

Managers across the whole of the NHS are now living in a world where financial mechanisms lie at the heart of their working lives. Successful managers in the future will be more numerate and have to learn to operate with the new information technologies that are increasingly part of the day-to-day life of managerial colleagues in the commercial sector. But more than mere numeracy is necessary—a commercial flair combined with canny judgement and a real feel for the values of the NHS and its clinical professionals will mark out the best.

One of the other skills that will begin to emerge, particularly amongst provider managers is marketing. Marketing to general practice, marketing tertiary referral services, marketing to the local communities are all now important for NHS Trusts. Internal trading within Health Authorities is growing apace. Services at Region and District that live on income from users within the NHS are now having to learn how to market their skills. Trading across clinical directorate boundaries within hospitals is already developing. Those managers who let the market simply arrive at their doorstep will find, over time, their share and their future eroding.

The management agenda of the early period of the NHS was dominated by industrial relations problems. Pay in the National Health Service is still generally poor and Health Authorities are still in the business of running a low wage economy. This was never a conscious decision but instead the product of a central pay bargaining system (Whitley) that was linked to other public sector pay systems and dominated by the need to keep settlements as low as practical. In this latter regard, the system performed well. As a mechanism for agreeing relevant and creative reward systems, it failed. We need staff in the NHS paid a sensible, realistic rate for what is a very important and demanding job. To see them at the bottom of the public sector league table demeans them and the NHS itself. If the trade-in for better pay is less staff, that is the price that will have to be paid. A workforce that is sensibly paid, respected and well led will be more productive, more creative and more flexible. As pay devolves, as it will and should, it will reshape the nature of the Manager's job yet again and industrial relations skills will have to be re-learned. It will also change the

relationship between the General Manager and those of his colleagues whose salaries he and his Board are determining, including senior clinical professionals. The move away from standard pay scales for all consultants whatever their specialty looks to be inevitable. We do not fully understand this piece of important organisational chemistry but it is likely to be one of the fault lines between management and doctors over the course of the next five to ten years. Managing the human resource in health will always be one of the prime tests of the good Manager at any level.

RECRUITMENT

Where is the next generation of senior Managers coming from? There seems to be a number of different issues here. The service ought to continue and expand the process of seeking to grow Managers from within the organisation. The NHS employs nearly a million people and that represents an enormous pool of potential talent. And yet nationally, or even Regionally organised management development programmes will become increasingly difficult to promote in the pluralistic and competitive world of the new NHS unless they are supported, at least initially, by top sliced cash. Enabling facilities like MESOL and the new Open University courses are a very good way of making standardised learning packages available to a widely spread and differentiated community. This is a fruitful form of investment. However, there are other ways of enriching managerial talent. Trent and Yorkshire RHAs have created Executive Development Programmes designed to bring into the NHS senior people from commerce and industry, and equip and prepare them to take on the most senior posts within two or three years. This seems to be a better tactic than trying to bring people into the NHS immediately at the most senior levels and expect them to succeed. The evidence is they do not. . . even at the very top. The NHS is going to need all the talent it can muster as it develops. Women represent perhaps the best potential for early gains as the service secures the targets set for it in Opportunity 2000.

Pay represents another problem that needs addressing. Managers in the National Health Service are simply not paid enough. In comparison to colleagues in industry and, indeed, with other parts of the public service, managers in the National Health Ser-

vice have been badly rewarded. Kenneth Clarke's insistence on putting Managers onto short-term contracts had the effect of focusing managerial targets much more narrowly but also had the effect of creating much shorter time horizons. Performance related bonus payments (averaging around 4 per cent per annum) are too small to be anything other than a modest incentive but they also represent a source of considerable tension and irritation. In any case, the current system has by 1992 run its natural path and needs replacing by one with wider ranges in it, so that really talented people can earn a decent income that is not too far removed from their contemporaries in the private sector or their colleagues in clinical practice.

The great asset the NHS has in recruiting externally is the vocational element of the challenge. Serving the community is still valued in our society.

MANAGEMENT: C M L SERVANTS

The relationship between those managing the NHS on a day-to-day basis and those advising Ministers grew much closer with the emergence of the NHS Management Executive. The Management Executive, which has been described as the 'action arm' of the Department of Health, itself contains a mixture of people drawn from line management roles within the NHS and career civil servants. However, the civil servants are in the majority and few of them have experience of day-to-day management in the health service. Too often their prime focus is watching and monitoring rather than doing. David Owen's analysis still fits today 'The department gets bogged down in detailed administration covering day-to-day management that has been sucked in by the parliamentary process.' Many Health Service managers respond by developing a 'feeding the beast' strategy to provide the system with the information constantly being demanded, thus keeping 'them' at bay and allowing some space for the real management work to go on. All organisations face a problem with the information flow up and down but the NHS has never come even close to getting the balance right. Those Regions who put their computer departments out into the private sector quickly reduced their previously avaricious demands on the service once a cash

price had to be paid. Perhaps the information flow in the NHS should be priced and charged.

In recent times the Management Executive has attempted with some success to improve the situation. It is encouraging more interchange of staff with the NHS and developing a more effective communications strategy with the NHS itself. Information strategies have a sharper, clearer focus. In the future the ME will need to move on from its traditionalist civil service raison *d'etre* of serving Ministers and watching their backs and move into the role of NHS Head Office. To survive in that role it will need to tread carefully so as to ensure that it retains credibility and influence with Ministers. It will have to make sure it does not create impossible political problems for Ministers as a consequence of closer links and more credibility with the NHS itself. If it fails to secure a relationship with Ministers based on trust and self respect, the NHS will undoubtedly suffer.

Relationships between managers and civil servants are complicated by their differing cultural environments. Managers have a wealth of practical NHS experience; they are fixers who are used to living on their wits and their instincts and being expected to achieve at least six impossible things before breakfast. Their agendas are predominantly short-term. They are usually emotionally as well as intellectually engaged with what they are trying to achieve. For many they understand that their jobs and careers are always on the line and at risk. Civil servants are intelligent and hard working: their ability to capture and then describe complex policy issues is very impressive; their emotional commitment is usually lower--perhaps to protect the balance they aspire to. They always have a political perspective. Senior civil servants tend to operate in a more rarefied atmosphere of fellow mandarins and senior politicians. The policy issues they grapple with are tough and complex and have long-term implications for the health and well being of the country as a whole. They consult extensively before instructing others to take action. They are not usually cast in the dynamic leadership mould but are strong on analysis, debate and advice—rather grey and serious people with a strong wedge of instinctive caution in their make-up. They are an excellent support and foil for their ever changing political masters and their contribution to effective government must never be underestimated.

Civil servants sometimes view managers as politically naive and simplistic whilst managers often view civil servants as procrastinators divorced from their reality. The truth, of course, is that reality is in the eye of the beholder. Sometimes the cultural divide is too wide—oil and water. However, when the two sets of talents feed and support each other they make a powerful engine for progress.

The stereotypes may be uncomfortable but they are important. Who will judge whether a mixed NHSME is successful, the NHS or the Civil Service?

What the NHS now needs is a structured management development programme for managers, healthcare professionals and civil servants in their mid-careers, where they can go away together and learn about the challenges facing them and what contribution each can make. A sort of Cabinet Office Top Management Programme but focused primarily on the NHS. Drawing in managers from the independent and private health sector would enrich the experience for everybody. More junior civil servants might also benefit from short placements in the health service from time-to-time and *vice-versa.* The NHS and the civil service will benefit and flourish from this interchange of their respective skills. The NHS Management Executive provides an excellent setting for such initiatives to thrive.

Managing the NHS has never been easy but it has always been challenging, always exciting and immeasurably worthwhile.

This manager's tale ends in 1992 with a service still alive and developing... the story has a long way yet to run.

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