Physician, Heal Thyself

The NHS needs a voice of its own

Duncan Smith

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The NHS needs a voice of its own: a cautionary tale

by Duncan Smith

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The Author

Duncan Smith served with three large public enterprises before joining the staff of the National Coal Board, at a time when coal was the foundation of Britain's economy. As Head of Staff Training Branch he helped to make training a dynamic part of the modernisation of the coal industry.

Moving to Health in 1963 he became, by an unusual route, the Chief Training Officer of the National Health Service. He found huge gaps in the provision of training and although he was able to fill some of them, the promise of a major expansion of training, made in a Department of Health and Social Security circular in 1974, was never fulfilled after he retired in 1977.

More recently, he revived his proposal for a Staff College of the National Health Service in an Editorial in the *Journal of the Royal College of Medicine* and decided that an account of his experiences in the Department of Health and Social Security (DHSS) might be relevant to the current situation. His pamphlet therefore contains some constructive proposals, placed in a historical context.

Preface

By Alistair Service, C.B.E.
former Chairman of Wessex Regional Health Authority

Health is at present Britain's biggest single preoccupation. Every week millions of people watch hospital dramas on their television screens. Conservative leaders have toured Europe seeking ideas about Health. The clash between Tony Blair and Iain Duncan Smith about an elderly patient dominated the headlines for almost a week. As regards finance, on 20th November 2001, the Prime Minister told the House of Commons that 'Of course, the proportion of Gross National Product spent by Britain on Health would be equal to the European average by the end of this Parliament'. Since this would cost the equivalent of six pence on the income tax, it is not surprising that within days Tony Blair started to hedge on this promise. Even more worryingly, he appointed on 1st December the ex Director General of the Confederation of British Industry to conduct yet another enquiry into NHS management. Further involvement of the private sector is threatened.

All this looks like more instances of making policy 'on the hoof' and there is a grave danger that history may repeat itself. This pamphlet by Duncan Smith (who has no connection with Iain Duncan Smith!) is a cautionary tale about his experiences in the DHSS, where he did something, years ago, to alert the powers that be to the importance of training. Large promises were made at that time but little was achieved and he points out in the following pages that a recent report by the Audit Commission has an eerie resemblance to the Circular of 1974 (from which he quotes) purporting to deal with this very matter.

The main theme of the pamphlet is that the DHSS, and more recently the Department of Health, have repeatedly failed to provide any mechanism which would allow directions from the top to be complemented by feedback from below. The author proposed a Staff College in the 1970s and explained how this could have enabled hypotheses about thorny problems to be discussed by inter-disciplinary groups of leading experts and practitioners to be tested by discussions at Trust level with the staff on the ground. The experts (or Fellows of the College) could then have pooled their findings and made recommendations to the Secretary of State on the basis of wide consultation. As suggested in Part II below, such a College would be even more appropriate now.

The new NHS Leadership Centre which has now been set up could organise something of this kind, but there is no indication that it intends to do so. And the new NHS University which is proposed is concerned with individuals rather than with the work of the organisation. In 2001-2 there has been a further flurry of 'top down' initiatives. There has been the NHS Plan, a revised organisational structure with regions and 28 new Strategic Health Authorities, the Modernisation Agency, a promise of decentralisation and more freedom for successful hospitals, and a revolution in the pattern and working of Primary Care. All this is being rammed down the throat of a demoralised Service without any real attempt to obtain feedback from those with experience at the 'front'. This pamphlet reminds us that similar activities have taken place in the past without appreciable results and what is now needed is some system which can distil, in a systematic manner, the wisdom and idealism that is latent inside the Service.

The present hyper-activity bears all the signs of desperation and an incorrigible desire for a 'quick fix' which would derive, at least in part, from the private sector. The unions and other critics are right to be suspicious. What is needed is a period of hard working but calm evolution based on internal discussion and feedback. Duncan Smith suggests a way in which this might be achieved and, putting his ideas in a historic context, has produced a pamphlet which is indeed a constructive and cautionary tale. Christ's injunction 'physician, heal thyself' may well provide the key to a wiser and more effective National Health Service.

March 2002

Physician, Heal Thyself

The National Health Service needs a voice of its own: a cautionary tale

by Duncan Smith

I
A Historical Background

Is the National Health Service an icon, to be regarded with reverence, or an obstacle to the creation of a really healthy Britain? For many years the British people had a real love affair with the Service, partly because of its history. The old system of voluntary hospitals, supplemented by local authority provision for the mentally ill and for the aged infirm had been a remarkably ramshackle affair. But it lasted until the end of the Second World War when Nye Bevan created, by an imperious act of political will, a state funded and unified Service in 1947. This was so great a change that it immediately won the hearts of the public. They found it wonderful that they could consult a general practitioner or enter hospital without any charge, and were provided with free prescriptions, dentures and spectacles into the bargain. Some of these privileges were whittled away and Bevan, indeed, resigned when it was decided to charge for prescriptions. But the system as a whole survived and developed pragmatically for a quarter of a century. Change was however needed and the Thatcher Government began an uneasy era of 'top down' regulation.

Experience with the National Coal Board

I became connected with the Health Service in 1962 after having worked for 15 years for the National Coal Board. I joined the Board's staff in 1948 because I wished to take part in the development of a nationalised industry and coal, at that time, was the foundation of the British economy. It provided fuel for 95% of all the factories, offices and homes in the country and it was in desperately short supply. The Board had a large number of obsolescent collieries and there was a grave shortage of miners. My bosses were Lord Citrine, ex-Secretary of the TUC and Professor Reg Revans, who later became the well known apostle of Action Learning. Together they had created an ambitious scheme for bringing new talent into the industry and for making the maximum use of all that was inside it. The Board realised that though the Government could provide capital, the success of the

industry depended primarily on brains. It therefore agreed that training should play a key part in implementing new policies and, though Revans and Citrine soon went on to other work, this policy was maintained and in the fields of mining engineering, mechanisation, supplies, method study and other ancillary activities, training played a key role. This was recognised by Lord Bowden when he was brought in to Harold Wilson's Government to launch the Industrial Training Act.

Speaking in the House of Lords he said, 'The scale on which the job of training should be tackled might alarm some people, but it would be quite wrong to think that these things are impossible to do. We have before us one extraordinary example in this country, where problems as great as this have been tackled and tackled successfully, I refer of course, to the coal industry. On Vesting Day', he said, 'the industry was gravely backward, there were no proper training schemes; the morale of the workers was low; the plant was worn out. Today we have a complete transformation.'

Sadly, even as he spoke, fate was knocking on the door of the coal industry. During the 1960s cheap oil began to pour into Europe and the economics of coal were irreparably undermined. For 20 more years the industry remained an important one but, in 1984, the disastrous miners' strike gave it what was almost a *coup de grâce*.

From Coal to Health

In 1962, realising that coal faced an uncertain future, I was ready for a fresh challenge. Sensing that the Health Service seemed to be backward in the training field, I accepted an invitation from my old boss, Reg Revans, to help to run a large project for the DHSS on internal communications in hospitals.

Revans main job was at this time in Brussels, and he delegated to me the day to day supervision of the scheme which gave me a wonderful opportunity to learn about the administrative problems of the NHS. After a year or so however, I felt that I ought to get back to training, and through the project, I had become friendly with Alan Fisher, the General Secretary of NUPE (National Union of Public Employees). Alan was interested in my Coal Board experiences and was very concerned that his members in the NHS, who numbered nearly a quarter of a million people, received almost no training. He therefore asked whether he should recommend to the Department that I should advise them about this problem. They agreed and I spent a year looking at the wide expanse of ancillary functions and

interviewed hundreds of ancillary workers and also officials at all levels in the organisation.

My conclusions were that there was an urgent need for improved Personnel Management in the Service and that better supervisory training would pay large dividends. I said that my extensive contacts with ancillary workers had been a fascinating and almost humbling experience because there was amongst them a touching loyalty to the Service, based on a realisation that their jobs were worth while.

The DHSS liked my report and gave me a temporary post, initially to develop the training of ancillary workers. It soon became evident however, that I ought to start with training the middle managers who looked after them and since I was the only professional trainer in the Department, I soon became involved in many wider aspects of training. The Department seemed to approve of this extension of my role, and in 1967 I was given a permanent post as Chief Training Officer, National Health Service.

A Staff College?

It was, however, a lonely position and I felt that training should receive far more attention from the top management of the Service. The Industrial Training Act had set up Training Boards in all industries and, by 1967, the Engineering Training Board had raised a levy of £70 million. The Act did not cover Crown Services of which the NHS was one, but the Government said that they expected that these would provide training at least as good as that promoted by industry. In the Health Service, however, apart from clinical training, little had been done and except for a scheme for administrative trainees, there were yawning gaps in the fields of vocational and management training.

In order to try to involve top management, I therefore drafted a paper proposing a Staff College at which talented members of all the main disciplines would discuss practical problems within the Service and seek feedback from the wards and the surgeries. This paper remained on file until Sir Keith Joseph, the Secretary of State, said he would like to consider the question of a Staff College. My paper was sent to him and he convened a high level meeting to discuss it. All went well at first, until the Permanent Secretary of the Department of Social Security said that as Sir Keith was also in charge of his Ministry, it obviously ought to be included in the Staff College scheme. This provoked claims by other organisations associated with Health for a place in the scheme, and Sir Keith said that he would have to consider

these new bids. In the event, it was decided that instead of a Staff College, there should be a Centre for Courses and in my view, this decision was, for the reasons explained in the Appendix to this pamphlet, very regrettable.

The NHS contained, as it does now, a host of very able and wise people with constructive ideas about the ways in which improved health might be promoted. And yet there was no official focus in which these ideas could be pooled and policy suggestions distilled from them. There were lots of authoritative voices, the Royal Colleges, the Chief Medical Officer, the Kings Fund, the medical press, and the heads of branches of the DHSS. But there was no machinery which encouraged the organised development of ideas, based on the experience of the Service. In the Department itself, the Civil Servants in charge were not experts on health and there was no cabinet in which operational decisions might be discussed by the main interests concerned.

Politicians and Consultants

This situation left the Department a prey to two influences, neither of which was necessarily good for its long term future. The first was the politicians, who were the real elephants in the jungle. They could, like Bevan, create beneficent revolutions but, though other Ministers were not Bevans, they all wished to rise in public esteem by making their mark on the Service. For example, the reorganisation of 1974 abolished Hospital Groups which had existed since 1947 and replaced them with larger Areas. This process caused great disruption and all officers had to resign their posts and apply for new ones. This caused terrible worry and uncertainty, and particularly in fields like Supplies, where there were alternatives outside the Service, there was a great wastage of talent. The new Areas did not work very well and a few years later there was another reorganisation, with equally disruptive effects which created smaller Districts, which later became Trusts.

The other influence was that of management consultants. Politicians, when making their proposals, tended to lack confidence and hence sought advice from high powered consultants. In a sense, this was a case of the blind leading the blind. Consultants knew less about the Service than the people in it, and yet after a fairly brief survey, they made prescriptions, which, if endorsed by the politicians, became policy. Hence the Service, instead of being a self-regulating organisation, which, through a Staff College and other internal mechanisms, kept its policies under continuous review, it became an

anatomy on which outsiders were allowed to operate with very little opportunity for the patient to express its opinion.

It is remarkable that there has never been any constitutional method of 'taking the temperature of the Service'. Unlike the nationalised industries, there have been no Joint Consultative Councils at national or regional levels, no suggestion boxes for bright ideas, and no annual conferences, like the summer schools run by the National Coal Board. Hence the feedback which could have been sparked off by a Staff College and by the concept of mutualisation was never made available. The 1974 reorganisation was not however confined to geography, since it also attempted to co-ordinate the Hospital Service with the community services run by the local authorities. It also introduced the concept of consensus management, by which Areas, like Quaker meetings, were expected to reach decisions through mutual agreement.

Vocational Courses and a Promise of Reform

The decision to establish a Centre for Courses, rather than a Staff College, was prompted in part by the success of a number of internal courses which I helped to run. As part of the 1974 reorganisation, Sir Keith Joseph initiated a rather modest form of Personnel Management. This was developed with great enthusiasm by an Assistant Secretary named Ray Petch, who worked closely with me in running a number of courses for newly recruited Personnel Managers. Unfortunately these all had to be drawn from inside the Service and therefore the training we were able to give them could not compare in depth with that provided by the Institute of Personnel Management. Similarly, we held courses for Training Officers, but the number of training posts which were established were too few and many of the trainees drifted off into other disciplines. In a Circular issued in 1974, headed 'Policy and Organisation for Training Services', the Department recognised many of these inadequacies with remarkable frankness.

'Training in the National Health Service' it said, 'has hitherto suffered from two major disadvantages: a) training activities as a whole have not been knitted together to form a coherent pattern, b) the absence in the general training field of qualified staff in the employ of the majority of authorities has made it difficult to organise effective training on the required scale, at or near the place of work'. Ambitious job descriptions for Regional and Area Training Officers were published and it was stated that 'many influences are forcing the

Service to become a dynamic learning system, and that training should aim to focus learning on matters that are important to the efficiency of the system. Training', it was further stated, 'would not become fully effective until the necessary infrastructure has been created and in allocating manpower resources, and Authorities will no doubt wish to take account of the relatively small resources allocated to training in the past'.

The Circular derived partly from my activities inside the Department. But these were inevitably limited because I had no training staff under my command inside the Department and the eight Regional Training Officers, with whom I collaborated closely, were inadequately equipped for their tasks. They had some success in organising supervisory training, but were not regarded as the eyes and ears of their Boards.

As a sequel to the courses arranged in the Personnel field, an interesting activity lay in the Supply field. There I was assisted by my experience in the National Coal Board where, in collaboration with the Director General of Supplies, I had organised a large number of courses for staff at all levels. In the NHS a number of senior Supplies officials had been lost through the 1974 reorganisation and it was necessary to fill the gaps. I suggested a scheme based on a National Coal Board model which involved attaching bright youngsters to Area Supplies Officers who arranged planned experience for them. This scheme aroused the interests of the Area Supplies Officers in training but the Regional Supplies Officers were unmoved and I could not persuade them to agree to a comprehensive training scheme. I therefore searched for a way of breaking the deadlock and heard that a member of staff at the prestigious Henley Staff College was an expert on Supplies and had heard about the success of the Coal Board scheme. He was therefore keen to help and together we persuaded the Principal of the College to lend a hand. He wrote personally to each of the Regional Supplies Officers to invite them to a discussion at the College and, flattered by such an invitation, they all came.

We then had an intensive discussion about the role of Regional Supplies Officers, and big divergences in practice between the Regions emerged. Further seminars and discussions were arranged which lead to a set of reforms, containing a large training element, which was implemented successfully with the agreement of the DHSS.

A similar development occurred in the Pharmaceutical field. The Regional Pharmacists invited me to meet them and said that though

they dealt with millions of pounds worth of drugs, they had never had any management training. Could I recommend any courses which might help them? I said there were many forms of management training and before trying to decide which, if any, would be appropriate, they ought to agree about their own roles. We therefore had a discussion, similar to that held for the Supplies Officers, which had similar results. After reform proposals had been agreed, they were successfully implemented through a series of courses attended by all Area and Hospital Pharmacists.

In another field, I unfortunately failed. One of the results of the 1974 reorganisation was the appointment of the cadre of 'Community Physicians' who were concerned with populations rather than with individuals. Many of them had been Medical Officers of Health and, though they were given consultant status, they were rather looked down on by their clinical colleagues and were uncertain about their responsibilities. I felt strongly that seminars to sort out their roles were urgently needed, but I failed to carry the Department with me. I could not even find a Branch which was willing to provide an authoritative job description of a Community Physician! I am sure that the refusal of the Department to bite this bullet set back the development of preventative medicine for several years, until Directors of Public Health were at length appointed.

Participative Management and Management Training

Finally, an interesting effort was made to inaugurate participative management, which was sparked off by a charismatic consultant called Llwelyn Jones. Schemes were launched by training volunteers in discussion techniques and then by forming groups to study problem issues and to link these together as seemed appropriate. Although results varied, the overall gain was such that, in 1976, participative management was commended to the Service by the Secretary of State. It was defined as a way of 'encouraging staff to take a fuller part in the organisation of the Service in which they are engaged, with the object of securing improvements within sustainable resources'. The Circular recommended that each Region should nominate officers for training in the necessary techniques and it was hoped that they would, in turn, train others to train others. A training manual was circulated and officers who had run successful schemes were recommended as mentors for those who wished to follow them. Unfortunately, this 'do-it-yourself' policy was too much for the Service which was grappling with a major reorganisation, and the

refusal of the Department to provide consultant help to back up new schemes unfortunately led to their gradual decline.

Some useful experiments in management training were conducted by the Industrial Training Service and by certain universities but they were limited in scope partly because, until the 1980s, it was difficult to enunciate a coherent management philosophy for the National Health Service. There was, in the Service, a fundamental ambiguity about where the seat of power lay. In most organisations it was evident which group was paramount. In the Civil Service the administrator was king, in the National Coal Board mining engineers were dominant, and in electricity technocrats tended to rule. In the NHS, however, the balance of power was unclear. The doctors had by far the most prestige, but little operational responsibility. The nurses, although they formed the massive foundation of hospital care, had, until the Salmon reorganisation of 1966, no hierarchy and little formal part in administration. Group Secretaries, in charge of administration, though influential were not traditionally regarded as dominant figures and it was not clear whether they were primarily facilitators, co-ordinators, monitors or executives. Different Group Secretaries seemed to lay emphasis on different aspects and this diversity probably contributed to the evolution of consensus management. As might be expected, this improvisation was not destined to last.

In 1975 I reached the age of 65 and should have retired. There was, however, so much to do that I was invited to stay on for two more years and finally left in 1977. The Department then made the curious decision to set up a Training Health Authority, to be located in Bristol and headed by a Chief Executive at a higher salary than I had received! This divorce of training from the core of the Department must have been a handicap and though a National Training Council was appointed, the Service never became the 'dynamic learning system' visualised in the 1974 Circular. The responsibility for creating such a system lay with top management and in some valedictory articles, I quoted Clemenceau, the French Premier, who said 'War is too serious a matter to be left to Generals'. Equally training is too important for decisions about priorities to be left to Trainers or Personnel Officers. In its formative years, the leadership of the National Coal Board habitually used its Staff College and its training army to promote policies to modernise the industry and valuable results were achieved. In the NHS such high level managerial guidance has sadly been lacking.

When I retired in 1977 I decided that I would not attempt to seek training consultancy assignments in the Service but that, inspired by Schumacher, I would use my spare time to try to assist 'green' activities. I did not therefore follow in detail the progress of the new Training Health Authority or the tangled policy initiatives of the Thatcher era. I have, however, retained a keen interest in the NHS, have collected a library of cuttings and have been able to keep in touch through practical experiences, through reading and through a number of influential friends. I have therefore retained a deep concern for the Service and three years ago I thought that if I were to record my experiences they might have some relevance for the present situation. Careful study of the dramatic developments now taking place confirms this feeling, and it will be disastrous if history repeats itself and if government rhetoric takes the place of organisation development based on the experience of the Service.

II
'Physician, Heal Thyself'
A Way to Distil the Wisdom of the Service

Health Since 1977: NHS Management

The arrival of the Thatcher Government in the 1980s signalled a major change in the way in which the NHS was controlled. The first effect was that the ambiguity about the seat of power in the NHS was decisively resolved by the creation of the NHS Executive. Though it contains a sprinkling of doctors, the Executive and its regional offices form a business type hierarchy which under the direction of the Secretary of State has given instruction about the goals of the Service. The existing Health Authorities are now to be replaced by 28 new 'Strategic Health Authorities' and it is alarming that the establishment of new structures is being added to the huge changes referred to below. It is stated that a stronger voice is to be given to patients and although this may be admirable, consultation with the staff is probably even more important. Since there is no consultative machinery to mitigate the torrent of change which pours down the line, and since there is no constitutional right of appeal, it is not surprising that there is a sense of frustration throughout the Service.

The so called 'internal market' was a business concept and can properly be described as a Procrustean bed – which New Labour promised to dismantle. As Charles Webster, the official historian of the

NHS, points out, it was neither 'internal' (because it was designed by the Tories to benefit the private sector) nor a 'market' because it gives the patient little chance to decide about his treatment. The choices which were made by GPs via Health Authorities were also very limited because it was recognised from the start that if there had been true competition between the various 'providers', it would have produced chaos. The system, after numerous expensive adaptations have been made, now aims, according to Webster, at 'mutual dependence between commissioners and providers whose constructive negotiations aim to achieve optimum satisfaction to all parties'. In other words, we are almost back to our old friend 'consensus management'!

The 'market' experiment has had one salutary effect in focusing attention on costs, but it has done so at considerable expense. In all international comparisons the NHS has always scored highly on account of its low costs of administration, but these have soared from 5% of Health Service costs in 1980 to 12% in 1997 and the number of senior managers swelled from 1,000 in 1980 to 26,000 in 1993. As the Sainsbury Report pointed out, the Service had lacked a professional-type management and its growing sophistication demanded more management staff, but the enormous influx may have increased the weight of bureaucracy too much. Though New Labour has tried to reduce transactional and contracting costs, it has not, so far, made the savings in bureaucracy of which it spoke before the 1997 Election.

Centrally generated new initiatives and targets have been very numerous and the White Paper 'Modern and Dependable' reads like a recipe for heaven. Ills of all sorts are to be cured by an array of new initiatives and bodies. There is a National Institute of Clinical Excellence and a National Schedule of Reference Costs, a National Service Framework to bring together the best evidence of clinical and cost effectiveness, and all these are to be welded into Health Improvement Programmes. But these are not all. The Public Health White Paper 'Saving Lives — Our Healthier Nation' aims at saving 300,000 lives by 2010. The four main killers — cancer, heart failure, accidents and suicide — are targeted with percentage reductions required for each. Finally, as the Preface to this pamphlet recounts, there has been a further flurry of 'top down' activities in 2001-2.

All these are admirable hopes but there are doubts about whether there will be the political will and enough extra money to enable them all to be carried out. The question of resources is crucial because the NHS started from an artificially low resource threshold and has in no

way caught up in terms of revenue with the other Western health care systems. They absorbed a third more of the share of gross domestic product granted to the United Kingdom Health Service, which has had the impossible task of matching their standards with two-thirds their resources. The fact that the Service has been able to produce, over a very wide field, an admirable standard of service with relatively few blemishes is a great tribute to the soundness of its architecture and to the dedication of its staff.

The Private Finance Initiative

Clearly, in many parts of the Service, there is a great need for physical renewal. The NHS has many fine hospitals, but also many obsolescent ones, and the new buildings planned and in the course of construction should, in due course, increase its standard of efficiency, though the Private Finance Initiative may reduce the number of beds and increase the burden of debt. Why New Labour insists on maintaining this folly remains an infuriating mystery. Nick Cohen, *The Observer* columnist, is particularly vociferous about the burden which this will place on the next generation. He described those who are now imposing it as 'greedy, selfish, cheerless and narcissistic'!

The private finance initiative was initiated by the Tories to give private enterprise a foot in the hospital camp. Why New Labour should regard it as rational to pay private entrepreneurs, who take no risks, interest at 15% to build hospitals beggars understanding. At a time of low inflation there seems no reason why Government could not borrow money at about 5% and build its own hospitals. Alternatively, there could be a bond issue and it might be sensible, as President Lincoln advocated 150 years ago, to print money in order to serve public ends! In a devastating critique of the private finance initiative, Will Hutton and George Monbiot have shown that because of Treasury shibboleths 'Big money is stitching up the NHS. Private firms will build the hospitals, charge Trusts far more than they used to pay the Treasury and produce smaller hospitals and less beds. Various hospital facilities are also to be contracted out on terms which ensure a profit for private contractors'. The New Economics Foundation, echoing James Robertson, an ex Treasury Official, now advocates a serious proposal that the Government should bypass the banks by printing money itself, within strict limits, for lending, without interest, to Health and Railway Authorities. There would be a condition that the money was to be repaid for cancellation over an agreed number of years, and hence there is no reason why such a

procedure should be inflationary. There is evidence that the public is worried about the effects of the private finance initiative, and the amazing victory of Dr Taylor at Kidderminster in the General Election in 2001 is a blunt warning that similar results may occur elsewhere if the Government ignores the suspicions of many people about the jiggery pokery of the private finance initiative and the public-private partnership. These arrangements also involve elaborate contracts, controls and measurements which greatly increase bureaucracy, so that accountability is hard to pin down.

The Personnel Crisis

It is, however, in the personnel field that the real crisis lies. The 'Plan for Health' has stated that in 2001 the Service needs 7,500 more consultants, 2,000 more GPs and 20,000 extra nurses; 6,500 more therapists are also needed and no structural change or 'quick fix' modernisation can suddenly produce the necessary recruits. Even after foreign countries have been raided for possible talent, there will have to be a long, slow campaign of recruitment and training. The fact that such huge gaps have now been revealed is a tacit admission of the inadequacy of the personnel and training arrangements during the last quarter of a century. If the plans announced in 1974 had been carried through with vigour, manpower planning would have anticipated the current needs and a training structure would have been in place to produce the 'dynamic learning system' which the circular then proclaimed to be necessary.

Long ago, when I was Chief Training Officer of the NHS, I tried to base training on 'action learning' i.e. the discussion of actual problems by active executives. This, however, was not followed up in later years and I was therefore glad to see recently that the Head of the new Leadership Centre has stated that 'Action Learning has emerged as the hottest approach to leadership training in recent years'. As in so many spheres, there is a democratic deficit in the NHS and, as staff in the field know much more about the problems of the Service than the bureaucrats in Whitehall, a means must be found of getting their participation in solving outstanding problems. This process should start at the top, and if there was a Staff College based on 'Action Learning', the mechanism suggested on pages 29 and 30-32 would ensure widespread consultation.

The Service consists, essentially, of a million men and women, each of whom has a brain which is more complex than the most sophisticated computer. Its success depends on the knowledge and

skill of an army of staff and their effectiveness in the way in which they co-operate. Gleaming new hospitals provide welcome treats for some lucky staff but splendid work is going on in all sorts of depressing surroundings, and in the end, it is the human factor on which success or failure depends.

In hospitals the 'top down' approach to 'modernisation' enacted by Ministers has added considerably to the stress and paperwork of both nurses and doctors. It is one of the major causes of the acute nursing recruitment problem which is affecting the Service, and the Departments attempt to cure it by stealing youngsters from Spain and the Third World does not seem an ideal solution. In spite of its problems the NHS still has the respect and affection of most people and any attempt to privatise the Service will meet with fierce resistance. It seemed that New Labour is beginning to recognise this and additional funds should enable many gaps to be plugged. But staff morale is even more important, and if the Government could combine good intentions with techniques which enable staff at all levels to feel that they 'owned' the necessary reforms, they would be much more likely to succeed.

Primary Care

Primary Care is perhaps the one sphere in which we could both save money and improve human health in the future without undue stress. If more attention could be given to social factors, community facilities could be expanded, more responsibility given to highly trained nurses to economically run community hospitals, and more encouragement of volunteers, it may be possible to reduce the number of patients needing expensive treatment in general hospitals. This links up with the shocking inequalities of health which are recorded in the Acheson Report. The poor, especially those in Northern Britain, have vastly different standards of health from those of the middle classes and if unemployment could be reduced, nutrition, education and housing improved and further positive health measures encouraged, the burden on the NHS could be substantially lightened.

One of the reasons for the shortage of beds in hospitals is that many are still blocked by old people who do not need active treatment but for whom Local Authorities are unwilling or unable to provide residential care. These authorities have been even more worried about financial pressure than the NHS and have had no incentive to provide more old peoples' homes. Indeed they have disposed of most of them, and the number of private homes is declining. Some old

people who no longer require acute care do need rehabilitation before returning home and facilities for this should be increased. Others could return home if domiciliary assistance was made more comprehensive by recruiting and training an army of volunteers. Perhaps 'Carer Clubs' could be set up to allow carers to socialise, to exchange experiences and to find help in emergencies.

Now that the old mental hospitals have almost disappeared, the task of looking after mental disability places a big responsibility on Primary Care. Small hostels provide good care for very many who would otherwise be in hospital, but life 'in the community' can be dangerous for many ex-patients or potential patients, both for themselves through drugs, homelessness and depression, and to the public. Responsibility for dealing with these difficult cases is shared by hospitals, Primary Care Trusts and Local Authorities and the creation of effective joint policies has been hampered by administrative hurdles.

The new Primary Care Trusts have been formed to try to overcome these problems, but unless they and Social Services use effectively their new powers to design joint budgets and jointly controlled staff, they may not succeed. Some people feel that Public Health should be a Local Authority function and this is a typical example of a difficult problem which needs to be examined not only in Whitehall, but also on the ground by people who actually handle the hard choices that have to be made. It is vital that preventive medicine should be handled in a more imaginative way, making the maximum use of the leisure facilities of the Local Authorities and by organising a major campaign to recruit volunteers to help old people to remain in their homes instead of needing residential care. Now that modern medicine is making us live longer, fit people who have retired should be encouraged and trained to take over much of the task of looking after the old who are frail and handicapped.

In spite of all the recent changes, has the gulf between the NHS and Local Authorities been adequately bridged? The Primary Care Trusts originally catered for a dozen or so GP practices, but recent changes now cause them to cover wider areas. They will have a 'patient' representative on their boards but only one representative of the Local Authorities Social Services and none from the Local Authority itself. As yet, there are still separate budgets and it is vital to clarify the financial responsibilities for the old and mentally disabled who oscillate between care and hospital. The fact that doctors and social workers often have very different outlooks compounds existing disconnections.

In Northern Ireland there have been for some time Health Boards which have charge of all community health functions belonging both to the NHS and the Local Authorities. They have one budget and act as a unified service. The results are encouraging and these arrangements could well serve as a model for Primary Care Trusts in England and Wales. These could then form Health Improvement Plans jointly with Local Authorities and gradually merge their functions.

Public Enterprise *versus* Privatisation

My forthcoming book, *Gleams of Light,* deals not only with Coal and Health, but also with my previous experience with the London County Council, the London Fire Brigade and the Army and debates, at considerable length, the relative values of the public and private sectors. It claims that the Attlee Government of 1945 nationalised the Railways, Electricity, Gas, Water and Steel as well as the Health Service for good social and economic reasons, and that, in the main, they performed well. It is therefore a cause for sadness that only the NHS now remains in public hands. Privatisation was ideologically driven, but one of the reasons why the Thatcher Government was able to carry it out was that the nationalised industries had been shamefully neglected by the two Wilson Governments in the 1960s. Coal was dramatically betrayed and little attention was given to the management of the other nationalised industries which were given no coherent role in the national economy. Once they had been broken up, it would have been difficult to have considered re-nationalisation — though there has been much public support for bringing the railways back into public ownership. None the less the book accuses New Labour of abandoning its principles by repealing Clause Four without putting anything in its place.

Many factors, including the fiasco of the railways, have changed public perceptions about the merits of public enterprise and the enthusiasm of the Blair Government for injecting the alleged expertise of the private sector into the NHS has not impressed the majority of people. Indeed the Government have lagged far behind progressive public opinion and the left centre press have changed their tune strikingly about public service. In March 2001 and in March 2002, *The Guardian* published two big supplements summarising interviews by 200 reporters with a large cross section of public servants ranging from a general and a judge to cleaners and clerical workers. Almost all said that though their jobs were often

surrounded by difficulties they got satisfaction from them because they were useful. The leaders covering the two supplements gave resounding tributes to the value and ability of the public service, and to the dedication of the respondents.

In a strong leader, *The Observer* has also stressed that Railtrack 'cannot simultaneously serve its profit hungry shareholders and Britain's need for low cost, high quality transport'. Will Hutton, in a series of striking articles, derided the idea that 'only the private sector can provide value for money and efficiency, everything touched by the State is, by definition, a disaster'. He pointed out the great success of the publicly owned Japanese railways and showed how many of the alleged efficiency gains claimed by the private sector are phoney. The quality which dominates the public sector is co-operation, whereas that which propels the private sector is competition. Competition is a basic urge and can have economic advantages, but in a service or industry, whose object is to serve the public interest, co-operation should prevail. In Health, competition is possible, but where it takes place, as in the United States, it involves very high costs and much social injustice. It is, therefore, a blessing that few people in Britain challenge the principle of a free health service, but there is room for much debate about how it should be provided, and there are difficult problems of control surrounding a number of industries and services. Some think that Mutualisation provides a promising half way house.

Mutualisation

A 'Mutual' organisation is one whose aim is to serve the public interest, but not to make a profit which goes to shareholders. Its main characteristic is that there is a direct involvement of stakeholders — normally the staff, the people that the organisation serves, and the community. Ideally, the stakeholders should own the organisation, but in any event they should be represented on the controlling body and be committed to its aim. The New Economics Foundation has produced a Pocket Book entitled *The Mutual State* which has a Foreword by Patricia Hewitt, the Secretary of State for Trade and Industry, who writes, 'In a second term, Labour should be seizing the opportunity to promote social enterprises — not-for-profit businesses, committed to social goals'.

In industry there is great scope for an expansion of Mutualisation through the co-operative production of socially desirable goods and services and through the acquisition of Government shares in private businesses. This would be controversial but there will be general

agreement that a degree of Mutualisation should take place in Health, Education, and Social Services. In the Foreword referred to, Patricia Hewitt has said, referring to social enterprises 'That they have three great advantages when it comes to improving our public services. First, they are more likely to experiment and innovate. Second, they can find it easier to attract and retain highly motivated staff. Third, they are often free of the bureaucracy that hampers many large organisations, both public and private sector. Most social enterprises have a high degree of employee participation and many are partly or wholly owned by their employees'.

In Health it would probably be good, both for morale and for efficiency, if the three main stakeholders, patients, staff and the community, were strongly represented on Trust Boards as well as on Patients' Forums and on consultative bodies. In schools thousands of parent and staff governors make a striking contribution and thought should be given as to whether pupils should have a role on governing bodies. In hospitals, Leagues of Friends might also be represented and have their functions widened.

Mutualisation, however, goes beyond representation and should involve some participation in running an organisation. Exercises in participative management were successful in the NHS in the 1970s, and further experiments in these techniques should be considered. Indeed, in an interview with *The Guardian* on 7th February 2002, Alan Milburn said 'We are looking at a governance structure that might better represent the local community, the hospital services and might better represent local staff. One thing the NHS has been spectacularly bad at is communicating with its staff. They have a lot of expertise and we have not been good at harnessing it'. He likened the foundation hospitals to co-operatives or mutual societies that begin to get beyond the old public-private decisions. It will therefore be interesting to see what forms of staff participation the Government will be able to propose.

Another form of participation which would be well worth considering would be to hold an annual NHS 'Parliament' modelled on the successful Summer Schools, run by the National Coal Board in the 1950s and 1960s. A need was felt to unify the industry and 500 people drawn from all grades and disciplines and including 100 miners, assembled for four days at three large colleges in either Oxford or Cambridge. Addresses were given to the whole School by the Chairman of the Board and by the General Secretary of the National Union of Mineworkers and by two or three other

distinguished lecturers. The mornings were however devoted to discussions and 50 discussion groups each including two miners, debated some of the crucial issues facing the industry and their views were fed back to plenary sessions later in the day. There were also a number of specialist lectures and seminars. The School was attended by all the members of the National Coal Board and there is no doubt that they were greatly enjoyed by all who attended. They only ceased when it was felt that they had achieved their object in promoting the solidarity of the industry.

In the field of Primary Care the scope for participation is clearly very wide. Reference has already been made to befriending old people and it is equally urgent to deal with the needs of the young. Promising results have been obtained by persuading young people to work amongst peer groups and individuals. Single mothers have been successful in helping others in their neighbourhood to raise their standards of health care and to help Health Visitors to spread knowledge about sex education and parenting. Ex-young offenders and potential offenders have also given useful advice about sentencing in Juvenile Courts and in helping Probation Officers.

The list of social enterprises which exist and could be developed is a long one. It includes credit unions, housing co-operatives, managed workplaces, farmers' markets, recycling initiatives, local exchange and trading schemes (LETS), and time-shares. These activities and many others are described in *The Mutual State,* referred to above, and they all need to be reviewed and encouraged by the establishment of appropriate legal frameworks. They also need to be stimulated by large education campaigns, promoted both by voluntary organisations and Local Authorities. The launch of a Mutual State would involve many novel and diffuse problems and would require 'joined up thinking' of an exemplary kind. Consumerism has made very many people indifferent to their responsibilities as citizens and all the arts of education and public relations will be needed to reduce this apathy.

What is 'Modernisation'?

The phrase 'Modernisation of the NHS' is the great mantra of the Blair Government, but it has never been clearly defined. There is a Modernisation Board and *Chambers Dictionary* defines the word as 'an adaption to the present time, conditions, needs and language'. This does not imply a revolution, but merely that we should take account of changes that affect an organisation. One change, however, which is distinctively 'modern' is the growing use of Information Technology,

which is used extensively in diagnosis, prescribing, costs control and measuring. Maybe some improvements are still required and no one will object to the Service seeking technical advice from Bill Gates and his minions. But information technology can have its dangers. The quip 'junk in, junk out' reminds us of the perils of relying on doubtful data. The fundamental duty of the NHS is to 'care' and since there are so many aspects of 'care' that it is impossible to measure, reliance on computer control can be perilous. The first of the admirable 'Trust' programmes on Channel 4 television show how intensely difficult are the decisions made daily by surgeons and by the staff of Intensive Care Units. Who is to judge whether the unfortunate death of the brain surgery patient was in any was due to failings on the part of the surgeon or the staff on the ward? Transparency about the records of surgeons may have advantages, but it may also drive them into a 'no risks' policy which would be fatal to patients. The fact that some members of the irreplaceable ward team admitted that the strain under which they work was making them consider moving to other activities raises a whole raft of social and political issues.

Structural Change

Difficulties such as these cannot be cured by 'quick fix' solutions and it is hard to see how they can be eased by making structural changes. This pamphlet comments on changes made in the past and this process is still continuing. In the 1990s the number of Regional Health Authorities was reduced from 14 to 8 in favour of (primarily) county Health Authorities, and now, on 1st April 2002, 28 Strategic Health Authorities (many covering three counties) will take over from them. Such changes cause great trauma and this one seems to impose an unnecessary burden on a Service which is already punch drunk with change. It is claimed that the change to Strategic Health Authorities will save £100 million, but the Kings Fund has shown that this is an illusion and it will cause painful disruption to all the staff who are involved. The analogy of moving the deck chairs on the Titanic does not seem unduly far fetched!

Possible Cures

(1) The Private Sector Modernisation should therefore be concerned with adaptation rather than with changes produced by whim or fashion and the ambiguity underlying the Government's use of the term 'Modernisation' has caused a widespread suspicion that they have a hidden agenda. In spite of talks at Downing Street, the trade

unions are still acutely fearful that the Government intend to embark on further privatisation schemes and the fact that Blair continues to appoint advisors from the private sector adds fuel to such fears. Apart from the technicalities of information technology, how could the private sector help the NHS? If there is spare capacity in some private hospitals or hospitals abroad, it may be reasonable for the NHS to use it — though it might be better to try to lease rather than to hire. Apart from such marginal cases and the highly contentious private finance initiative, it is hard to see how further input by the private sector could benefit the NHS. The spectacular failures of Enron, Railtrack and Marconi are poor advertisements for business prowess and Andersen's (the accountants) seem to have wasted much public money in dubious private finance initiative schemes. Generally speaking, impartial observers agree that the organisation of a general hospital or a Primary Care Trust is far more complex than that of any factory or service organisation in the private sector.

(2) Decentralisation and Local Autonomy The Government now claims that it favours decentralisation and that if a Trust performs well, it would be given a substantial degree of local autonomy. There are two dangers in this approach. The first is, do we want to divide Trusts into sheep and goats? Apart from the difficulty of making measurements, Trusts are not homogeneous. One that has had a series of failures in some respects may yet have departments or units which perform excellently and have no guilt to confess. In any case, would not help be better than condemnation?

What is needed is careful diagnosis of the reasons for failure and the creation of some mechanism, on the lines suggested below, of putting them right. Competition between Trusts and between thrusting managers seeking business-type salaries, is the last thing that is desirable. The way to progress must surely be for Trusts with centres of excellence to share their expertise with others which may not have yet attained it.

Secondly, it is hard to see clearly what degree of autonomy is desirable. Health is an infinitely complex subject and maximum effectiveness must be based on a flow of ideas and research results which are diffused evenly throughout the Service. Too much autonomy might discourage the flow of feedback to the centre which is very desirable and might lead to some parochialism. Ideally the ideas and suggestions of every one of the million employees of the Service should be taken into account, but obviously they cannot all be listened to at once. We therefore need a system by which a

representative sample of all of them can be consulted, on the lines suggested below, at their place of work. Nonetheless, within a comprehensive framework, an increasing degree of local decision taking and target setting will clearly be valuable.

(3) Insurance Based Systems Powerful voices have urged that Britain should follow the practice of Germany and France in securing funding for health through compulsory insurance. This is taxation by the back door and will be an attraction to governments anxious to minimise general taxation. But is it, in fact, an expensive option because, inevitably, the collection of contributions means increased bureaucracy and a recent report by the King's Fund rejected it. They, however, warned against political interference and favoured decentralisation.

(4) The Government's Proposals The NHS Plan announced in July 2001 is 'Designed to give Britain a Health Service fit for the 21st century' and one 'designed around the patient'. The plan reiterates earlier announcements about setting standards, 'clinical excellence' and Primary Care. It also states that 'for the first time, patients will have a real say on the NHS'. They will 'help to decide on how much cash is provided for local health services', patient advocates will be appointed in every hospital and patients' surveys and forums will help to make the Service more patient centred'. Goals are set for dealing with cancer, chest pains, mental health and old people and it will be interesting to see whether the proposals for patient involvement will prove effective.

As regards staff, reference has already been made to recruitment needs and there are ambitious projects for staff development. There is a Leadership Centre, whose original Director praised Action Learning, but whether this will continue to be the inspiration of the Centre remains obscure. Then there is to be an NHS 'University', which will help to cater for the training needs of all the million staff now employed, each of whom will have an individual learning programme, supported by 'individual learning accounts' worth £150 a year. Staff everywhere, it is stated, will have further opportunities to extend their roles and £280 million is being set aside in the next three years to develop these skills.

This is training on a gigantic scale and will need very careful organisation if money is not to be wasted. There will also be a need to plan staff needs and to estimate future requirements with great sensitivity if overlapping and confusion is to be avoided. If, however, this is achieved there is no doubt that the effectiveness of the Service

will be increased and if the rhetoric about training which was proclaimed in the 1970s had been followed by action, most of the current staff shortages would not have occurred. But to carry out such a programme now will be a long hard slog and will need the services of many able trainers.

It should be noted, too, that all these plans are designed to improve the skills of individuals and it appears that the University will operate, to a large extent, through its web site rather than by face to face teaching. But even if it succeeds in producing a constellation of brilliant students, this will not guarantee that the organisation is effective. Organisations are organisms rather than machines and are more than assemblies of highly polished parts. It is the interaction of skilled staff in their teams and across disciplines which can produce the flexibility, co-operation and sensitivity which is needed in order to modernise the Service. Training to achieve this requires special skills and is one of the reasons for recommending a new type of expertise which is described below.

Unsolved Problems

The Mobilisation Board is faced with a bewildering array of problems and to solve them they need the good will and co-operation of the Service. Nearly all staff are loyal to the NHS, but many have doubts about the Department of Health which has traumatised them with a torrent of change without possessing any means of consulting them. There has obviously been widespread consultation at the top of the tree, but there has been no means of finding out the views of those working in the hospitals and surgeries.

Milburn's words about staff participation quoted above are very welcome, but so far his reorganisation has been an outstanding example of a change programme imposed from the top. This is a grave defect, because nearly all the most intractable problems involve subjective opinions and value judgements. It may be worth noting a few of them that affect hospitals:

Waiting – The old lady left waiting on the trolley is the symbol of NHS failings and it is caused mainly by lack of resources. There are 2.0 beds per 1000 patients in the United Kingdom compared with 4.5 in France and 7.1 in Germany; there are 1.6 doctors for each 1000 patients in the UK, compared with 3.3 in France and 3.5 in Germany. These disparities will take time to change but there are factors that can be altered — the organisation of operating theatres, surgeons'

rotas and private work, slow communications and length of stay in wards. These and other matters merit intensive examination to find out if any blockages can be removed.

Surgeons' Records – So many factors distinguish good from poor surgeons that to concentrate on the number of people who die seems absurdly crude. Is it possible to devise a simple but just formula which will assist transparency and guard against irresponsible litigation?

Morale of Staff – The need to feel valued and an easing of pressure are perhaps the greatest factors at the present time. They are linked with a desire for opinions to count and for the worth of all jobs to be respected. Suggestion boxes with prizes attached and staff/patient forums are among methods which might help.

There are also other problems and practices which cause controversy such as the private finance initiative and the categorisation of hospitals which urgently need objective examination.

Primary Care – In this field there are even more difficult problems, such as –

General Practitioners are grossly overworked and the figures cited above explain why. An average consultation of 7 minutes for each patient is frequently inadequate to allow a GP to explore the underlying reasons for ill-health. Should people with adequate means pay to visit their GP? Could administrators reduce the load of paperwork and nurses with wider skills take on additional duties? Is NHS Direct helping or hindering?

NHS and Local Government Hospitals, Partnership and Primary Care Trusts and County and District Councils are all deeply involved in Primary Care. Recent legislation makes real co-operation more possible and promising examples of integration are taking place in some areas. There is, however, a need for much thought about the best ways of establishing equitable joint budgeting and about the development of a common outlook.

Role Definition and Volunteers At present District Nurses, Health Visitors, Practice Nurses and Midwives all work in the Primary Care field and all wish to expand their roles. How can they and Social Workers best co-operate? Could willing and trained volunteers reduce the numbers required?

Patients' Representation Community Health Councils are to be abolished. Will the proposed 'Advocacy and Liaison Service' be an adequate and independent substitute? How will Patients' Forums be organised?

This short list of questions could be greatly extended.

'Wreckers'

Many people were puzzled and dismayed by Tony Blair's outburst at Cardiff on 1 February 2002, when he denounced the Conservative Party for being 'Wreckers' who wished to discredit the NHS and, by implication at least, put the left wing of his own Party and the trade unions into the same category. This is a dangerous strategy because, apart from the blind devotees of New Labour, it antagonises nearly everyone who values the NHS. Indeed the sorry story of Mrs Abby, whose children complained to their MP, Tory leader Iain Duncan Smith, about her treatment at a London hospital, suggests that it is high time that the NHS was removed from political controversy. The trade unions have particular cause to be affronted because their attitude towards the NHS has been wholly reasonable. For very good reasons they have opposed the private finance initiative and are rightly suspicious of the intrusion of privatisation into the Service and of the introduction of more managers from the private sector. They, like the public, want a reliable and efficient Service and they have done nothing to rock the boat. Most non-medical staff of the Service are underpaid but there has been no hint of industrial action and it is hard to see any good reason for suspecting antagonism to the Service on their part. If some changes were to involve the shedding of jobs, it would be madness to consider redundancies from a Service which is under stress, and redeployment and retraining should take place in collaboration with the unions. The Service faces severe recruitment problems and the Department and the unions have an equal interest in creating a reasonably paid labour force which is also efficient. There should, therefore, be scope for constructive discussion between the Government and the unions which could do much to restore confidence and stability. There are, however, alarming signs that the Prime Minister is still insistent on pressing for more privatisation. The franchising of more NHS services to private contractors has been mentioned and the unions will have grounds for resisting this strongly. It would mean divided control, a lack of accountability and if there were any savings, they would be marginal. Would it not be wiser to raise the standard of existing units by intensive training?

Another proposal is to try to cure 'failing' hospitals by installing new management drawn from the private sector and from successful NHS hospitals. This is a type of 'quick fix' which seems dubious. A year or two ago there was much talk about curing 'failing' schools by appointing 'Super Heads' but, in practice, failures have outnumbered successes. The importation of outsiders is bound to cause recrimination and co-operative measures of the kind suggested below may be slower, but are more likely to be sound.

One can only pray that the Prime Minister can be persuaded to heed the words of Alan Milburn and to seek wisdom from inside the Service rather than from outside.

A Blue Print for Evolutionary Modernisation

(a) A Staff College

Reference has been made to my grief that the idea of a Staff College was not taken up in the 1970s. I attempted to revive the notion in an 'Editorial' in the *Journal of the Royal Society of Medicine* (see Appendix). I now feel that at the present time, a College could be more appropriate than ever and that it could be fitted fairly easily into the current modernisation programme. Suggestions about the shape, activities and organisation of a possible College are therefore set out in the following paragraphs.

The Leadership Centre could, fairly quickly, acquire a hotel or country house and set up a semi-autonomous residential College headed by an experienced Principal. It should have a small staff, a good library and research facilities. To it could be seconded, for a period of about three months, groups of 40 or 50 of the ablest representatives of the main disciplines of the Service. They could be called 'Fellows' and each input could be formed into two or three multi-disciplinary groups, each of which would be invited to examine and report on one of the kind of difficult subjects that have been noted above. On arrival at the College they would be offered some training in group dynamics, action learning, diagnostic and negotiating skills and some aspects of personnel management provided by a small 'Learning Wing' attached to the College. Each group would then spend up to a month examining its problem and seeking outside advice as necessary. Sources might include the Audit Commission, the World Health Organisation, the Royal Colleges, the Trade Union Congress, the King's Fund and universities which have studied health problems. At the end of the month they would consider whether they had arrived at an agreed hypothesis about a

solution to their problem which was ready for testing at working level.

Whether or not they all agreed, they would then disperse and each 'Fellow' would spend a month visiting two of the 28 Strategic Areas. They would hold consultations with Trust Boards, wards and units, patients forums, trade unions, representatives of professional and ancillary staff and all the organisations involved in Primary Care. They would be assisted in arranging meetings with appropriate people at organisations by local 'organisational clinicians' or facilitators whose role is discussed below. Notes would be made of the opinions expressed and an assessment produced about whether or not there were wide differences between the two Areas visited.

At the beginning of the third month the 'Fellows' would reassemble at the College to pool and compare their findings. They would discuss whether or not the process of consultation had inclined them to vary their original hypothesis. Their next task would be to frame a report to the Modernisation Board and to the Secretary of State about the policy which they recommended. As with Royal Commissions, there could, of course, be minority reports if necessary. They would then return to their previous jobs and might, after about three months, reassemble for a weekend at the College to meet a representative of the Modernisation Board who would tell them about what decisions had been made and about their implementation.

Implementation would in many instances involve development training for staff in the sector in which change was desirable and it would be highly desirable to have, in each Area and possibly in each Trust, a facilitator of the kind mentioned above whose title could be a matter of debate and whose duties are suggested below.

(b) 'Organisational Clinicians'?

The provision for obtaining feedback which has been outlined would provide a sounder foundation for policy decisions than has been hitherto available. During the last half century the NHS has not been able to speak for itself and has been a passive patient, the victim of a surgeon, in the person of the Secretary of State, who has operated at the behest of management consultants who have known little about Health. It is hard to find evidence that this surgery improved the patient's condition and in the last year or two the Service has undergone a series of operations of unprecedented complexity. It is still too early to say whether or not they will be successful, but this time they have been accompanied by a massive blood transfusion in the form of billions of pounds of extra money which has kept the

patient from collapse. The Service is, however, still in a state of shock and what is needed now is convalescence, rehabilitation and medical rather than surgical treatment.

It is proposed that the Modernisation Board will oversee the programme of change which is already in place and it appears there will also be Modernisation Boards at the Area and possibly at Trust levels. They will presumably be formed from existing officers serving in a part-time capacity. They will face tasks of great difficulty and would benefit enormously from the services of a highly skilled change-agent who would have a wide range of functions. He or she could help the Board to implement the new programmes, form links with the inspectors and commissions responsible for them, and work with the Leadership Centre to install a training and personnel infrastructure needed to make full use of the facilities offered by the NHS University. Such work would provide evidence about the kind of training needed to effect change.

In training, as in medicine, diagnosis is the foundation of success and before any training scheme, at whatever level, is undertaken, there should be a close consultation with all the people concerned. When a physician has made a clinical diagnosis, it is usually not difficult to decide what drugs or treatment to prescribe. Similarly, for trainers, a good diagnosis should enable him to choose from a repertoire of training techniques the one which is likely to produce the best results.

A good trainer is, therefore, a kind of 'organisational clinician', 'enabler', 'healer', 'trouble shooter' or 'diagnostician'. When I was a practitioner, I always saw myself in that light — though I never dared to say so publicly! But the time for such reticence is past and I would strongly urge that a cadre of 'organisational clinicians' or 'healers' should be recruited as a matter of urgency — at least one for each of the new Areas. They should be selected from the brightest and best of existing staff and could come from any discipline. Those selected would be familiar with the organisation of Health and Social Services, but would be helped by some training of the kind mentioned above. They should be accorded consultant status and be supported by able training officers skilled in the implementation of training techniques. Unions and professional organisations should be consulted at all stages in the development of such a scheme and about the changes that would result from it. It should be explained that in this context the term 'clinician' has nothing to do with clinical medicine, but refers to the generic meaning of the word which means 'to observe closely'.

Alternative terms might be 'facilitators' or 'enablers' which reflect the dynamic element in the role.

These 'organisational clinicians' or 'facilitators' could also look after the organisational health of the authorities which they served. It is always easier for communications to follow hierarchies down vertical channels than to ensure that they also flow horizontally between disciplines and, where bottlenecks occur, participative management exercises or seminars may be a good way of removing them. The role could also include that of a trouble shooter who could help to avoid crises if possible, or to surmount them if necessary. Liaison with the College, as mentioned above, would be important and other useful jobs would be to participate in patient forums and to invite and discuss suggestions by members of staff.

A job with so many facets would require high ability and the holder would need to have a status which gave appropriate prestige. The selection of suitable candidates would therefore be important and a spell in the proposed post might be an ideal preparation for future Chief Executives.

The cost of the structure proposed above would be small compared with the £280 million set aside for skills training over the next three years and it would not only provide a flexible and continuous method of obtaining feedback, but would also provide a means of joining together the diverse strands of monitoring, inspecting, communicating and development which are involved in modernisation.

Conclusions

This pamphlet claims that the defects of the NHS which have been proclaimed in so many headlines are not due to the failure of the staff of the Service, who have shown remarkable dedication, or to the principle of a state funded Service that relies on cooperation rather than profit. The culprits are, in fact, the politicians and the civil servants. The Appendix to this pamphlet suggests that throughout the history of the NHS 'too much depended upon Ministers, who pushed their way, elephant-like, through a jungle of competing claims. Sometimes they were uncertain about how to proceed and brought in management consultants. Thus the blind tended to lead the blind, because, although consultants knew less about Health than the people who worked in the Service, their advice, if accepted, became policy.' Instances are given about past errors and it would be tragic if history were to repeat itself.

Powerful voices are now again urging that the politicians should bow out. They come from the King's Fund, from Sir Peter Morris, the President of the Royal College of Surgeons, and from much of the press. Sir Peter has said that the Government is 'desperate' to make the NHS a success, but he himself doubts whether the politicians should run the Service at all. Charles Webster concludes his 'Political History', written in 1998, with the words 'given a policy track record that has shaken a great public service to the point of breakdown, it would be nice if some better way forward was found which would command the kind of support that Bevan was able to obtain ... It would be a pity if the great reservoir of expertise and enlightened opinion available in the UK could not enable people to live free from pain, in a state of optimum health and to die with dignity'. These opinions form an impressive indictment, but it is unlikely that the politicians are ready to throw in the towel. But these warnings might remind them that pride is a deadly sin and that humility is the beginning of wisdom.

The charge against the civil servants is one of omission. Administrators are managed by mysterious Establishment Branches which give them no training, but move them about, like pieces on a chess board, to widen their experience. The so-called Civil Service College at Sunningdale represents a significant misnomer. It is not a College but a centre for courses and this is perhaps the reason why that was all that was given to the NHS. The difference between a College and a Centre can be understood if one looks at the Armed Forces. Before the 1914-18 War, the Forces had a very stereotyped form of training and consequently stolid and unimaginative generals led their vast armies into an appalling bloodbath on the Western Front. After that War a completely different system was evolved. After basic training, young officers attended Colleges at Sandhurst, Cranwell and Greenwich before moving on to service units. Then after some years, carefully selected officers were sent to the Joint Services College and a small élite attended the Imperial Defence College. At these colleges they had intensive operational and theoretical training and, as a result, between 1939-45 victory was achieved over the Fascist powers with a third of the casualties which were suffered in the previous War. Half of those who served during the Second War never saw the enemy but were engaged in research, development, supplies and training. It was a war that was won by brains as much as by valour in the field.

Some civil servants in the Department of Health and Social Security

performed brilliantly, but in the main, the motto of the Department was 'safety first'. It neither gave real leadership to the NHS, nor allowed it to have the means to develop leadership itself. This, of course, is why Blair has been trying to impose change on the Department of Health and the danger is that the Service is being force-fed with too rich a diet of ideas which its thousands of units are finding hard to digest.

Brought up in the Establishment tradition, civil servants have had no conception of the dynamic role which good training and personnel management can play in an organisation. Apart, therefore, from a scheme for young administrators which was evolved by the NHS Staff Committee, the neglect of training which has been portrayed in this pamphlet can only be described as astonishing. Personnel management has also been followed up half heartedly and the current recruitment crisis is the result.

Ambitious plans have been produced for expanding skills training on a vast scale but there are now very few people with training experience in the public service who can ensure that learning is effectively integrated with operational needs. Some universities and independent colleges may be able to help and the Revans Centre at Salford University can provide insights into Action Learning. The successful integration of learning, training and personnel management with operational activities requires abilities of a high order and hence I hope that genuine consideration will be given to my plea for an elite band of 'organisational clinicians'.

Hospitals will clearly remain a massive element in the NHS of the future, but the field of Primary Care offers a real hope of creating a healthier Britain. The Primary Care and Partnership Trusts now have a tremendous opportunity to integrate their work with that of the health functions of the County and District Councils, but it is also vital that they should reach out to the other functions of government that affect health. Stress, for example, has become an ominous cause of disease and Primary Care should consult with the departments concerned with work about whether changes could be made in working patterns which would reduce strain on workers. Has the successful introduction of the 35 hour week in France had any effect on sickness rates, for example?

Obesity is also a growing menace which has reached epidemic proportions in the United States. It has been estimated that obesity kills an average of 325,000 Americans each year, nearly as many as the 430,000 killed by smoking. But whereas smoking is declining, obesity

is increasing and in the United Kingdom 20% of adults and 13% of children are obese. But schools are doing little to help. The number of physical education sessions is declining, 79% of adolescents get no physical education at all, and many schools have sold their playing fields. We should also strive to make the streets safer so that children can play in them and walk or cycle to school. And if we seriously want to stem the flow of patients to GP's surgeries we must find means of preventing Britain becoming a nation of spectators and couch potatoes. Local Authorities can help to encourage a more active lifestyle in many ways, such as by developing more leisure centres, making better use of parks and by providing effective cycle routes.

Mutualisation could also be a path to health. It encourages a more active sense of citizenship and time share schemes, which allow volunteers to amass credits which they can use for services for themselves, could rouse millions of people from passivity. The successful use of Parent Governors in schools is a step towards Mutualisation and maybe Patients' Forums will do the same for Primary Care and Partnership Trusts. Like the Measles, Mumps and Rubella (MMR) vaccination controversy, all these subjects arouse strong feelings, but debate is better than silence and it is to be hoped that all political parties will agree that, as far as possible, questions of public health should be kept outside the political arena.

What should be said to the diverse interests which are pressing for a different kind of governance for the NHS? There are still those who are pressing for an insurance based system and others including, it appears, Mr Blair would like to see an increasing private sector involvement in NHS services. Others favour a greater variety of forms of governance, either the use of non-profit making companies or the taking over of hospitals by charities or churches. The argument against insurance and privatisation have already been cited and the person whose intentions seem most ambiguous of all is Alan Milburn. Almost every week he makes a new pronouncement, some of which seem incompatible. He has now said that he will create a new leadership academy to train 100 of the brightest public servants to turn around poor hospitals. This might suggest some resemblance to my Staff College proposal, but it would have a different purpose. It is a 'top down' idea whereas my proposal is to secure feedback and to use this to promote changes. It seems indeed to be another of the many interventions that lend weight to the judgement of Andrew Rawnsley, in *The Observer*, that the Department of Health is 'riddled with tensions between increasing local innovation and imposing

central controls'. Hence, he continues, 'This Government lacks a worked-through view of the proper relationship between the state and the private sector. New Labour still does not have a coherent idea, consistently applied, of what it is for and where it is going'.

Is the NHS an icon to be revered, or an obstacle to a healthy nation? Today, it is less of an icon and more like a middle aged lady, who has worked gallantly for 50 years to look after her charges in spite of poverty and poor leadership. In her maturity she has acquired wisdom and if she is given the means of distilling it and feeding it into policy formulation, she could, with the extra resources now available, find her own salvation without interference by outsiders. One of the greatest faults in the last 50 years is the failure to take seriously the challenge of Primary Care. In the 1970s, the Department deliberately averted its eyes from the problem. Now the creation of Primary Care and Partnership Trusts could transform the pattern of neglect and begin the process of changing the NHS from an 'illness' Service to a real 'health' Service.

Finally, there is a chance that patients will, at last, begin to have a real say about their treatment, to have transparency regarding their medical conditions, and to have freedom to use alternative medicine if it is appropriate. They could now become real stakeholders, both in hospitals and in Primary Care Trusts, and once they have gained experience, it may be possible for all Trusts to move along the road to Mutualisation. The side-lining of patients and the neglect of public health has, in the past 50 years, made the NHS to some extent an obstacle to the creation of a healthier nation, but the way is now open for a basic change.

St. Luke tells us, in the 4th Chapter of his Gospel, that when Jesus was speaking to the people of Nazareth, he said they would surely know the parable 'physician, heal thyself' and when they chased him out of the town, he remarked that 'no prophet is accepted in his own country'. Both these quotations are relevant to the present situation. The self satisfaction of politicians and civil servants have led them to assume that health staff have to be told what to do and have failed to recognise that they could find out how to cure themselves. The second question reminds us that the Department has never expected to find prophets inside the Service. In my view therefore, the paramount need today is to allow the NHS to find a voice of its own and to act on it.

The public is deeply anxious for the Service to succeed and the Wanless Report shows that its basic feature, public funding, gives it a

sounder and more economical support than insurance based systems. But money is like muck and though it is welcome, it needs to be well spread, and in making the changes which will overcome the waiting lists and the disparities in treatment, it is vital to utilise all the wisdom and idealism that is latent in the Service. If the new money that is becoming available is spent on making changes that have been tested by feedback, if Primary Care is developed with vigour and imagination and if patients become more influential in making their claims and more conscious of their responsibilities, the National Health Service could have a triumphant revival.

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Appendix

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Editorial

The National Health Service needs a voice of its own.

The political storm which struck the National Health Service in the early weeks of the new century has had at least two positive results. It has confirmed that, despite the imperfections, the British public is still in love with the NHS, and it has forced the Government to admit that the Service is seriously under-funded. In his Budget, the Chancellor of the Exchequer promised the biggest sustained increase in the history of the Service — a 35% real increase by 2004. Such an undertaking is indeed unprecedented, and the Prime Minister himself will head a task-force to 'modernise' the Service. Doubtless this top-level political intervention will have positive results, but there is also a danger that it will confuse the issues. Will the additional money be spent wisely and effectively? Judging by past form, this is by no means certain because, over the years, the political direction of the Service has been very uneven. Unlike the nationalised industries, the NHS was never given a collective voice in the form of consultative machinery, and depended for success on the devotion and enthusiasm of its staff.

Successive Ministers found that, although there were many lobbies and centres of influence in the Service, there was no single forum in which wisdom and experience could be distilled to form the basis of policy. Too much, therefore, depended upon Ministers, who pushed their way, elephant-like, through the jungle of competing claims. Sometimes they were uncertain about how to proceed and brought in management consultants. Thus the blind tended to lead the blind, because, although the consultants knew less about health than the people who worked in the Service, their advice, if accepted, became policy. In 1974, on the advice of MacKinsey's, consensus management was established, and this prolonged the endemic uncertainty about where the real seat of power lay in the NHS. Doctors had great prestige but little operational responsibility, and no one knew whether an administrator was primarily a facilitator, a monitor, a co-ordinator or an executive. Consensus management had some merits, but was not good for making clear decisions. Moreover, the first Griffiths Report of 1985 remarked that the NHS lacked the training for management that was normal in business. Consensus management therefore could not stand up to the cold winds of Thatcherism, and on the advice of other consultants from across the Atlantic, the concept of the market was imposed. The resulting changes involved a drastic shift to an authoritarian mode, and after 1991 power was firmly vested in a new NHS Executive. Controls burgeoned and, whereas in 1986 there were 1,000 general or senior managers, in 1991 there were 16,000, and in 1993, 26,000. Administrative costs also rose from 5% of health service costs in 1980 to 12% in 1997. 'New Labour' hopes to reshape the machinery in order to reduce transactional costs and to improve co-operation, but it may not wholly succeed.

Could these violent swings in policy have been avoided? From 1969 to 1977 I held the post of Chief Training Officer of the NHS, and before that time there had been no co-ordination of training arrangements by the Department of Health and Social Security (DHSS). One of my early moves was to propose a Staff College, so that the problems of human and financial resources could be considered objectively at the highest level. I proposed that the College could have two wings — an upper tier in which senior doctors, administrators, nurses and officials could discuss in seminars and workshops, confidentially and free from political constraints, the urgent problems of the Service; and a second wing that would offer, for the brightest of the younger generation (who might be selected by examination),

NHS Trusts will need to develop and involve their staff. In the past this has not been a high priority, and in the new NHS it is'. We have heard this before: as far back as 1974 the Secretary of State admitted that training in the NHS had been under-resourced and uncoordinated, and since that time it has never been a central concern of the Service. Could a Staff College, aided by a Health Commission, become the forum which the Service needs? In the future, medicine, nursing, management and social services will have almost equal parts to play in ensuring that medical care is sensitive and efficient. Groups of students from the top echelons of these four disciplines could be formed into working parties to study subjects suggested by Ministers, the NHS Executive and professional organisations, and they could be given a deadline of a month or so before making recommendations. These could be passed up to Ministers, out to trade unions and down to the Service where working groups could discuss them before policy was formulated. The NHS Executive might find such a process cumbrous, but 'more haste, less speed' is a maxim that executives neglect at their peril. The Armed Forces have long appreciated the value of staff colleges, and though a Health College would be very different it would have a similar value in harmonising professional expertise and in promoting rapid and effective learning. Could it provide an answer to the hope expressed in *Modern and Dependable* that front-line staff should be more closely involved in shaping new patterns of health care?

Duncan Smith

References

1 C. Webster. *The National Health Service. A Political History.* Oxford University Press, 1998
2 Secretary of State for Health. *The New NHS — Modern and Dependable.* London: Stationery Office, 1997
3 Secretary of State for Health. *Saving Lives — Our Healthier Nation.* London: Stationery Office, 1999

intensive one-year courses on health administration. The then Secretary of State, Sir Keith Joseph, favoured the idea for a time, but disputes arose about aims and boundaries, and it was then decided to establish instead a centre for courses at Harrogate. This flourished for twenty years, but in my view the failure to embrace the quite different concept of the Staff College was most regrettable. The College could have drawn together research from several different quarters and, as has been suggested by Charles Webster in his magisterial *Political History of the NHS*,[1] there could also have been a Health Service Commission, which, like the Audit Commission, would conduct a rolling review of the main policy issues. From a College the views of top management could be regularly fed to such a Commission which, with a revolving membership, could also keep in touch with the many interests concerned, including the unions representing the staff. A College, helped by the Commission, could thus have acquired an expertise based on a deep experience of the Service, and would have been able to offer advice much more authoritative than that of management consultants. A new NHS Management Training Scheme has now emerged, but by itself this will merely consolidate authoritarian leadership, and will not ensure the calm, objective discussion involving all the major disciplines which a College could promote.

At present, the Service is particularly in need of a voice of this kind. The Health Department has, in the past, consistently promised more than it could produce, and now proposes a torrent of new ideas. The White Paper *The New NHS — Modern and Dependable*[2] reads almost like a recipe for heaven. Ills of all sorts are to be cured by an array of new initiatives and bodies — a National Institute for Clinical Excellence, a National Schedule of References Costs and a National Service Framework, to bring together the best evidence of clinical cost effectiveness. And all is to be welded into Health Improvement Programmes through a system of clinical governance. In addition, the Public Health White Paper *Saving Lives — Our Healthier Nation*[3] aims at saving 30,000 lives by 2010. The four main killers — cancer, heart disease, accidents and suicides — are targeted with a percentage reduction specified for each one.

These proposals for sustained quality improvement are no doubt admirable, but it is not clear how they can be co-ordinated, and no effective means are proposed to enable the staff of the Service to discuss and feel they 'own' the proposed reforms. *Modern and Dependable* indeed states that 'to succeed in the NHS of the future,

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