REORGANISATION AND INDUSTRIAL RELATIONS IN THE NATIONAL HEALTH SERVICE IN SCOTLAND[1]

JOHN W. LEOPOLD and P.B. BEAUMONT
UNIVERSITY OF GLASGOW

Introduction.

The long drawn-out dispute in 1982 saw industrial relations in the National Health Service at an all-time low. That dispute was the first to involve in a united way all of the many sub groups of staff employed in the NHS – administrative and clerical, nursing, ancillary, para-medical, technical, works and doctors. The decade of the 1970s had seen a steady build up to this situation; a dramatic growth in trade union and professional association membership and organisation; various groups of health service staff taking industrial action for the first time; and difficulties associated with a relatively strict enforcement of incomes policy. Industrial relations in the NHS were also characterised by an extremely centralised bargaining system through one general and eight functional Whitley Councils; a relatively under-developed personnel and industrial relations management function; inter-union competition and rivalry between trade unions and professional associations.[2]

In the aftermath of the 1982 dispute, industrial relations in the NHS have somewhat faded from the public eye. But developments are taking place in four particular areas – reorganisation of the NHS in Scotland, privatisation, expenditure cuts and the possibility of the recommendations of the Griffiths Report being introduced into Scotland[3] Each of these issues will be examined in this paper, but central consideration will be given to the process of reorganisation as through this some of the dominant problems and concerns about the way the NHS is managed can be examined. These include the relationships between the government, via

the Scottish Home and Health Department, and the fifteen Scottis
boards; the relationships between the health boards as employers a
employees; the complex inter-relationships between trade uni
professional organisations; and the role of the personnel functio
management of the health service.

Reorganisation of the NHS in Scotland

The details of the policy which led to the reorganisation of the
Scotland are dealt with in David Hunter's chapter and need no
elaboration. Rather we will concentrate on the substantive issues
to be settled between management and staff interests once the decis
taken to remove districts. These included the timing of reorganisat
oversight of grading levels of senior posts in the new structures; the
the new structures; the arrangements for slotting in and competitio
new posts; the arrangements for officers displaced by the restru
appeals procedure and details of a premature retirement policy.
these points were for negotiation, others consultation; some on
Scotland basis involving all the relevant trade unions and prof
organisations, others at a health board level, sometimes
organisations, sometimes only with those representing a pa
category of staff. It is a complex picture which we will attempt to
under the headings outlined above, relating the events to the
features of the industrial relations system in the NHS.

The Impetus Towards Reorganisation

Following the publication of *Patients First,*[4] which outli
Conservative government's philosophy for the management of the
service in England and Wales, the Scottish Home and Health Dep
issued its consultative paper *Structure and Management of the N
Health Service in Scotland.*[5] The health service in England had th
of organisation – regional, area and district and *Patients First* pr
among other things, the removal of the area tier. Scotland, on th
hand was essentially a two tier system, area and district, but fiv
fifteen health boards operated without districts. The remaining te
boards had between two and five districts, giving a total of twe
districts in the country as a whole. The decision to create districts
administrative act of the health boards at the time of th
reorganisation; in Scotland only the health boards are statutory bo

The government's aims for reorganisation in Scotland at this st
be summarised:

1. Boards should work towards removing districts and replace them by units of management, but those boards which felt that this was not possible could make a case for their retention.

2. Management arrangements at local level should be strengthened with greater delegation of authority and responsibility to units of management.

3. Local functional managers of non-clinical support services were to become accountable to unit administrators not to area functional managers.

These basic aims were later confirmed in March 1981 when the SHHD issued its circular on reorganisation.(6) Health boards were still permitted to be flexible in their implementation of the circular. The size and shape of the new units of management were left to local circumstances and no date was prescribed centrally for the reorganisation.

The laissez-faire approach in fact meant that a number of boards, Argyll and Clyde, Grampian, Greater Glasgow, Highland, Lanarkshire, Lothian and Tayside decided to devolve greater responsibility to unit management within a framework of districts. Three boards, later known as the 'first wave' boards, Ayrshire and Arran, Fife, Forth Valley, decided at an early stage that they would remove districts, while Borders, and Dumfries and Galloway health boards, although not having districts, also proceeded to revise their management structure in line with the philosophy of maximum devolution to units. Between March 1981 and the autumn of 1983 two boards, Argyll and Clyde and Grampian shifted into the removing districts camp, but then Argyll and Clyde changed its decision yet again and this, as we shall see, precipitated a directive approach by the Secretary of State.

Although the first wave boards examined their structures and produced proposals for new units, some based on geography, some on functional specialities, some on a mixture of these two basic principles, a period of uncertainty, confusion and frustration ensued in the attempts to designate a date for reorganisation and in establishing the staffing arrangements for the new posts. The Secretary of State's hoped for implementation date of April 1982 proved impossible to achieve. Meanwhile, in England the new District Health Authorities took over on 1st April 1982, and the Welsh reorganisation was effected a year later.

The staffing arrangements for England and Wales were jointly determined by management and staff interests in the General Whitley Council, with details for specific staff groups being negotiated in the appropriate functional Whitley Council. A new mechanism was established to deal with arrangements for reorganisation in Scotland, the General Whitley Council, Reorganisation Sub-Committee (Scotland). Representation on the staff side of this body was via the functional Whitley Councils which eliminated any potential difficulties of TUC affiliated unions refusing to sit on the same body as non-TUC professional organisations. This committee met three times, in July October and December, 1983.

There was, however, a basic difference of opinion between management and staff over the timing of reorganisation; management favoured an early date because two years had passed since circular 1981 (GEN) 14 was issued, while the staff side favoured a later date so that all boards could move simultaneously. Initially a compromise date of 1st April 1984 was agreed; posts affected by reorganisation which became vacant were frozen and the first wave boards proceeded with local consultation and negotiation.

It is worth noting at this stage that not all organisations involved in the health service actually favoured the proposed reorganisation in Scotland. Trade unions and professional associations felt that it was an unnecessary imposition on Scotland from London and, moveover, that it was stimulated by political prejudice rather than any logical approach to the efficient management of the service; the prejudice that the service was over-administered and that therefore the number of administrators should be reduced. As we have seen a number of health boards had decided not to remove districts and when Argyll and Clyde health board again changed its decision and decided not to remove districts, the laissez-faire approach of the Scottish Office turned to compulsion and direction.

The Secretary of State's announcement that boards would be instructed to remove districts came in the form of a written answer to a parliamentary question on 10th November 1983.(7) The details soon followed in a circular.(8) But this was direction from the centre without the direct hand of the Secretary of State. Both the parliamentary answer and the circular clearly stated that the decision followed a meeting between the Minister for Health and Social Work and the health board chairmen and had "the concurrence of the chairmen". This is further evidence of the growing power and influence of the chairmen, some of whom in this instance were party to a decision which was not the policy of their health

board. The parliamentary answer also reflected the latest development in health service management thinking in England – the Griffiths Report.[9] The Secretary of State took the view that a common form of organisation would provide a firm basis for consideration of Griffiths – a point to which we shall return.

The compulsory removal of districts threw the timetable into disorder. Those boards which were well on the way to meeting the 1st April 1984 deadline did not want to be held up. As they had all decided in principle to abolish districts some two years earlier many senior management posts had been left unfilled or were held by people 'acting up' one or more grades. On the other hand those boards which now had to devise new structures needed as much time as possible. The staff side of the Reorganisation Sub-Committee (Scotland) favoured a late common date, although there was some division as to what date was actually feasible and indeed a minority of the trade union representatives wanted to meet the Secretary of State and argue the case against compulsory removal of districts in all boards. The final compromise was that the first wave boards would proceed on 1st April, 1984 the others would reorganise by 1st June 1984, but that no board could make appointments to reorganised posts from outwith their own board until such time as all boards were ready to proceed to the round of appointments for officers 'displaced' as a result of reorganisation. Thus the first wave boards had to wait at least two months with vacant posts before being able to appoint displaced officers from outwith the boards, and in practice the delay was much longer. In effect it could be argued that through this device the staff side achieved their objective of a common date at the point where it mattered – when competition for posts moved to an all-Scotland basis.

The Overview of Gradings

The delay in fixing an implementation date for Scotland did have an advantage in that the experience of reorganisation in England and in Wales was available to management and staff sides alike. Indeed the principal agreement, that on staffing arrangements which determined the procedures for filling posts, was reached in the General Whitley Council prior to the first meeting of the Reorganisation Sub-Committee (Scotland). One vital issue which both the English and Welsh Authorities had had to deal with was the question of ensuring that there was consistency of grading of senior posts in the new structure. In England this task had been undertaken by the Regional Health Authorities, whereas in Wales the task was undertaken by chairmen of the Welsh Health Authorities on an informal basis. What device would be used in Scotland?

The need for some overview of gradings arose because the decision on what exactly should replace districts was left to health boards to determine. This was consistent with the devolutionary philosophy of the restructuring exercise, but in marked contrast to the 1974 reorganisation when the Scottish Home and Health Department authorised all the senior grades. But the devolved approach had the danger that grading drift could emerge and similar posts in different health boards could be graded differently. Grading drift is seen by the Department as against the interests of the taxpayer to the extent that people are paid more than the appropriate rate for doing a similar job.

The initial proposal by management was to use MAGOG, the Management Group on Gradings. Created in 1981 as MGAFGS, the Management Group on Administrative and Finance Gradings, its remit was extended to senior nursing grades in April 1983. MAGOG was a way of devolving collectively to health authorities grading control based on a system of job evaluation so as to achieve consistency. It was intended to operate both in normal circumstances and in the context of restructuring. Its creation and the extension of its remit were both agreed by health board chairmen who also agreed that boards would comply with the Group.

There were some fears from within the service that MAGOG would not be able to cope with the demands that restructuring would have placed on it, and that involvement in restructuring could undermine MAGOG's role as a grading review mechanism. Even more fundamental objections came from the staff side. Firstly, the trade unions opposed MAGOG anyway because it is a unilateral management job evaluation technique with no trade union input, and secondly because in the context of reorganisation the use of MAGOG to evaluate grades would cut across the agreements on grading reached jointly through the Whitley system.

A new ad hoc body then emerged – the Scottish Chairmen's Grading Committee, subsequently known as the Fyfe Committee after its own chairman, Mr. W.S. Fyfe, the chairman of Ayrshire and Arran health board. In the first instance the Fyfe Committee comprised the chairmen of the five first wave boards; two members from the mainland single district boards; three assessors, a board secretary, a treasurer and a chief area nursing officer and was serviced by a secretariat of two drawn from serving health board officers. Later chairmen from the other boards were added. Like MAGOG, but unlike many similar exercises in private industry, there was no staff side input.

The Fyfe Committee was granted full delegation of power to ensure consistency of grading by the Secretary of State. Thus he could claim that any grading decisions arrived at by the Committee were not those of the Secretary of State, nor of the SHHD, but of the boards themselves acting collectively through their chairmen. The service as a whole had been given the responsibility of policing the decisions of individual health boards.

The role and powers of the Fyfe Committee were the subject of debate in the Reorganisation Sub-Committee (Scotland) and the staff side were assured that its task would be equivalent to that done by the Regions in England and that it would not impose decisions. On the other hand the Department circular on the Committee makes it clear that unless boards can supply further information to justify their grading then the decision of the Fyfe Committee stands.

Clearly with these two contradictory views problems would arise if, and when, the Fyfe Committee overturned any grading submitted to it by boards. This indeed happened. The situation is further complicated by the fact the boards discussed their structures and gradings with their staff locally. The trade unions take the view that these discussions took the form of negotiations and that the grading structure finally reached was in effect negotiated agreements, especially as they were agreed within the context of the reorganised structure costing no more than its predecessor, and in the light of functional Whitley Council agreements on grade indication factors. The Department took the view that local talks were only consultative and that the boards acting in concert through the Fyfe Committee took the final decision and that is the one which has to be upheld. Each board was represented on the Committee through its chairman and could therefore not justifiably object to the decisions reached.

Many boards, however, did find themselves in an awkward situation when the Fyfe Committee altered gradings. Their staff sides were arguing that Fyfe was only advisory and therefore boards ought to honour their agreements with the staff side. In some cases boards did re-submit, but usually without success, and the ad hoc mechanism had no appeal channel built into it, although the original MAGOG proposals did allow for disputed gradings to be the subject of discussions betwen the board and MAGOG and for final resolution by the SHHD. With Fyfe, however, reasons for changing gradings were not given to boards. Individual officers, on the other hand, have a right of appeal on the grading attached to their post under existing Whitley agreements, and staff sides are threatening a number of individual appeals once the new structures are in operation. Such appeals are likely to be strongly resisted by the Department on the

grounds that it was the health boards themselves who agreed to accept the Fyfe Committee's verdict on the grade, rather than their own original view. Indeed the Department felt it necessary to caution health boards against premature appeals and urged them to allow a reasonable time to elapse for new posts to become fully established and post holders to settle in.[10]

Lack of Coterminous Structures

It is not yet clear how many posts actually had their grading proposals altered (and some were upgraded), but it does appear that a disproportionate number were nursing posts rather than administrative or finance ones. This relates to another feature of the structures a number of health boards have determined – administrative, finance and nursing units of management are not coterminous.

Boards were given a free hand to determine their own structures by the SHHD, and did so in consulation with their staff interests. Some boards, such as Ayrshire and Arran evolved a structure that was largely based on functional specialities; others, such as Forth Valley based the structure largely on geography. The norm, however, has been to draw up structures based on a mixture of functional speciality and geography.

With the removal of districts the previous management body, the District Executive Group (District Administrator, District Finance Officer, District Nursing Officer, District Medical Officer) ceased to exist. In its place came the Unit Management Team which comprises the Unit Administrator, Director of Nursing Services and a senior member of the medical staff and usually, but not always, the Finance Officer. The fact that what is understood by a 'unit' varies according to the staff group concerned may indeed pose some difficulties when the new structures are functioning. It is not clear in situations where two nursing units relate to one administration unit, whether the two Directors of Nursing Services will be part of a unit team with the administrator covering both nursing units, or whether the administrator will be part of two unit teams, or indeed whether the DNS of the smaller unit will only relate to a unit team via another DNS.

To fit in to the philosophy of devolved power and responsibilities, the administrative units had to be of such a size to attract salaries which would in turn attract competent senior managers, but at the same time be close to the delivery of patient services. Finance units are related to budgets and there tend to be fewer finance units than administrative units in all the structures that have been evolved. The problematic area, however, was nursing. Where administrative units were determined by functional

speciality – acute services, geriatric services, psychiatric services – then it was relatively easy to have nursing units to match them. The difficulty lay with what to do with two particular services – maternity and community. The first is characterised by relatively small numbers of beds and staff; the second by geographical spread. In some administrative units one or both of these services were subsumed within larger units; in other boards they constituted a separate unit.

On the nursing side, however, the nurses who worked in these services are generally represented by separate organisations from nurses in other areas – the Royal College of Midwives for maternity, and the Scottish Health Visitors Association for community. These organisations see themselves as professional associations rather than as trade unions, and in their view it was vital for the future well being of their profession that separate maternity and community units existed for nurses, so that midwives and health visitors could aspire to become Directors of Nursing Services for their respective specialties. The pressure to have these separate units was particularly strong in Greater Glasgow where the agreed structure comprised eleven administrative units, nine finance and nineteen nursing. The RCM was outraged at Lanarkshire Health Board's proposal not to have a separate midwifery unit.

The corollary of being separate was that the small maternity and community units tended to attract lower gradings when assessed by the Fyfe Committee, and indeed in some cases the removal of maternity from a larger general nursing unit threatened the grading of that post as well. Thus it is the nurse organisations which are most affected by and concerned about the grading reversals of the Fyfe Committee.

While the particular interests of the RCM and the SHVA pressed them towards separate units, the main professional organisation for nurses, the Royal College of Nursing, strongly favoured coterminous units, particularly with the spectre of the Griffiths Report in the background. This proposed general managers in the units and if these were to be drawn from the existing second in line officers in units, then nursing would be at a distinct disadvantage if nursing units did not match administrative or medical ones.

While Greater Glasgow presents the most extreme picture, the situation in the rest of Scotland varies markedly. In some boards all the maternity and community services were grouped together to form reasonably large units which attracted relatively high gradings for both nurses and administrators, but where separate small maternity and

community nursing units exist the gradings are generally low. While this may create a limited career structure for midwives and health visitors in their own speciality, it does mean that senior nurse managers will continue to be drawn from the general and psychiatric areas.

Consultation/Negotiation at Health Board Level

The question of timing, the overview of gradings and staffing arrangements were dealt with at national level, but a number of issues arising out of reorganisation were dealt with at health board level. The mechanisms developed for dealing with local consultation and negotiation were essentially the same throughout the country. Initially meetings were held between management and all the staff interests in the board but with the NALGO branch secretary always acting as the local staff side secretary, as was the case nationally. These were based on ad hoc reorganisation committees rather than on existing joint consultative committees and thus got round the problem, which exists in many boards, of TUC and non-TUC organisations refusing to sit together in the same committees. Once consultation had taken place on structures, the large all-embracing committees broke down into smaller groups dealing with particular categories of staff.

The essential issue to be decided was which new posts were for slotting in and which for competition and the agreement on staffing arrangements clearly stated that this was a mattter for negotiation at board level.[11] Slotting in was where the job was virtually unchanged and the post holder continued to undertake substantially the same duties; competition was for posts where a number of detailed definitions were met. These agreements are designed to give existing board employees the first opportunity to be appointed to the new posts and to minimise the number of officers displaced by the reorganisation. An additional agreement gave personal protection of salary and conditions of service for a specified number of years for officers whose posts were downgraded as a result of reorganisation.

Local negotiations had to take place within the confines of agreements on equivalent grade and substantial promotion which were reached in the relevant functional Whitley Councils. There was some delay in reaching this agreement for administrative and clerical staff as the staff side insisted that Board Secretary and Treasurer posts should be subject to competition as these posts had all been upgraded by one main scale to reflect new responsibilities. Management resisted this for some time, and in the absence of a firm agreement the first wave boards proceeded locally on the

basis of the management offer, which reflected the agreement which had been used in England some two years previously.

One specific area where representation from staff interests led to changes in board plans for restructuring concerned the establishment (or not) of area posts for professions supplementary to medicine e.g. physiotherapists, speech therapists, radiographers. In some boards such posts were established for one or more of these professions, usually on a part time, part managerial, part clinical basis. One exception to this was the attempt to establish area radiographer posts. This was opposed by the BMA which argued that the responsibility for radiography lay with clinicians and a dangerous conflict could arise if radiographer managers were appointed. This is but one reflection of a continuing conflict between doctors and a range of medical related professions which have responsibilities and duties in similar areas.

Generally these local negotiations seem to have operated smoothly through the special reorganisation committees that were established which were made up of all organisations, both trade unions and professional associations. What potential might there be for such arrangements to continue?

The TUC unions' basic objection to the presence of non- affiliated organisations is that they undermine the possibility of developing common staff side positions because their views on matters such as privatisation, financial cutbacks and overseas patients are so diametrically opposed to those of the TUC unions. Indeed some trade union officers would go as far as to argue that it is only the trade unions which are interested in the overall service that the health service provides, whereas the professional associations are largely and primarily interested in their profession. Thus the trade union view is that the arrangements for reorganisation were a one-off arrangement which came to an end once reorganisation was in place. Indeed negotiations on procedural agreements for the new structures are taking place in the existing joint consultative committees rather than the reorganisation committees. Without the common purpose of reorganisation it is unlikely that TUC and non-TUC organisations will work together. This will be particularly so as issues such as Griffiths, privatisation and financial cutbacks come to the fore in the autumn; issues on which the TUC and non-TUC organisations are divided.

Personnel Management and Industrial Relations in the New Structures

District Executive Groups operated on a consensus basis, with

collective responsibility for running services, budgets, and personnel matters. In effect any one chief officer had a power of veto over the others. Consensus management has been under fire for some time; accused of 'lowest common denominator decisions' and of long delays in the management process.[12] The thrust of reorganisation is towards individual accountability and responsibility, although some element of collaborative team working is expected from unit teams. Second in line officers will have control of budgets and resources and will also have responsibility for industrial relations at unit level including the power to dismiss.

With the removal of districts the twenty District Personnel Officers were also removed. The essential dilemma facing boards in reorganising the personnel function was whether to centralise at area level or to decentralise to the units. If unit personnel posts were established it was unlikely that they would attract senior gradings and hence would not attract senior experienced people to the posts. On the other hand if all the personnel resources were centralised at area headquarters then all sorts of problems and difficulties could arise and possibly grow at local level if assistance and advice was not readily on hand.

Most boards have evolved a compromise whereby there will be a personnel presence at unit level, but these officers will essentially be dealing with the personnel administration aspects of the function – appointments, recruitment, contracts of employment, terms and conditions of service, and while providing some limited industrial relations advice, the burden of this work will be undertaken by unit administrators and area personnel departments. The latter have been strengthened by drawing in the former DPOs and allocating responsibility for developing policies to specific officers. In some cases the area personnel department has been further strengthened by the appointment of additional officers with special responsibility for industrial relations policy. Thus the intention is to have the area personnel department developing policy and guidelines and, indeed, training for the new unit managers who now have industrial relations as a major element of their responsibility. This centralised policy and advice service is supported by unit personnel officers dealing with the more routine aspects of the personnel function.

It remains to be seen whether this structure can overcome a problem which existed previously in multi-district boards of policies being interpreted in different ways in different districts, and of trade unions seeking to level up practice in all districts to the level of the best. If anything, with the multiplicity of units which now exist in *all* boards the potential for variation increases and thus places additional responsibility on

both unit managers and central personnel policy makers and advisors.

One controversial point in this reorganisation of the personnel function has been the question of the need for separate nursing personnel officers. Under the district structure, Senior Nursing Officers (personnel) existed in a number of districts, but there was evidence that their duties largely fell into the personnel administration category and when industrial relations issues were to the fore the District Personnel Officer became heavily involved. There has therefore been considerable pressure to establish a unified personnel service at unit level. In some boards this has been achieved; in others it is still a matter of controversy.

The devolution of the power to dismiss to single officers, rather than the consensus management group has concerned trade unions. They felt that the consensus system meant that any one chief officer wanting to dismiss an employee had first to justify their position to three other senior managers, and that this often tempered what might have been ill-advised decisions. In Glasgow in particular the trade unions attempted to press that the authority to dismiss should be vested in more than one officer. Their concern was that errors in judgement would be made by senior managers which from the trade union point of view would have to be challenged through the appeals mechanism. If individual senior managers were frequently the subject of appeals this would result in a situation where the board would either have to dismiss the appeal or dismiss the senior manager. While private companies might be inclined to the latter, it was feared that health boards may opt for the former.

Displaced Officers and Premature Retirement

A central concern of the staff sides was that the reorganisation should not lead to compulsory redundancies. Boards had to achieve their reorganisation in such a way that the new structures cost no more than the old, and their targets for reducing management costs, set in 1982, were adhered to.[13] The General Whitley Council agreement on staffing arrangements protected those officers displaced from their employing boards by ensuring that they had first opportunity for posts in other boards at the first stage of all-Scotland competition. When the second wave of boards commenced reorganisation at the end of 1983 it was agreed that this stage could not commence until all boards had completed their internal process. Thus the first wave boards would have to wait until at least 1st June, or longer if any board had not completed its internal processes.

In the event the number of displaced officers was relatively few; about

a score on the administration and finance side, somewhat less for nurses, but they did cover the entire range of the grading structure. The small number was largely because posts likely to be affected by reorganisation were left unfilled or filled by officers in an acting-up capacity even before the formal agreement specified that this must be the case after 1st August 1983. In fact a number of first wave boards were unable to fill all their unit posts and began the reorganised system on 1st April with key posts vacant, despite attempts by at least one board to obtain a special dispensation from the agreed staffing arrangements timetable. Overall, at the end of the internal stage of the process there were more unfilled posts than displaced officers, although the grades and specialisms of these did not necessarily match. Some boards chose to retain officers in a supernumerary capacity until such time as a suitable vacancy arose.

In order to try and coordinate the lists of displaced officers and vacant posts a clearing house was established which came into operation in July and even at that stage some boards were still holding up the process as they had not made appointments to their new unit posts. The net effect of these delays and uncertainties was that open competition for vacant posts did not take place until October and in some boards key posts in the new structures were unfilled for over six months.

A notorious feature of the reorganisation in England had been the massive number of premature retirements over and above that estimated by the DHSS; 435 compared to 2,830.[14] In January 1984 the SHHD estimated that some 200 posts at District level would be directly affected by reorganisation but that it was not possible to estimate accurately the number likely to come forward for early retirement.[15] Anxious that the public criticism of the situation in England was not repeated the Department embarked on an informal estimate of likely premature retirements with the Area Personnel Officers' group. In Scotland individual applications had to be vetted by the health boards and submitted to the Department for approval. In this way a stricter control was kept in the number of premature retirements.

An SHHD circular in 1983 stressed that there was a need to demonstrate where the reduncancy was occurring to justify a retirement claim and that the call upon the superannuation fund had to be totally justified. This letter was later the subject of a staff side complaint in the Reorganisation Sub-Committee as in their view this was the SHHD exceeding the terms of a Whitley Council agreement. Notwithstanding this, the Department continued to interpret the agreement in a very rigid way in Scotland, to the extent that a number of officers seeking premature

retirement, but whose cases were not immediately accepted by the SHHD, had to apply for posts they did not really want, and to which boards did not really expect to appoint them, in order to remain eligible for premature retirement.

By the end of the first stage of reorganisation some fifty five applications for premature retirement had been approved. It was expected that the proportion of early retirers/total staff employed would be even lower in Scotland than Northern Region which had the lowest proportion of premature retirements in England. A number of applications were rejected either because the applicant was too young or because subsequently they were offered posts, and two of the rejections were the subject of an appeal by the relevant trade union.

Cat and Mouse

While reorganisation has been the focus of events in the NHS in Scotland, privatisation, cuts and, most recently Griffiths have been the key words in England and Wales. Until June 1984, these issues were rather dormant in Scotland, partly because attention and energy has been directed towards reorganisation, but partly because of different attitudes and policies of health boards in Scotland to them. While health boards used reorganisation to justify their delay in responding to the Secretary of State's September 1983 circular on privatisation, equally the Department was slow to produce a promised discussion paper on Griffiths in Scotland. This cat and mouse response ended abruptly when the document on Griffiths was produced on June 6th(16) and some two weeks later boards were instructed to put some of their services out to tender.(17)

Privatisation

In the summer of 1983 health boards were requested to test the cost effectiveness of catering, domestic and laundry services by putting them out to tender, and to report to the Department by April 1984.(18) Compared with England little progress has been made in contracting-out services in Scotland. Boards were treading cautiously, partly out of a concern not to rush into changes which might be regretted later, partly from a belief that the in-house service is best and partly from a fear of industrial action by unions whose members would be affected.

What happened between the autumn of 1983 and the spring of 1984 was that boards examined those areas of the services under threat in which costs were above average. Such areas have been, with trade union

approval, thoroughly examined by work study teams and in some cases bonus schemes introduced in the belief that this would improve efficiency and make the service less vulnerable to outside tender. In short the threat of privatisation has enabled boards to reach agreement locally with trade unions to improve efficiency, sometimes at the cost of jobs, in areas which management had long felt required change but in which they had not been able to implement it. In return there was an understanding that boards would not proceed with privatisation.

Although aware of these developments, Ministers were not satisfied. Hence the circular instructing health boards (except Island boards) to put services for their headquarters and at least two hospitals out to tender by the end of 1984 and to prepare a three year programme for other services. Significantly this decision followed discussions between the Minister for Health and Social Work and health board chairmen.

Trade unions in the NHS and the Labour Party were immediate and strong in their condemnation of the circular. NUPE discounted the alleged savings to be made from privatisation and saw the decision as a political, ideological act. A campaign of active resistance was called for. The STUC, through its health and social services committee, pledged to fight the decision and to co-ordinate the trade union response. In August the main TUC unions involved obtained legal advice that the circular was not mandatory on boards. This opinion, combined with considerable trade union activity helped Fife Health Board not to put the services out to tender, but instead to seek full co-operation with all parties to make savings and increase efficiency under Board managerial control. Fife were the first board to decide on the issue and their decision has since been challenged by the Minister, but the Fife decision remains a significant one from the unions' point of view in that the chairman of Fife Health Board is also the chairman of the Ancillary Staffs Whitley Council. Since the Fife decision in August some other boards have followed suit, whereas others are pressing ahead in putting the required services out to tender. Privatisation will be the dominant issue in health service industrial relations in the autumn of 1984 and beyond.

Griffiths

The Griffiths Report on management in the NHS recommended, inter alia, the appointment of general managers at each level of management. The government accepted the recommendations and were proceeding to implement them in England.(19) In Scotland, the Secretary of State was in general agreement with the principles underlying the Report's

recommendations, but the SHHD promised a discussion document early in 1984 before proceeding. The date for this was progressively put back and the document only appeared in early June calling for comments by the end of September. While again reorganisation proved a convenient excuse for the delay, it was clear that there was not a unified view among all the professional interests in St. Andrews House.

The Secretary of State favoured the appointment of general managers at board level by the end of 1985, but at unit level there is to be an examination of unit structures, management information and budgeting systems prior to the introduction of general managers. This examination is to be completed by the end of 1986. General managers are to be appointed "on the basis of the criterion of the best person for the job, regardless of discipline" and "might be, but need not be, drawn from existing chief officers."[20]

The professional organisations whose members will be affected by the appointment of general managers are opposed to the plan.[21] A major concern is where the new general managers will be drawn from and how such a general manager would relate to the professional and clinical responsibilities to the chief officers in each management area. It is in those boards without coterminous units that most problems in this area will arise and this is primarily why the Royal College of Nursing was particularly concerned about such structures. What chance have nurses got of becoming general managers if nursing management is divided between two or three units, whereas administrators and doctors command large budgets and staff resources? What authority will non-nursing general managers have over nursing managers?

The trade union responses to the Social Services Committee expressed concern about the removal of consensus management. We have already seen that the change from districts to units has ended consensus management at that level and has led to problems on the question of the authority to dismiss. The appointment of general managers at health board level will pose similar questions there. The relationship of the personnel officer to top management may need reviewed. Should the APO continue to be responsible to the board secretary, or should his or her role as personnel officer to the whole board be emphasised by making the line of accountability direct to the general manager? A whole number of detailed questions about how the general manager will actually operate remain unanswered and while some points may be clarified during the consultation process, many will only be answered when general managers are actually in post.

Financial Cuts

While financial cuts and closures have been the focus of much trade union activity and opposition in England, this has not been the case to the same extent in Scotland. During 1983 there was a one percent cut in resources, but this was later reinstated and Scottish boards were not subject to forced staffing reductions as their English and Welsh counterparts were in September 1983.[22] Where financial savings are being made by boards they are not dramatic. It is largely a case of new things not happening; a ward not opening, a building not being upgraded, a facility not being developed. Therefore there are few concrete issues for the trade unions to focus on and attempt to rally their members and the public around, although protests are made as each new saving exercise is announced.

At an all-Scotland level, the Scottish Trade Union Congress initiated the Scottish Health Service Campaign, calling for a real two percent growth in health service spending to cover the changing age profile of the population and developments in medical technology. This campaign has involved trade unions, local authorities, health councils and health consumer groups. A network of thirty local committees held over fifty public meetings throughout Scotland in the spring of 1984. A petition calling for the two percent real growth raised 250,000 signatures, and was presented to the Prime Minister on 27th June 1984. The steering committee of the Campaign recognises that its task is a long-term one and intend campaigning for the NHS through the lifetime of the present Conservative government and possibly beyond.

Summary and Conclusions

Issues about the management of the National Health Service and its industrial relations remain to be settled. The autumn of 1984 will see the questions of privatisation, cuts and Griffiths to the fore in public debate in Scotland and their resolution during 1985 will merit future study and analysis.

Debate on the reorganisation process has largely been confined to the service itself although some of the decisions on management structure will clearly have implications for service delivery. After all the philosophy of *Patients First* and its Scottish counterpart was to move decision making closer to the point of service delivery. But the precise impact on patient services which the multi-variant unit structures will have remains to be seen, particularly in those boards which had concluded earlier that they

should retain districts.

Our main concern has been the way in which this reorganisation has been brought about and the implications for industrial relations. The reorganisation in Scotland has also had implications with regard to the relationship between health boards and the SHHD. In this the role of health board chairmen has become decisive. The Secretary of State claims that the decision to remove districts in all boards was not taken by him, but by the chairmen. This raises fundamental questions about the powers of chairmen and their accountability to boards, which in turn raises questions about democracy and accountability of health boards themselves. For example, the STUC are concerned that their nominees on health boards have been reduced from 40 to 19 since the Conservatives took office in 1979. Two boards, Forth Valley and Lothian now have no STUC nominees. Similarly the creation and use of the Chairmen's Committee on Gradings is further evidence of the growing power of chairmen. Its operation has left a number of aggrieved organisations and individuals in its wake; and the formal elements of appeals mechanisms may yet come under strain if a large number of gradings are appealed. There is legitimate concern that the Whitley Council machinery and its agreements on grading criteria, and the capacity for staff interests to agree matters such as structures and gradings locally, have been circumvented by the use of the Fyfe Committee.

Otherwise at the health board level consultation and negotiation appear to have operated satisfactorily. In particular the slotting in and competition arrangements for posts in each board have gone smoothly although there have been examples of disappointment, frustration and bitterness when some individuals have not been appointed to particular vacancies. It is unlikely that there will be any compulsory redundancies resulting from reorganisation. While consultation and negotiation took place on an all-staff interest basis, it is unlikely that staff sides comprising both TUC and non-TUC organisations will continue in existence at the end of the reorganisation process. Reorganisation has been seen by most parties involved to be a special case, where the common purpose involved has drawn together the staff side and indeed management. This is not to say that there have been no differences but that these have in most cases been resolved. The experience of the Reorganisation Sub-Committee (Scotland), however, may well prompt the staff side to press for the establishment of a Scottish Whitley Advisory Committee to deal with Scottish issues in the future. However, the fundamentally political issues of privatisation and cuts will again find the TUC and non-TUC organisations opposed. Industrial relations in the National Health Service will therefore continue to be both interesting and controversial.

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1. The research on which this paper is based was financed by a grant from the Scottish Home and Health Department. We acknowledge the assistance of those trade union and professional association officials, health board officers and SHHD civil servants who were interviewed, and Ann Adamson who transcribed tapes. The views expressed, however, are entirely the responsibility of the authors.

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