Industrial Relations in the NHS–

the search for a system

Edited by Nick Bosanquet

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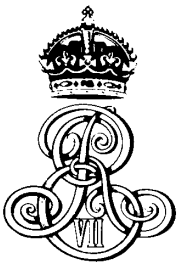

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Preface

The aim of this book is to stimulate discussion and action about the serious difficulties facing the NHS in industrial relations. We do not subscribe to a theory of spontaneous cure. Nor do we think that the main way of improvement lies through changes in mood or behaviour by staff representatives. The unhappy events of the last few years are rooted in objective difficulties: the problems are not likely to be alleviated until the objective issues are faced.

This is not a textbook, nor is it an account of every aspect of industrial relations in the NHS. It is a series of explorations of key issues. The book is mainly factual and, we hope, informative. Any opinions or comments found in the chapters are those of the individual authors and do not in any way represent the views of the King's Fund.

Industrial relations in the NHS have been much generalised about. We attempt to replace generalised impression with detailed evidence and analysis. There is still much to be done both in terms of detailed research and above all in terms of action. We hope that our book will help to reverse a real deterioration which is putting at risk the standing and performance of one of the world's great social experiments.

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1979

Preface

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NICK BOSANQUET

Before 1972, industrial relations in the National Health Service (NHS) were a matter of sentences lost in fine print. The Grey Book[42] does not mention the subject at all. Now it has joined the ranks of accredited national problems. The remedies range from defibrillation by prime ministerial statement to a long course of procedure agreements. The most serious warning comes from the Advisory, Conciliation and Arbitration Service (ACAS), in evidence to the Royal Commission on the National Health Service. 'Unless effective remedies are introduced urgently, we can see little prospect of avoiding continued deterioration in IR with associated frustration of management and staff, increased labour turnover, and noticeably poorer quality patient care.' [3]

This introduction aims first to trace the chronology of change. It also aims to set industrial relations (IR) in the NHS in some more general context and to assist judgment on the badness or otherwise of industrial relations in the NHS. We have certainly seen the breakdown of an 'old colonial system' in IR, and some of the consequences have been felt by patients. But much generalisation seems to judge current events against an ideal model of a health service in which management is wise, staff pay and conditions are first class, and in which the needs of patients are met with alacrity. If none of these conditions applies all the time, some trouble may certainly be expected and may be at times a positive force towards improvement, and towards clearer understanding. Improvements

in organisational systems and procedures are important, but they will never guarantee that all differences can be solved without conflict. Even if the NHS system of IR had been highly advanced, the real stresses set up over the last four years by economic and administrative changes would probably have led to major conflicts. For the future, it is pointless to try to bring back a lost world in which a sense of vocation made conflict unthinkable. Improvements in procedures will not eliminate all conflict: what they can do is ensure that conflicts are resolved more speedily and less messily. Even the improvements in local procedures so widely recommended by ACAS and others may prove disappointing unless they are accompanied by remedies for the problems of pay and of management in the service.

Ironically, for many years of the old colonial system, the Ministry of Health's best efforts were directed towards closing whatever tiny loopholes there might have been for local bargaining. The whole point of the Whitley Council machinery—a great advance in its time—was to establish uniform national pay scales. The highly independent Guillebaud Committee of Inquiry supported the Ministry of Health's policy of closing off local option.[74] Clegg and Chester recorded in 1957 that 'the management side had been anxious to limit the powers of the Appeals Committees, lest they should grant what had been or would be refused in the National Councils'.[16] The General Whitley Council was unable to agree on a disciplinary procedure in 1951 because the management side was unwilling to allow a greater role to the region. The Ministry issued its own 'interim guidance', which held the field until 1975.[52] In practice the Whitley Councils had difficulty in coming to voluntary agreements. Of the 53 major settlements in the NHS from 1948 to 1955, 26 were the result of arbitration. Nor did the system guarantee that all groups kept up with changes in average pay. Up to 1955 only nurses received increases greater than increases in the cost of living. The system hinged on the weakness of the unions. As Clegg and Chester wrote, 'The system might be made to work differently and to produce different results if the staff organis-

ations could discover new means of bringing pressure to bear on the management side. Amongst the main reasons for differences in pay between the Health Service and the engineering or mining industries is that the employers in these industries fear the unions more than the management side fear the health service staff organisations.'[16] There seemed little hope of finding new weapons. The strike weapon was unlikely to appeal to many of the organisations involved and was more likely, if used, to lead, in Clegg's and Chester's phrase, to an 'outburst of public indignation' than to public sympathy. Other forms of direct action were more feasible—in fact an overtime ban began among mental nurses in the Manchester region in 1956—but were unlikely to have much effect. The Whitley Council was dominated by the management side. The staff sides of the 1950s could opt either for arbitration or for acquiescence.

Local industrial relations in the 1950s were extremely quiet. There were few shop stewards apart from those with the craft unions. Jobs in the health service had a well understood combination of disadvantages in low pay and of advantages in fringe benefits and job security. To describe the system as 'paternalist' would be to give it too uniform a quality. The old system varied quite a lot from a mixture of deference and indulgence, traded by some time-served ancillary workers, to the often rather high-handed treatment of student and junior nurses by their superiors.

Break-up of the old system

The system came under pressure nationally long before there were any signs of change locally. A series of government initiatives stirred staff sides from their former passivity. The most important of these were connected with incomes policy. With the dispute between the nurses and Enoch Powell, Minister of Health in 1962, for the first time Whitley Council decisions drew attention outside a small circle of professional negotiators. The protests, however,

did not win the day; and unlike later troubles over incomes policies in the 1970s they did not lead to any permanent increase in trade union membership or activity locally. They, however, set a precedent and established a rhythm for further and worsening confrontations, on roughly a four-year cycle, between the nurses and government. The National Board for Prices and Incomes' (NBPI) report on nurses' pay in 1968[59] also helped to encourage the slow change in atmosphere by the controversies over the 'pay as you eat' scheme, by which nurses were asked to exchange free meals on duty for higher pay.

Another official initiative—the NBPI's report on pay among local government and NHS ancillary workers—had a more sustained local impact.[57] In 1966, during an arctic phase of incomes policy, the government called for a report on low pay among these workers. Instead of recommending large increases in the basic rates, the report concentrated on allegedly low labour productivity. It recommended more rapid introduction of incentive schemes beginning with a crude interim scheme. The spread of bonus schemes was slow—by 1972 only about 11 per cent of ancillary workers in the NHS was covered by bonus schemes as compared to 60 per cent in local government—but where they had started they presented a great opportunity for shop stewards. For the first time in the history of the NHS there were some really important *local* decisions to be made about pay. An administrator at the Doncaster Royal Infirmary saw the effect. 'Joint consultation in the Doncaster Royal Infirmary portering department dates back to 1969. In its present form the JCC [joint consultative committee] was set up to negotiate a work studied bonus scheme for the portering and stores department.' Management prerogative was open to new challenge. 'A small routine job had been missed from the bonus specification . . . This was a job traditionally disliked by porters . . . but before the scheme was introduced it had always been performed when requested . . . during extended negotiations the workers' representatives refused to agree and countered veiled threats with rather less veiled

threats of industrial action.'[35] The NBPI report had important legacies—in some places, local trade union activity and, more widely, a sense of bitterness about low pay.

As late as 1970, the old colonial system was substantially intact. The NBPI's second report on ancillary workers found an apathetic management, and a low paid labour force little interested in staff relations. Ironically the main complaint was of too little union activity locally '. . . while the trade unions play a full part in the central negotiating machinery, their activities at other levels are on the whole very limited'.[58] They had failed to press strongly enough for local incentive schemes. The NBPI found that the workforce was older than the average—more than half were over 50, and valued above all the security of work in the health service.

The 1971 Industrial Relations Act[68] applied to the health service but, as with its associated Code of Practice[38], failed to make very much impact. One positive effect was a letter from the Ancillary Staffs Council recommending the grant of facilities to shop stewards.* An administrator in Bury noted a 'marked growth in the setting up and the training of shop steward representatives', but cautioned that 'to date these officials have been little more than collectors of trade union subscriptions'.[98] The best picture of management in the old system, on the eve of its rather sudden collapse, is to be found in a survey carried out by some administrative trainees in 1973, on a large sample of authorities around London.[99] They showed that in a very 'large number of cases authorities were not matching up to the standards recommended in the Code of Practice', or even to the statutory requirements of the Act. Only about half of the groups visited employed any personnel specialists. All too frequently, 'the will and the incentive' to carry out simple improvements were not present.

* Ancillary Staffs Whitley Council. Advance letter AC2 (71 Appendix).

Since 1972–3, the old system has irretrievably broken down. The collapse has affected both attitudes and institutions, particularly the former. At national level, the institutions of Whitleyism have survived after a time of intense strain in 1973–6. They owe their survival not to respect but to disagreement on alternatives. They exist as a shell and as a forum for acceptance of incomes policies. At local level, the old pattern of attitudes is much changed, and the absence of local institutions and procedures regretted. Major changes in labour legislation have also been important. These changes have been patchy, and overt disputes have been their least common form. We may not have exact measures of the change in intensity of activity locally, but they are there in day-to-day experience.

The first disputes

The troubles since 1972 have had three main phases. From the end of 1972 to the beginning of 1976, there were three years dominated by national disputes about pay. These had been foreshadowed in the laboratory technicians' dispute of 1968–9 and the electricians' dispute of 1970, but there was a new intensity after 1972. Some disputes arose from incomes policy, others were unsettled issues of grading arising from reorganisation of the NHS in 1974. These disputes had elements of novelty, in terms of readiness for local industrial action: but there was also much that was traditional. The disputes over hospital doctors' pay had many echoes from earlier disputes over conditions for family doctors and over the Kindersley report in 1970.[76] The nurses' pay dispute was preceded by the argument with Enoch Powell and by the Royal College of Nursing's 'raise the roof' campaign in 1970. The most important new feature, however, was that the disputes contributed to a permanent increase in membership and activity of trade unions locally. This was consolidated in the second phase of the troubles from 1976 to 1977, a period of local disputes without national focus. From the beginning of 1978, we seem to have

entered a third phase, in which a new series of national disputes has been added to continuing local disputes. We turn now to look at each of these phases in more detail, and then to assess the causes of the breakdown and management's response to it.

The first major national dispute was the ancillary workers' strike in 1972–3. The immediate cause was a quirk in incomes policy. The pay of NHS ancillary workers had always been linked, after a few weeks' delay, to settlements for local government workers. Local government settled before the pay freeze and the traditional link was broken. The National Union of Public Employees (NUPE) would probably have accepted this even though under protest, if it had not been under pressure both from other unions and from its own membership. The pressure of unofficial action, particularly from members of the Transport and General Workers' Union (TGWU) in the Bristol area, led to a stronger response from NUPE and the Confederation of Health Service Employees (COHSE) than would possibly otherwise have been forthcoming.[123] An official one-day strike on 17 December 1972 was followed by a ballot on further action. The ballot produced a majority for a national strike, but the unions decided instead on selective strikes, an overtime ban and a withdrawal of cooperation. There was little detailed guidance from national union headquarters, however, and a great deal was left to the initiative of the local shop stewards. It was up to them to negotiate both about types of action and also about the type of emergency cover, if any, to be provided. A later report on the dispute in the Leeds region described the process of negotiation. 'The need for agreements with stewards about emergency services became suddenly very urgent once the action began . . . What made the crisis worse, where strikes occurred, was that often there was no committee of stewards with whom to negotiate. The machinery had to be set up first and all the time things like laundry stocks were going down . . . The longer these negotiations dragged on the weaker management's position became, whilst the stewards grew more confident.'[25] The stop-

pages did not achieve their main objective, but they left both increased membership and a new mood of determination.

The next national dispute also arose out of incomes policy and was made more intense by rivalry between unions. This was the conflict over nurses' pay in 1974. Nurses had a large catching up pay increase in 1970, but by 1974 they had been left well behind again. Rivalry between unions had begun with the Industrial Relations Act of 1971.[67] This led the Royal College of Nursing (Rcn) to adopt a more active local role, including the appointment of stewards. It also led COHSE to leave the Trades Union Congress (TUC), a decision which protected its membership from the Rcn but which left it open to attacks on the other flank from NUPE. The nurses' pay dispute was one chance for COHSE to re-establish itself and also for the Rcn to consolidate its new role. In practice, there was little scope for dramatic local action because after the initial marches and demonstrations, the government set up a special committee of inquiry under Lord Halsbury, which was widely expected to be generous.[46] This absence of local action was one reason why the longer term effects of this dispute—greater membership and activity—were not as great as those of the ancillaries' strike. There were local disputes among nurses in the later phase, but they were nearly all in the traditionally well organised psychiatric hospitals.

The doctors were the next to take the now well trodden track across the Rubicon. First the consultants worked to rule in early 1975, in protest about the breakdown of negotiations on their new contract. These had started in 1972. Then junior doctors took industrial action, in fear that the new system of pay for overtime would work to the detriment of some of their colleagues. Both disputes had an element of hysteria from the start. As one of the BMA's chief negotiators on the consultant contract put it in the BMA conference in 1974, 'We are in a jungle gentlemen and unless we fight like the others we will go down'.[22] The atmosphere did not get any calmer after the issue of the consultants' contract

became linked temporarily to that of the future of private practice, as a result of local union action against private practice. The consultants at least had the excuse of genuine grievances about pay and the unsettled state of negotiations. Little can be said in favour, however, of the junior doctors' leadership in the 1975 dispute. This was certainly an unnecessary dispute.[34]

The junior doctors were striking against a settlement that they themselves had freely agreed to, on points of interpretation that could have been and later were cleared up by the Review Body on Doctors' and Dentists' Remuneration. The particular issue of detriment proved, in fact, to have little substance and was soon forgotten. The final irony was that, although the junior doctors won little in the announced settlement, the new payment system actually proved rather more generous in its effects than had been expected.

In both cases, competition both for negotiating rights and for membership raised the tempo of the disputes. The British Medical Association (BMA) was faced with a challenge on its sole negotiating rights for consultants from the Hospital Consultants and Specialists Association (HCSA). The greatest effects of rivalry were felt in the junior doctors' dispute. In the critical weeks towards the end of 1975, it was the acute competition between the Junior Hospital Doctors' Association (JHDA) and the BMA which led to the start of industrial action. Public discussion mainly concentrated on the novelty of industrial action by doctors. It should surely have been at least equally a cause for concern that, as two junior doctors put it, '[in] twenty years of negotiation with the Department of Health, the fundamental problems of junior doctors . . . figure little if at all'.[34]

The three major sets of disputes affecting ancillary workers, nurses and doctors were only the largest. There were some associated 'relativity' claims for large pay increases by radiographers and other staff, such as physiotherapists. In the case of the radio-

graphers, rivalry between organisations again played a part. There was also a number of claims for regrading arising from NHS reorganisation. The most important affected catering officers, works officers and ambulancemen. Ambulancemen had always been active in trade unions locally, and this continued; but, as with doctors, these disputes in the 1972–6 period did not lead to any general change locally in the tempo of industrial relations.

The period 1972–6 was dominated by a number of national disputes. Management, preoccupied with the problems of reorganisation, was reacting to events and to initiatives from unions at local level. The disputes were fairly similar to those in many other public services at one time or another since 1969. The second phase of 1976–7 is less easily summarised. Nor would it be fair to say that local disputes were the only, or the main, feature of industrial relations in this phase. The local disputes captured public attention and became, for many people, 'IR' in the health service. The more important change was, however, a fairly general heightening of industrial relations activity, both by staff and by management. On the staff side there were more shop stewards, more competition for membership and increased scope arising from new labour legislation, particularly on disciplinary matters. On the management side there was a greater willingness to take initiatives, even though these were often confused and hampered by the management structure. Most area health authorities negotiated their own disciplinary procedures and many agreed on grievance procedures. The activities of personnel staff began to make more impact. A few authorities, led by Newcastle, negotiated agreements on facilities and time off for shop stewards. Even fewer, led by Northampton, began to move towards a union membership agreement. The disputes are only part of the story: the underlying changes in relationships and attitudes and the attempt to accommodate them in new procedures were the more common themes.

These changes in activity affected many more staff, directly and personally: but, as public events, the disputes commanded attention, helped by an enormous amount of press reporting, particularly in the *Daily Mail* and *Daily Express.* Local disputes before 1976 seem to have been mainly about disciplinary matters. For example, there was a strike at Morriston Hospital in Swansea in June 1975 by 400 ancillary staff in protest against action against a shop steward. In December 1975, industrial action was threatened in Liverpool unless a letter of reprimand to a shop steward for allegedly being absent without permission was withdrawn. From 1976, local disputes became much more common. It must be emphasised, however, that at worst only a small number of areas was directly affected and that many changes were brought in without industrial action. Thus, over 6000 beds were closed in 1976–7, most of them without industrial disputes.

Pattern of disputes*

What was the pattern of local disputes taking both those of the second phase and those in the third phase beginning in 1978 of mixed local and national disputes? The information is taken from reporting in the national press. Some correction has been made for this bias by looking at the files of a number of newspapers—the *Guardian, Financial Times, Daily Telegraph, Daily Express* and *Daily Mail*—as well as the *Health and Social Service Journal.* The information may be subject to further bias because of the tendency to report more fully disputes which are close to Fleet Street. Local experience would suggest a heightening of activity, together with small, short disputes in many other places, but it seems likely that most prolonged disputes involving sizeable numbers of staff get reported in one paper or another. This is especially likely because of the strong interest of the press in the topic. It is unlikely, however, that the reported disputes are the tip of an iceberg. The pattern of greater activity and of minor

* See Note on page 22.

incidents (such as one-hour walkouts) in other places is different from the experiences of the few chronicled by the national press.

There has been a concentration of disputes in a small number of places in the country, with London and Liverpool very much to the fore. In these areas, one union (NUPE) has been pre-eminently involved and certain full-time NUPE officers have been prominent. Other unions may have contributed to particular disputes but the lead came from NUPE. The local disputes in the London area were mainly in 1977 and 1978. They included an industrial dispute at the Royal Hospital of St Bartholomew over new rotas and cuts in service (January 1977), action over cuts in service and porters' duties at The Hospital for Sick Children, Great Ormond Street, and Queen Elizabeth Hospital, Hackney (April 1977), a dispute over the issue of back pay at The London Hospital (June 1977), a sudden stoppage as a protest against allegedly inadequate medical treatment for a porter at Westminster Hospital (February 1978), a dispute about staffing in the operating theatre at Dulwich Hospital (February–March 1978). There have been disputes in other areas involving NUPE, most notably in Basingstoke in 1976; but there has been a definite concentration on the London area. The main dispute which does not fit the pattern was that in the Epsom area from January 1977, involving the TGWU. Disputes in the Liverpool area are less easily pinned down to dates: a later committee of inquiry report identified a state of chronic 'guerilla warfare' in the Central and Southern Health District of Liverpool.[100]

It would be wrong to jump immediately to the conclusion that NUPE was in some way to blame for this unhappy story. For example, the back-pay dispute at The London Hospital took place in a district where relations had generally been very good and stemmed very largely from the inconsistencies of DHSS advice on the subject. It was also in London and Liverpool that the effects of the report of the Resource Allocation Working Party (RAWP) were felt most acutely. There may also have been

a certain use of London as a test case for issues that were of national significance. The report of the committee of inquiry on Liverpool distributed the blame pretty evenly for day-to-day troubles. 'On the management side the absence of a commitment to full open and *early* consultation gave rise to hostile and sometimes ill-informed action. On the staff side, there is some evidence of a tendency, especially on the part of NUPE, to take precipitate industrial action in the face of real or supposed management action.'[100] More importantly, it also showed how the context of day-to-day relationships had been shaped by management's mishandling of issues stemming from spending cuts and the opening of the new hospital. Management had frequently changed its mind. 'Inside eighteen months, two thirds of the hospitals in the city have been or still are threatened with closure, reduction or redesignation either now or in the future.'[100] Nevertheless, NUPE has been much more constantly involved, and some other evidence—such as the report of the committee of inquiry on the Dulwich dispute, which found unanimously and which included a full-time NUPE officer—suggested that local stewards had acted in an unreasonable manner.*

There has been a concentration of disputes in operating theatres. The major disputes at Greenwich Hospital over the employment of operating department assistants (ODAs) and at Dulwich Hospital over a porter's bicycle, were preceded by earlier friction at the Manchester University Hospital and the Birch Hill Hospital, Rochdale, the Royal Northern Hospital in London and Seacroft Hospital, Leeds. These disputes would seem to reflect several special features of operating theatres. Close contact between occupational groups brings into relief glaring differences in their pay and status. There is also ambiguity about supervision and about the balance of various kinds of staffing. The last uncertainty has grown with the creation of a new grade of ODA.

* Report of a committee appointed to inquire into a situation within the main operating theatre suite at Dulwich Hospital, London, 1978.

There has been some concentration of troubles in large psychiatric hospitals. These have often had little to do with detailed issues of pay and conditions but have revolved around more general issues of the care of patients and the running of the hospital. COHSE has been in the lead in taking action in Tooting Bec, Normansfield and Brookwood hospitals. In many other places, COHSE has brought the issue of staffing levels in psychiatric work into negotiation. However, there are many precedents for local disputes in psychiatric hospitals, going back to the 1950s.

The length and bitterness of some of the disputes have been out of proportion to the size of the issues involved.

From the beginning of 1978, we entered a third phase. Local disputes continued, although perhaps rather fewer of them. A number involved issues connected with bonus schemes for ancillary staff. In addition, there were two major disputes—involving electricians and telephonists—which could be resolved only through the Whitley Councils. The electricians accepted an immediate increase and the offer of a bonus scheme. The telephonists were promised an evaluation of their job which would compare the work of hospital telephonists with that of Post Office operators and which would report within ten weeks. Sporadic and, in the case of the telephonists, highly controversial local action, had preceded these two national settlements.

Causes of breakdown

Events since 1972 add up to a breakdown of the old system, most fully at local level; at national level the shell of institutions survives even though attitudes have changed. We turn now to the possible causes of this breakdown. There have clearly been some longer term changes which have affected the context of local industrial relations. In Dunlop's terminology, the 'system'—at its centre the rules, procedures and understandings, which govern

conduct—has been under severe stress.[23] There have been changes in technology. Occupations have become more complex and varied, and technology has increased the bargaining power of various groups. The financial position of the service has changed, with much stronger pressures to cut costs, and shifts of power in the wider society have affected attitudes within the NHS. There have also been changes in attitudes. Thus, in Berridge's phrase, the 'internal culture of dedication and vocation' has changed.[8] The world of the NHS has become rather less closed.

On top of these slow—and in some cases rather nebulous—changes, the service was suddenly exposed, from 1974, to a great deal of stress arising from reorganisation, from restrictions on public spending and from changes in labour legislation. Hurried attempts are now being made to adapt the industrial relations system, but they cannot conceal the fact that the NHS was remarkably backward for such a large employer. The breakdown of the system since 1972 was hardly surprising. It had not the capacity to deal with cumulative changes, let alone the great stresses imposed on it after 1974. The NHS was, of course, far from being unique among the public services in experiencing troubles. The effect of incomes policy has been to create a persistent tension about pay in the public services. There were, however, some special and particular features about the breakdown. One was the strongly assertive policy adopted by a particular union. There was also the continuing difficulty over handling quite routine issues and controversies—the lack of an effective local system. The national disputes over pay were not as surprising as the continuing local stresses. Finally, there was the strength of feelings about status which were aroused in many disputes. The NHS is unusual in the extent to which people with very different levels of pay, training and status are brought together so closely during the day's work, and in which basic inequalities are so clearly visible. This contributed to the special charge of emotion which entered into many of these disputes.

Without over-stressing the similarities, it is worth looking at the case of the airline pilot in the late 1960s—another case of breakdown in an old colonial system. The period of pilots' strikes and militancy seemed to follow from more gradual changes in attitudes and in circumstances. The airlines had got larger and the pilots felt themselves to be more distant from top management. The airlines themselves were under more commercial pressure and keen to improve the use of pilots' time. There had been changes in the organisations which had inserted a layer of highly unpopular personnel specialists between pilots and top management. Pilots were more aware of their lower earnings compared to their colleagues abroad, and also that their bargaining power had increased as airlines had become more capital-intensive. There was dissatisfaction with the negotiating machinery. Local personality factors, such as the behaviour of the managing director of one of the independent airlines, also contributed. The best study of the breakdown, by Blain, tends to put the emphasis on the element of status and the greater feeling of distance between pilots and management in bringing it about.[9] The better record since seems to be related both to improved relative levels in pilots' pay and to changes in management, so that the pilots' voice could be heard more easily.

Response to breakdown

Within the NHS, the response of management to the breakdown has been of two kinds. There has been the formal response through circulars and through the McCarthy inquiry.[94] The first initiative here was to strengthen personnel management. Significantly, the main circular before reorganisation on this subject hardly mentions industrial relations.[44] The district personnel officer is seen as giving 'advice and services to line managers and staff in the District' on a number of topics, of which the eighth after such matters as 'advertising, recruitment and selection' and 'manpower information' is 'industrial relations, including joint

consultation'. Later events have drastically altered the emphasis. The second main strand in policy has been the attempt to de-centralise Whitleyism. The McCarthy report recommended that there be greater discretion to make agreements at all levels, and that there be a new regional tier. More important than these formal initiatives, however, has been the response of some areas and districts which have become more active and have developed their own agreements. Thus, in 1975, an area personnel officer wrote as co-author: 'We feel that managers need to base their working relationships and arrangements with employees on a series of agreements containing elements contributed by both parties and having strong moral authority over the parties as a result of voluntarily negotiated consent'.[6] This path has been taken with varying degrees of success by many areas and districts.

Local management has had several responses. It has negotiated agreements—most commonly on disciplinary and grievance issues and, in a few instances, on facilities—with shop stewards. It has also strengthened personnel departments. Another reaction has been for senior managers to spend much more time on industrial relations. All this sounds clear and simple but in practice the response has been confused by the number of different points in the hierarchy with unit, sector, district and area administration all potentially involved. The response has also been complicated by the advent of functional management which has further blurred responsibility for IR locally. The coincidence of new and un-expected crises with the new management structure has meant a difficult experience for local managers.

ACAS certainly seems rather pessimistic about the chances of improvement without rather major changes in management approach. It detects, in its evidence to the royal commission 'three fundamentally weak links' in the organisations. These are the 'Area/District relationship', the 'IR role of DMTs' and the 'IR role of line managers'.[3] ACAS also wanted to see clearer responsibilities for district personnel staff. However, some areas

and districts have already shown that there is nothing impossible about day-to-day industrial relations in the NHS, even with the present management structure.

The comments of ACAS were directed at the NHS as a whole. By mid-1979 it seemed, however, that districts and areas had fallen into two distinct groups. First there was the 90 per cent of districts which had made some adjustment to change. Second there was a minority—at most 10 per cent—of incident-prone districts. This group had a fluctuating membership concentrated in or close to central London. These districts were marked out by their high level of disputes, by obtrusive personality factors and, often, by the attention of the press. To the usual forces of change such as new labour legislation and reorganisation were added here a special intensity of bad feeling and lack of mutual respect between stewards and managers. Many reactions to industrial relations in the NHS were based on heavily publicised events in this 10 per cent of districts. The 'problem' of NHS industrial relations clearly differs between the two types of district. In the 90 per cent, the main problems were objective ones to do with the lack of a system—of procedures for dealing with change. The 10 per cent had all these objective difficulties, together with a strongly subjective dimension to do with attitudes and feelings. In this book we try to shift the focus towards the lot of the 90 per cent.

General changes in industrial relations in Britain

We have traced the chronology of change within the NHS. We have also looked at the response of management. We turn now to the comparative question. How does the pattern of change fit in with changes in industrial relations elsewhere? The general history of industrial relations in Britain over the last 20 years has been that of the breakdown of a system. The old system began to decay from the mid-1950s onwards. We may list its main features as follows.

The unions The rank and file membership was apathetic and there was little participation in union government or in elections. Shop stewards, where they existed, were not active and were seen by most unions as collectors of 'subs'. There was a strong sense of hierarchy and 'bossism' was not unknown. Unions mainly had settled constituencies and membership growth was slow.

Collective bargaining Agreements were mainly industry-wide and covered a limited range of subjects. Strikes were uncommon and, in the public services, almost unknown. Excluding stoppages in mining, there were about 600 stoppages of work a year in the mid-1950s compared to about 2000 a year in the late 1970s. There was no long official strike between the cotton strikes of the early 1930s and the London bus strike of 1957.

The economy The rate of inflation was gentle and the state of the economy had some influence on the level of claims. There were some well established comparisons in wage bargaining but it was not usual to make coercive comparisons across industries and occupations.

Attitudes to power There was no full recognition of how far the bargaining power of many groups in the labour force had grown within the more sophisticated and centralised post-war economy. There was a good deal of unexploited bargaining power. There was a degree of deference to government.

The legal context There was little legal regulation of relationships at work. The philosophy of voluntarism was accepted by all the parties. There were few guarantees in law of the rights of individuals at work.

The breakdown of the old system came about to varying degrees because of the pressure of 'more planning from above and more democracy from below', in Allan Flanders' phrase.[29] The pressures arising from change in the economic context, and in the expect-

ations of the membership and of shop stewards, had to be accommodated. This was done in the unions by changes in the balance of power within unions towards the shop floor, and by management through the negotiation of much fuller agreements in companies and plants as well as by the expansion of personnel management. Rising numbers and increased gravity of stoppages showed that the accommodation both in national pay bargaining and in plant had been far from perfect.

Peculiarities of the NHS

The old system in its peculiar NHS version survived far longer than in British manufacturing industry. We have seen, though, how from 1972 it began to break down in the NHS. Staff interest in industrial relations began to rise and the old pattern of union government to change. Somewhat belatedly, official policy came to encourage the negotiation of local agreements, taking a similar direction to the one taken by the Donovan report ten years earlier.[107] New labour legislation, as well as increased activity by shop stewards, added to the pressure for such agreements. Numbers of stoppages rose, and the transition to a new system is likely to be a difficult one. During this time, a number of special features became clear which distinguish industrial relations in the NHS from that in other services and industries. The first is the complexity of relations between unions, and between unions and professional associations. Even less than elsewhere do representative bodies have secure and settled constituencies. The sheer number of organisations, together with the differences between them, has made it very difficult to develop procedures and collective bargaining locally. The TUC and many other bodies have drawn attention to the evils of multi-unionism. The NHS would seem to be a particularly serious case.

A second special feature has been the frequency, and the intensity, of conflicts about pay. The impact of incomes policy from above

has been unusually unsettling. Few other negotiations on pay have been affected so powerfully by dissent. This is partly because of the uneven effects of incomes policy. There is some evidence for the view that incomes policies are applied more strongly to the public services, and that uneven application means that certain groups fall behind. But other public services have suffered in the same way without the same amount and recurrence of difficulty. The highly fragmented system of pay bargaining, combined with the strength of occupational and professional loyalties, has added to the difficulty. The NHS has no coherent pay structure and there cannot be, as there is in local government, a small number of decisions about pay from which a much broader range of consequences follows. Each small group and each Whitley Council bargain in isolation from all the others. This may partly be the inevitable result of the diversity of occupations in the NHS; but it also reflects policy across the years. It might have been possible to coordinate pay bargaining for some broad groups. It might also have been possible to reorganise the pattern of settlements so that they all started at the same time. The effect of the present system is to increase the sense of isolation and desperation within each group. There is a sense of 'now or never': each group wants to seize its moment. The present system makes the anomie of pay bargaining—the lack of any agreed norms or aims wider than those set by each group for itself—much worse.

The third special feature has been the impact of industrial disputes on the output of the service. By the usual measure of 'days lost' the NHS may not seem to have experienced much industrial action. This measure may not, however, do justice to the particular types of dispute found in the NHS. Some parts of the health service have been incident-prone without having many days lost. We do not have evidence on the direct effect of industrial action on the rate of treatment but we can infer that it has been quite serious. It is usually held that the consultants working to contract led to a rise in waiting lists from about 500 000 to 600 000. Even if other factors had been at work here, it must certainly have con-

tributed. In industry, the costs of strikes in terms of lost output are often reduced through overtime working and special efforts to catch up production. In the NHS, it has been more difficult to do this.

The care of patients has proved to be very sensitive to some effects of industrial action. The bargaining power of particular groups is great and, ironically, the pattern of pay negotiations has encouraged frequent use of it.

The common view is that industrial relations in the NHS are, in some sense, 'bad'. One test of badness would be in the increase in numbers of disputes, and their costs. Here the NHS would certainly seem to be in difficulty. The contributors to this book accept that there is an urgent need for change. They are trying to define where the health service is, and how improvements might be made realistically within the current framework of management. We try to cover most of the important issues that impinge on management and staff from day to day. At the end of the book, we return to the possible wider changes which may be necessary. We hope that this book will help the development of the more effective industrial relations which the service so badly needs.

This introduction has argued that the health service faced objective problems and that union behaviour can only be understood as an inevitable response to such problems. It is pointless to expect that subjective changes in mood and behaviour can make up for policies. The record suggested that the NHS has had about the IR it deserved and about what might have been expected, given the backwardness of the system. Press comment and public policy have, again and again, dealt with the symptoms rather than the causes.

Note Paragraphs 1, 2 and 3–5 in the section on 'Patterns of disputes' (pages 11–14) draw on research reported in 'Is the NHS really torn by strife?' Nick Bosanquet and Geraldine Healy. *New Society*, 10 May 1979, pp. 328–329.

2
Discipline and dismissal: legal aspects

MICHAEL WHINCUP

Disciplinary and dismissal problems are unfortunately at least as much a fact of life at all levels in the NHS as in other less 'dedicated' occupations. The extent to which they can be avoided, or if not avoided then resolved with the minimum of disruption and ill-feeling, is very much a matter for the exercise of managerial skills. It seems fair to say that the health service has been somewhat behind the general run of industry in recognising the need to develop those skills. Certainly in the years immediately following the introduction of the concept of unfair dismissal in the Industrial Relations Act of 1971[67] there were many industrial tribunal cases in which the conduct of NHS managers was sharply criticised and compensation awarded to employees because of arbitrary or inconsistent treatment which one would not expect to find in an enterprise more acutely aware of the importance of the personnel function. Fortunately, these deficiencies are now being vigorously remedied in some places.

In this chapter we begin our discussion of the practical problems facing management and how they may best be overcome. We shall consider first what the law says about the matter—not only because of the penalties and costs incurred in breaking it but because the law is in itself a broad guide to sensible industrial relations principles—and in the next chapter* give more attention

* Disputes procedures and grievance procedures (pages 55–71).

to practices and procedures necessary to comply with it.

Employment law is, of course, a very substantial area, and one which seems to grow and become more complex almost week by week. There have been three major Acts concerned, to a greater or lesser extent, with rights on dismissal—the Redundancy Payments Act 1965[73], the Trade Union and Labour Relations Act 1974[80] (repealing the 1971 Industrial Relations Act but retaining its basic provisions on dismissal), and the Employment Protection Act 1975.[62] The relevant parts of these three Acts and other miscellaneous provisions such as the Contracts of Employment Act 1972[60], are now conveniently restated without alteration in the Employment Protection (Consolidation) Act 1978.[63] Other individual and collective rights remain in the unaffected parts of certain of these Acts and in the Equal Pay Act 1970[64], Sex Discrimination Act 1975[78] and Race Relations Act 1976.[72] Apart from these various statutes there are hundreds of reported cases from industrial tribunals, and some from the Employment Appeal Tribunal and other higher courts, to tell us what all these Acts mean in practice and what are or are not acceptable standards of behaviour in aspects of employment not so far regulated by Parliament. More guidance still is given by the original Code of Practice[38] issued under the Industrial Relations Act 1971[67] and those on more detailed matters of dismissal, union membership and disclosure rights subsequently published by the Advisory, Conciliation and Arbitration Service. We refer in detail below to the ACAS code on disciplinary practice and procedures[1], which is, as we shall see, of vital importance in determining the fairness of dismissals and which provides the framework for NHS dismissal procedures.

I do not suggest that employers should know all these rules as well as if they were lawyers, but they must at least be aware of the existence and effect of the codes and the main statutory provisions. Personnel officers in particular should be reasonably well acquainted with them, and ought then to be able to conduct

a case with a fair degree of proficiency in an industrial tribunal. (On balance it is probably right to say that lawyers are better kept out of such proceedings—unless it is clear that the dispute is over law rather than fact.) But at the same time we must recognise that, however well management may know the rules and, indeed, follow them to the letter, nothing can stop an aggrieved employee from taking an issue to the tribunal, and as and when he does so management may suffer a great deal of inconvenience and financial loss simply through preparing for and attending the hearing. The system is commonly criticised by employers for this among other reasons, but it might be borne in mind that if employees' rights of access to tribunals were restricted by some kind of vetting procedure, they would have correspondingly less confidence in them and more reason to resort to other and much more disruptive methods of solving dismissal disputes. All we can say by way of consolation to the employer is that an understanding of and sympathetic compliance with the rules should make dismissal less likely in the first place and, if it none the less occurs, should result in a more agreeable outcome of the case from his point of view. In particular, as we shall see, it is possible to do a great deal at the outset of the employment relationship to bring about a favourable decision if it eventually has to be ended by dismissal.

The vital rule, and the one with which this chapter is mainly concerned, is that an employee can lawfully be dismissed only if the employer has a *good reason* for doing so and, as an additional requirement, *acts fairly* in dismissing for that reason. But before we can discuss these requirements in detail, certain essential preliminaries must be mentioned—in particular those managerial tasks just referred to which are so important at the beginning of the relationship, and partly also some matters of definition. We shall look at all these issues under four convenient headings—the parties to the contract of employment, the form of that contract, its terms and the circumstances in which it may be ended.

The parties

The short point here is the fundamental distinction which has to be made between employees and independent contractors. An independent contractor may be either a self-employed person or an employee of someone other than the person for whom the job is being done, for example a garage hand supplying a customer with petrol. The immediate importance of the distinction is that where work is done by an independent contractor, the person for whom it is done has no liabilities whatever under the disciplinary and dismissal rules we are about to discuss. The distinction is also significant, of course, for pay-as-you-earn (PAYE) and national insurance arrangements and may also be relevant to the worker's safety. The issue can arise in hospitals or other health services where labour is supplied by an agency. Is the agency nurse or radiographer an employee of the agency or of the hospital to which he or she is sent? Unfortunately, we can offer no definite answer to this question. It is not enough to ask whether or where there is a contract, written or otherwise. There is bound to be *a* contract—a mutual and enforceable agreement—but that does not answer the question whether it is one of employment or for services. Nor is it enough simply to ask what national insurance or PAYE arrangements have been made, because these in turn depend on the right decision having been made at some earlier stage concerning the worker's status. The decision can only be made in the light of all the available information about the relationship—not only tax and insurance details, but also information about the nature of the orders which are and could be given, the method of payment (lump sum or salary), the skills and/or equipment the worker brings to the job, and the like. Basically, the argument is that the more control that can be exercised over a worker the more likely is he to be an employee, while, conversely, if he can decide for himself how, when, where or with whom to do the job the more likely is he to be an independent contractor. On the face of it, therefore, a nurse or radiographer supplied to a hospital by an agency is likely to become,

for however short a time, an employee of that hospital. The visiting surgeon or doctor paid by the patient, on the other hand, is an independent contractor.

Once we have established that the worker in question is in fact an employee, we must then ask how many hours a week he works. If he works more than 16 hours a week by contract, including hours on call *(Bullock v Merseyside County Council,* 1978)*, or has worked over eight hours a week for more than five years for that employer or his predecessor, he is eligible for various statutory rights not given to those working fewer hours. In particular, he becomes entitled (subject to certain conditions and exceptions explained below) to written terms of employment, statutory minimum periods of notice, protection against unfair dismissal and protection against redundancy, and women become eligible for maternity pay and reinstatement.

The form of contract

Generally speaking, the validity of a contract does not depend on its being in writing. From the practical point of view, however, it is obviously wiser to record complicated or expensive transactions in this way so that the terms can be more easily proved and are not simply 'your word against mine'. This is the position in industry as elsewhere, subject to certain provisions under which writing is required by law. The main exception in industry was in the Contracts of Employment Act 1972[60], now Part I of the Employment Protection (Consolidation) Act 1978.[63] The rules here are intended to ensure that various basic terms agreed between employers and employees are available in writing. Certain workers are not covered by those requirements—most importantly those employed by the Crown, including therefore National

* Cases cited in this chapter are listed at the end of the chapter, pages 52–54, and are not included in the list of references at the end of the book.

Health Service employees—but only on the basis that they already have equivalent provision *(Wood v Leeds Area Health Authority,* 1974).

For all practical purposes, then, the rules are as follows. Within 13 weeks of starting work an employee must be given a written statement which either contains or refers him to another document containing these particulars: names of the parties, the date employment began, job title, pay, hours, holiday and holiday pay provisions, sick pay, pension, notice, and grievance and disciplinary procedures. Usually the statement the employee receives simply refers him for all but the purely personal details to a copy of the collective agreement—for example, the relevant Whitley Council agreement—available in some convenient place such as the personnel department.

Some of these matters merit further discussion. The date employment begins, for example, is important because of the various rights which depend on continuity of service. The date must therefore take account of any employment with the employer's predecessor which is continued by the present employment. It should be noted here that in the NHS each regional authority is a separate entity; thus, employment with another authority elsewhere is not counted for the purposes of statutory rights. By voluntary collective agreement, however, NHS authorities have accepted the principle of continuity with regard to pension and sickness rights.

The requirement of a written job title is an interesting one. Its purpose is presumably to reduce the incidence of 'who does what?' disputes. The job title alone, however, may not be sufficient to achieve this, and so employers should bear in mind that the 1971 Industrial Relations Code of Practice recommends that a written job description be given to every employee.[38] In my view this should be short and to the point, stating only those duties which are essential and inherent in the job title, any additional

mobility or transferability requirements, and the legal obligation to undertake any duties reasonably incidental to those specified. In practice, this last obligation is narrowly interpreted in the light of the duties specified in the contract *(Briggs v Imperial Chemical Industries,* 1968) but it is nevertheless valuable in providing a little elbow room in the relationship. Many dismissal disputes arise because of the absence of adequate job descriptions. Accordingly, one of the most useful steps management can take at the beginning of the relationship is to give time and thought to the preparation of such particulars.

The code of practice on discipline and dismissal

The written statement must also tell the employee how to initiate the grievance procedure, and refer him to the written disciplinary rules. These again are matters which, if given sufficient attention by management at the outset, can be of decisive importance when dismissal occurs. In so far as the vital question on dismissal is its fairness, it might seem necessary to set down in advance every single rule that management can think of and all the penalties for breaking them, but in practice, of course, this is neither necessary nor possible. One can only try to give examples of the kind of behaviour which justifies any particular kind of penalty. The ACAS code on disciplinary practice and procedures issued in 1977 gives some useful general guidance to employers on the form and content of the rules.[1] It accepts that there can be no model set of rules covering every different place and type of work. The employer himself must work out provisions best suited to his needs.

> 'The rules required will vary according to particular circumstances such as the type of work, working conditions and size of establishment. When drawing up rules the aim should be to specify clearly and concisely those necessary for the efficient and safe performance of work and for the maintenance of

satisfactory relations within the workforce and between employees and management. Rules should not be so general as to be meaningless. Rules should be readily available and management should make every effort to ensure that employees know and understand them. This may be best achieved by giving every employee a copy of the rules and by explaining them orally. In the case of new employees this should form part of an induction programme. Employees should be made aware of the likely consequences of breaking rules and in particular they should be given a clear indication of the type of conduct which may warrant summary dismissal.'[1]

It is preferable to draw up the rules in consultation with the union—but sometimes, of course, unions refuse to cooperate. Since rules of some sort remain necessary, their refusal does not actually achieve anything except to ensure that the rules are not as much to the unions' liking as they might otherwise be.

The code stresses that disciplinary procedures have a positive as well as a negative role. They

'should not be viewed primarily as a means of imposing sanctions. They should also be designed to emphasise and encourage improvements in individual conduct.'

The essential features of such procedures are given as follows. They must be

'in writing; specify to whom they apply; provide for matters to be dealt with quickly; indicate the disciplinary actions which may be taken; specify the levels of management which have the authority to take the various forms of disciplinary action, ensuring that immediate superiors do not normally have the power to dismiss without reference to senior management; provide for individuals to be informed of the complaints against them and to be given an opportunity to state their case before

> decisions are reached; give individuals the right to be accompanied by a trade union representative or by a fellow employee of their choice; ensure that, except for gross misconduct, no employees are dismissed for a first breach of discipline; ensure that disciplinary action is not taken until the case has been carefully investigated; ensure that individuals are given an explanation for any penalty imposed; provide a right of appeal and specify the procedure to be followed.'[1]

Managers and supervisors are advised by the code to establish the facts promptly before memories fade, and to take written statements. In serious cases a brief period of suspension on full pay might be appropriate while the facts are investigated. Before any decision is made or penalty imposed the individual should be interviewed, advised of his rights and given the opportunity to state his case. When the problem is one of improving an employee's standard of work or behaviour an informal oral warning will usually suffice, but a formal oral warning might equally well be appropriate. For more serious issues written warnings will probably be necessary, setting out the nature of the offence and the likely consequences of repetition, *viz* dismissal or suspension. It is most desirable that these guidelines are followed not only by those with immediate power to dismiss but also by the domestic appeal tribunal.

In Circular No 77/1, the General Nursing Council (GNC) gave helpful advice to management on the drafting and content of rules in health services, noting in particular the four main aspects of a nurse's life which might properly be the subject of disciplinary provision—on-duty work affecting patients, on-duty work not affecting patients, off-duty activities on the premises, and off-duty activities off the premises.[32] The GNC, like the code, attaches considerable weight to the positive role of disciplinary proceedings—that is, their use for counselling purposes and to bring about improvements in the work, and not simply for imposing penalties.

The difficulties of drafting acceptable and enforceable rules remain very considerable. They are well illustrated in the case of *Meridian v Gomersall,* 1977. A company notice declared that employees guilty of clocking offences were 'liable to dismissal'. The Employment Appeal Tribunal held that 'liable to' meant that some other less severe penalty might be imposed and that this dismissal was therefore unfair. The decision seems to leave the employer in a dilemma. If on the one hand he says categorically that dismissal is the one and only penalty for a certain offence he will be wrong, because he thereby prevents himself from exercising any discretion in distinguishing between minor and major breaches of the rule, but if he adopts a more flexible approach he is evidently equally wrong. His liability should surely not depend on fine shades of meaning which may or may not be attributable to workaday rules whose meaning and effect are really quite plain. So, in *Stewart v Western SMT Co,* 1978, the company was held entitled to dismiss under a rule which 'reserved the right' to do so in the circumstances which arose—a contradictory but preferable decision.

One of the most delicate questions facing the tribunals is indeed, as these cases indicate, the effect which a failure on management's part to comply with one or more of the code's principles should have on the fairness of a dismissal. If there is no doubt that an employee's conduct makes his continued employment impossible, should his dismissal nevertheless be held unfair because there was, say, no previous warning of dismissal, or a word in the disciplinary procedure agreement is ambiguous? We shall examine the tribunals' conclusion on this issue in more detail below.

We have now touched on some of the more important rules regarding written terms of employment. From these we have seen that not all the terms of one's employment need to be, or even could be, stated in writing. Many quite fundamental matters, such as the place of work, do not actually *have* to be written. In my view, however, it should be policy to record in writing as many

aspects of the agreement and as many incidental transactions in the course of it as is practicable. These are, after all, days when we—or some of us—are forever standing on our rights (with perhaps rather less reference to our duties) and so it seems most sensible to ensure that those rights are written. The more we leave to word of mouth or custom and practice, the greater the difficulty which must eventually arise in deciding once and for all what our rights and duties are.

Collective agreements

Before leaving this issue we should distinguish again between the individual's contract of employment and the collective agreeement to which it often refers and which may lay down most if not all of its terms. Legally speaking, the two types of agreement are quite separate and distinct. The individual's contract involves a mass of rights and duties on which he can sue or be sued by his employer. The collective agreement, on the other hand, is specifically declared by Section 18 of the Trade Union and Labour Relations Act 1974[80] to be of no legal significance whatever, unless it actually contains a written provision to the contrary—a somewhat unlikely event. Whitley Council agreements and the like are, in other words, the product of what we are pleased to call 'free collective bargaining', intended according to English legal theory as embodied in Section 18 to be binding in honour only. Whether this is a very convincing theory will depend no doubt on one's experience of each side's willingness or ability to abide by such agreements itself or to discipline those who take unofficial action in breach of them. Most employee's contracts, expressly or by implication, include or depend upon the terms of a collective agreement. The relevant part of that agreement then becomes enforceable by and against him personally. Otherwise, collective agreements are outside the law. While usually it is easy to say which parts of the collective agreement are also matters of individual rights—for example, when a man's contract states

'Your pay and other terms and conditions of employment are governed by the agreement made between your union and the company on (such and such a date)'—difficulties may occasionally arise. In *British Leyland v McQuilken,* 1978, for example, the employer agreed with the union to consult workers faced with problems of redundancy and retraining. When Mr McQuilken, as one of the workers in question, was not consulted he resigned and claimed compensation for dismissal on the ground that his employer had thereby broken his contract of employment. The tribunal found that the agreement was an expression only of management–union policy and not a term of each individual's contract, and so his claim was rejected. On the other hand, in *Brady v Leeds Area Health Authority,* 1976, Mrs Brady's contract recorded that her appointment was governed by the terms of the Nurses and Midwives Whitley Council Agreement and so when she was dismissed the tribunal held that Circular No GC118, an agreement on staff disciplinary procedures issued by the Council, was part of her personal contractual rights.

We have indicated the fundamental importance of Section 18 of the Trade Union and Labour Relations Act in withholding legal effect from collective bargains. We should now note another rule in the same Act—that laid down in Section 13—which again underlines the differences between the individual's contract and the agreement made on his behalf by his union. Section 13 declares that anyone who *in the course of a trade dispute* induces another to break his contract, whether a contract of employment or some other commercial agreement, is immune from the legal liability which would otherwise result.[80] The combined effect of these two sections is that a union (or, of course, management) can break its own word with impunity—or decline responsibility for unofficial breach—and it, or indeed any unofficial body whatever, can also make anyone else break his or her contract (for example, by calling out members in breach of their contracts of of employment, or thereby stop an employer from keeping his word with his customers) with equal freedom from liability at

law, as long as a trade dispute is in prospect. A trade dispute may be defined as one affecting conditions of employment at the place in question and not one that relates simply, for example, to outside matters such as political action. This immense freedom of action, which could fairly be said to set the unions above the law, is not counterbalanced by any corresponding duty of any kind to the employer, or to his customers or to society at large. By international or indeed any standards this may be thought a bizarre view of how society should be organised—amounting as it does to little more than licensed anarchy—but it is unquestionably one which British management must learn to live with.

The terms of the contract

Perhaps the single most important observation to make about this is that terms of employment must nowadays be seen as matters of agreement, not imposition. To say this is to recognise not only the reality of the power of trade unions, but also the rules of law which may compel recognition of a union and those which oblige employers to disclose all information reasonably required for collective bargaining (Sections 11–21, Employment Protection Act 1975[62]). Other much more far-reaching developments towards worker participation and worker directors can be anticipated in the not too distant future. Whether such power will be—or even should be—accompanied by responsibility remains, it seems, a completely open question.

We need not discuss here all the different kinds of terms which may or may not be suitable for inclusion in a contract, nor even those many recent provisions which by law have to be included—shop stewards' rights to reasonable time off with pay for union work, members' rights to take part in union activities, to lay-off pay, maternity pay and the like. For present purposes it is only necessary to note that there is indeed this basic division between the terms which are agreed between the parties, expressly or by implication, and those added by the law.

Broadly the position is that as long as these minimum standards imposed by law are observed, employer and employee are free to bargain their way to whatever more agreeable terms they wish. Once the terms are agreed, they are binding between the individual employer and employee—at least until such time as they are renegotiated and a new agreement reached, and subject also to the power of either side to compel acceptance of new provisions.

Termination of the contract

Before the introduction of the Industrial Relations Act in 1971 the only question of any legal significance in most dismissal cases was whether the dismissed employee had been given his due notice. If he had, then, subject in more recent years to the requirements of the Redundancy Payments Act 1965[73], he had no legal grounds for complaint. This state of affairs was obviously very unsatisfactory. It gave no reward for loyalty or long service, and indeed fostered insecurity and unrest. The Contracts of Employment Act made the situation a little better by linking length of service to length of notice. The present rules are in Sections 49–52 of the Employment Protection (Consolidation) Act 1978[63], under which an employee is entitled, after four weeks' service, to one week's notice, and thereafter to a week's notice for every year of service. The legal entitlement extends to twelve weeks' notice after twelve years' service, but this may be increased by agreement between the parties.

Today, however, the question of notice hardly ever matters. The vital question is whether the dismissal is *fair,* which is not affected by the giving or withholding of a week or two's notice. The details of this fundamental change in both social attitudes and the law are now to be found in Sections 54–80 of the 1978 Act[63], previously Schedule 1 of the Trade Union and Labour Relations Act and before then in the Industrial Relations Act. All dismissals after 26 weeks' service are presumed to be unfair, and may be so even

within that time if in consequence of union activities.* The onus of proving dismissal fair and reasonable is upon the employer. But what is dismissal? Employer and employee may part company for any number of reasons, misunderstandings and the like, or flagrant breach of contract by the employee, not all of which involve dismissal (*Futty v Brekkes Ltd,* 1974; *Gannon v Firth,* 1976).

By law, dismissal occurs either by the employer ending the contract, with or without notice, or by 'constructive dismissal', or by his refusal to renew a fixed term contract. Perhaps only the second and third of these definitions of dismissal require any further comment. An employee is constructively dismissed if he resigns because of some substantial breach of contract or other intolerable behaviour by his employer—the 'did he fall or was he pushed?' problem. To resign merely because of dissatisfaction with the way things are going or through over-hasty rejection of changes proposed by the employer will not suffice. And while non-renewal of a fixed term contract at the expiry of that term is technically a dismissal (unless in the case of a contract for two years or more the employee has agreed in writing to waive his rights), it should be remembered that all dismissals are not necessarily unfair. An employer who can prove that the job was always regarded as temporary (usually, for example, a locum's post) and that he is not thereby simply seeking to evade the law, will not be liable (*Toke v South West Thames Regional Health Authority,* 1977). The question is also important in the training context. When a contract, say, of apprenticeship or for nurse training is completed there can be no question of renewing that contract as such, that is as a further training contract. The employer is not in other words obliged by law to find jobs for newly qualified employees (*Baksi v Liverpool Area Health Authority,* 1977—no liability on failure to renew a senior registrar's post).

* The probationary period becomes 52 weeks under Conservative government proposals put forward in 1979.

Proving the fairness of dismissal is not easy, and indeed in certain exceptional cases cannot even be attempted. So, for example, the Act forbids dismissal because of an employee's union membership but expressly allows it on his refusal to join a closed shop, unless he has religious scruples.* Apart from these and one or two other 'inadmissible reasons' the employer must show first that he had a good reason for dismissing, and second that he acted fairly in the circumstances—substantially, that is to say, in accordance with disciplinary and dismissal procedures modelled upon the principles of the ACAS code of practice outlined above. The difference between the two requirements could be said to be that between *why* the employer dismissed and *how* he went about it. The good reasons are misconduct, incapacity, breach of statutory duty, redundancy, or other substantial reason. If any reason except redundancy is proved, the employee will probably get nothing—depending on the importance attached to procedural shortcomings—but on redundancy an employee is now entitled to up to £3300 in recognition of past service, and may receive more under special statutory schemes such as that for NHS workers or as agreed by collective bargaining. If he wins his claim for unfair dismissal, his primary remedy as far as the law is concerned is either re-instatement or re-engagement in suitable alternative employment. But these remedies depend both on the employee's wishes and on what is practicable in the circumstances, and for one reason or another—such as mutual ill-will or employment elsewhere in the meantime—re-instatement or re-engagement is hardly ever ordered. If such an order were made, the employer would have to pay up to £5750 compensation if he disregarded it. Much more commonly the question is simply one of compensation. Here the limit at present is £9050. This sum comprises a basic award of up to £3300 (representing accrued redundancy rights) and a maximum of £5750 for current economic loss and personal suffering. The exact amount awarded depends also on

* Rights of conscientious objection are envisaged by current Conservative government proposals.

whether the employee was partly to blame for his own dismissal and on the availability of other work. A further claim for two weeks' pay may be made if the employee is not given an adequate written statement of the reasons for his dismissal within two weeks of demanding it. In practice well over half the 30 000 or so claims made each year are withdrawn or settled by conciliation undertaken by ACAS, and of the remainder which go to the tribunal only about one-third are upheld. Most awards are of less than £500.

These figures incidentally indicate the great value of the conciliation officer's work. He is directed to intervene where either party seeks his assistance or where, on the basis of the parties' statements passed on to him by the industrial tribunal office, he believes there is a reasonable prospect of success. His role is, of course, capable of being misunderstood by both sides. In particular many employers seem to think it is his job to advise them of the wisdom of 'buying off' the employee's claim by offering a sum in settlement regardless of the merits of the case. This is not his function, which must be one of complete impartiality, but he can properly advise either side on the financial aspects of pursuing the case. The employer must decide for himself on this information whether the dismissal represents an issue of principle which he should not evade and which, inevitably at some risk of losing, he should seek to have upheld by the tribunal. We might note also that settlements negotiated by conciliation officers are binding upon the parties whereas other private deals on dismissal are not *(Dolby v British Hovercraft Corporation Ltd,* 1972).

Misconduct

Referring wherever possible to NHS cases, let us now look at how dismissal law works in practice. For reasons of space we must confine ourselves to some of the more common problems posed

by dismissal for misconduct and incapacity, and omit questions of redundancy law and 'other substantial reason' for dismissal. Misconduct is often just another word for disobedience. An employer seeking to dismiss for disobedience must first be prepared to prove that his order was a lawful one, that is within the terms of the original contract of employment. It is at this point in particular that we see the significance of written job titles and job descriptions. Useful examples are *Air Canada v Lee,* 1978, and *Huxtable v Devon Area Health Authority,* 1976. In the latter case, an employee was appointed as a nursing auxiliary and for several years worked in the hospital's maternity ward. When this closed she was told to transfer to the geriatric ward, which she refused. Was this essentially the same sort of work—which she would have to accept, or else be dismissed—or a different job altogether, which she was entitled to refuse? The tribunal decided that an auxiliary's job—and the same could no doubt be said of a trained general nurse—was necessarily one requiring mobility within the hospital. 'It would be almost impossible for a Health Authority to organise a hospital properly if it were precluded from transferring nursing auxiliaries between wards.' The case therefore makes the very important point that some degree of change or flexibility in working conditions is inevitable. But if the employee were required to transfer from one hospital to another, different considerations would apply. No general right to transfer people anywhere within an employer's area of operations will be assumed. Such mobility has to be an express requirement of the contract, or else implicit in the job; for example, that of a health visitor. The point is illustrated again in *Redbridge London Borough Council v Fishman,* 1978. Mrs Fishman was employed as director of visual resources at a school. She was ordered to undertake 18 hours a week English teaching, refused and was dismissed. Her dismissal was held unfair because this was a fundamental change in the nature of her work which she was entitled to refuse.

If we assume now that the employer's order is a lawful one, does disobedience necessarily justify dismissal? The answer is 'no'.

The same penalty cannot be equally appropriate for any and every breach of duty, and in any case we have to ask whether the employee knew or should have known of the importance of the order and the consequences of disobedience. This in turn reminds us of the importance attached by the ACAS code to written disciplinary and dismissal procedures, though as mentioned earlier no employer can be expected to lay down rules for every possible contingency and as likely as not the matter can only be decided according to basic principles of common sense. A flat refusal to do one's job, for example, may justify instant dismissal if life or property are endangered, but otherwise a warning may well be necessary first. *Riley v Kirklees Area Health Authority,* 1977, is a typical example. Mr Riley was a hospital general porter. His contract of employment included a written job description which stated among other matters that it was his duty to empty certain bins. One day he refused to do this, on the ground that the bins were dirty and contained obnoxious material. He was interviewed by the unit administrator who suggested ways in which the job might be made less disagreeable. Mr Riley rejected these proposals and was then warned that he would have to be dismissed if the bins were not emptied. He again refused and was thereupon given notice by the administrator. At the subsequent tribunal hearing the chairman said 'It would put employers in an impossible position if without any very compelling reason employees could suddenly refuse to do a job which is part of their contract of employment and which they have done before, and then expect to continue in their employment. It was open to the applicant to have raised this matter as a grievance with his employers had he so wished. The grievance procedure had been given to him at the time when he took employment. He now says merely that he complained about the bins to his fellow porters during the early part of his employment.' Taking account also of the warnings he had been given, 'although perhaps ideally he might have been given the opportunity to think it over until the next day', the tribunal was quite satisfied that dismissal was justified. But that was not the end of the matter. Was the procedure clear, and clearly followed?

As in many NHS cases, there was considerable criticism of the way the case was handled. Mr Riley's contract recorded only that he was employed on Whitley Council terms and made no express reference to any written disciplinary rules such as the law now requires. The terms themselves were inadequate. One crucial sentence said only 'Gross misconduct may lead to instant dismissal', but made no attempt to explain what might be covered by this phrase. 'It is not sufficient that the employers themselves should be guided by internal documents if the information is not communicated to the employees.' The tribunal was not satisfied that the alternative possibility of suspension had been considered by the authority and was also very perturbed that Mr Riley had not been told immediately that he had a right of appeal, as the rules provided. The general impression was that 'the officers with the power to dismiss are not sufficiently aware of the terms of the procedure'.

The vital question then arose as to how far these procedural failings should affect the propriety of the dismissal. The tribunal attached considerable weight to them, as indeed the Act obliged it to. 'At one stage in our deliberations we were disposed to reach a finding of unfair dismissal . . . arising out of the cumulative effect of these defects.' But eventually it decided otherwise, the main reason being that it could see 'virtually no merit whatsoever in the applicant's case in so far as his refusal to carry out his orders is concerned'. The other reason was that if his dismissal had been found unfair for these procedural reasons the amount the tribunal would then have felt it necessary to deduct from his compensation because of his own misbehaviour would have been so great as to make the award worthless. Mr Riley's claim was accordingly rejected.

The case is thus of additional interest in supporting the view that if a dismissal is in other respects right and proper and necessary it will not be vitiated by procedural faults unless they are so grave as to cast doubt on the ultimate justice of the decision.

Other authorities for this proposition include *Lowndes v Specialist Heavy Engineering Company,* 1976, *Retarded Children's Aid Society v Day,* 1978, *Brown v Hall Advertising,* 1978, and *Stewart v Western SMT Co,* above.* Failing to tell an employee of his right of appeal might well cost the employer his case, but even this could conceivably be overlooked if the facts were such as to leave the employer with no alternative but to dismiss in any event. Another illustration of the way these factors have to be balanced is *Amar-Ojok v Surrey Area Health Authority,* 1975. The case concerned a male nurse who had been dismissed from a psychiatric hospital after being convicted and fined for assaulting the group engineer. The tribunal held that, while the offence itself would probably have justified dismissal, the employer was on this occasion in the wrong because the employee had neither been interviewed before dismissal nor told of his right of appeal, and the appeal which he in fact made was dismissed by the district nursing officer without convening an appeal committee, both of which omissions were breaches of the current procedural requirements. The employer's liability for compensation was, however, reduced by 20 per cent, a small—and in the circumstances perhaps too small—recognition of the employee's share of the blame.

Problems of disobedience may arise in connection with the activities of a union. The greatest caution is necessary before dismissing anyone in these circumstances, particularly union representatives, but the law accepts that a line can be drawn against wrecking tactics or blatant disregard of disputes procedures or other terms of collective agreements. So in *Gregory v Liverpool Area Health Authority,* 1975, a nurse who as NUPE steward ignored instructions not to leave his wards on union business and refused an express order to return to duty, was held fairly dismissed. His primary duty was to do his work and care for his patients, and he had no special immunity as a steward. In

* A still more recent, and most important, decision to the same effect is *British Labour Pump Co v Byrne,* 1979.

South v Leeds Area Health Authority, 1978, a union representative was dismissed for advising an ambulanceman to disobey orders in accordance with a work-to-rule which, on the evidence, the representative almost certainly knew had been called off. He won his claim because of the tribunal's suspicion that he had been deliberately bypassed by management. But his compensation was reduced by half because of previous warnings about flouting procedural agreements and his likely knowledge that he was again behaving purely disruptively. We might note in passing that union representatives or members are still not entitled to attend union meetings whenever they please but only with their employers' express or implied agreement *(Bloomfield v Trust House Forte Ltd,* 1975). Consent may be implied from the general relationship between management and the union *(Marley Tile Co v Shaw,* 1978).

These cases clearly affect the so-called 'right to strike'. We saw earlier that in English law 'right' consists of an immunity from legal action conferred upon both official and unofficial bodies which cause breaches of contract in the course of trade disputes. The immunity is conferred, in other words, upon the *organisers*—but not upon the *participants.* A man who downs tools in response to a strike call (or even, perhaps, one who gives notice, since the purpose of notice is to terminate employment, not suspend it) must be in breach of contract and could therefore face disciplinary action—up to and including dismissal—unless his action is justified by a breach of contract by the employer. Section 62 of the Employment Protection (Consolidation) Act goes so far as to provide that dismissal during a strike is fair as long as all are treated equally and no one victimised thereby.[63] Since an employer is unlikely to want to dismiss everyone who is on strike this rule is rarely invoked. Once the strike is over, however, each employee's record can be looked at on its own merits. If his absence on strike is particularly lengthy, unjustified or harmful, dismissal is undoubtedly a possible remedy *(Ellis v Inner London Education Authority,* 1978).

A firm and authoritative statement of the rights of medical and nursing staff with regard to strike action is to be found in the 1978 report of the committee of inquiry into Normansfield Hospital.

> 'We wish to express our clear view . . . that nurses who take industrial action or encourage or order other staff, subordinate or otherwise, to do so and to expose patients to danger are on risk that disciplinary action may be taken against them by the employing authority (including dismissal) as well as by their professional body (including the power of striking off the Professional Register). In saying this we emphasise that the fundamental concern of nursing staff must be for their patients. To the extent that industrial action may be countenanced we think it essential that it is controlled strictly by the rules of the union or the professional association under whose aegis such action is taken.' [75]

Dismissals often arise out of criminal or alleged criminal behaviour—theft, violence and the like. There is no hard and fast rule that such conduct does or does not justify dismissal, nor can the matter be decided by asking whether the crime was committed at work or away from work. We can say, however, that a high standard of integrity is very naturally demanded in medical and nursing professions. The case of *Shan v Croydon Area Health Authority,* 1975, is instructive. A house doctor of previous good character was convicted of shop lifting to the value of £3 and fined £50 in the magistrates' court. When called to disciplinary proceedings by her employer she flatly denied having committed the offence, to which she had pleaded not guilty. She was dismissed nevertheless. The authority told the tribunal that theft was a major problem in its hospitals and argued that discipline could not be imposed if those 'at the top' were seen to get away with it—against which of course it could be said that that would mean penalising the doctor for other people's misconduct. The authority also pointed out that it had a rule making dismissal the inevitable

penalty for theft. On the doctor's side not only was there the denial of guilt in the first place but also the fact that the theft, if it could indeed be attributed to her, was of small value and not from the employer, and further the severity of the consequences had to be taken into account—punishment by the magistrates, dismissal by the employer and possible professional disqualification by the General Medical Council (GMC). The tribunal said with regard first to her denial of guilt that it was not a criminal court and so could not re-try the case. The magistrates' decision was in effect binding upon it. Second, the employer's rule against theft would not be enforced as such because it was too general and prevented the employer from distinguishing between trivial incidents and those which mattered, or where there were mitigating circumstances (as to which reference may also be made, for example, to *How v Tesco Stores,* 1974, *Jones v London Co-operative Society,* 1975, and *Davis v Lancashire Health Authority,* 1976). But the tribunal upheld the dismissal in this case because the doctor's position was essentially one of responsibility and trust and she had revealed herself as a 'bad risk' by this incident. It was quite immaterial that the theft was from a shop and not the hospital. The fact that other penalties had been or might be imposed was her misfortune, but was inevitable in the circumstances. The employer was then entitled in the absence of mitigation to protect himself and those in his care as he thought best, just as the GMC was entitled to lay down and secure obedience to professional standards.

As far as violence is concerned, we have discussed above the case of Mr Amar-Ojok, but one or two other aspects of the problem might perhaps be mentioned. The tribunals have no doubt that fighting at work is generally unacceptable conduct and is likely to warrant dismissal, but still insist that the circumstances of each case must determine liability. Bullying, for example, is obviously more objectionable than a punch or push in self-defence or under provocation *(Wilson v Racher,* 1974). A minor 'scrap' which hurts no one need not necessarily end in dismissal *(Meyer v Rogers,*

1978). If it is impossible to find out who is to blame for a more violent incident it may still not be right to dismiss both. One man may have a record of misconduct and the other may have behaved satisfactorily throughout his service. The latter should be given credit for his good character (*Sherrier v Ford Motor Co,* 1976).

If an employee is to be prosecuted it is clearly preferable for the employer to await the outcome of the tribunal before deciding whether to dismiss. In a case of any consequence he should meanwhile suspend the employee on full pay (which avoids any prejudgment of the issue). The problem might then of course arise that the employee has to be paid for months and months of inactivity while waiting for the trial, and possibly for longer still, pending the outcome of his appeal. The tribunals have said in response that if the employee is caught red-handed or if there are 'solid, sensible grounds for suspicion' dismissal may be justified straight away—assuming, as we have said, that the charge is not a trivial one and that the employee has been interviewed and given the opportunity to state his case (*Jones v Douglas Construction Ltd,* 1975; *Jones v London Co-operative Society Ltd,* above; *Harris v Harrison,* 1978). If the dismissed employee is afterwards acquitted by the criminal court the employer does not thereupon become liable for unfair dismissal, since all that can be asked of him is that he acts fairly and reasonably in the light of information available to him at the time (*Refund Rentals v McDermott,* 1977; *British Home Stores v Birchell,* 1978). Obviously a dismissal must stand or fall on its own merits at the time, and other events or incidents which only subsequently come to the employer's knowledge cannot be invoked to justify it (*Devis and Sons v Atkins,* 1977).

Among miscellaneous other forms of misconduct which have been held to justify dismissal are those illustrated in *Atkin v Enfield Hospital Management Committee,* 1975—refusal to wear correct uniform; *Robertshaw v Bradford Area Health Authority,* 1976—private use of the AHA's vehicle after clocking on and when

known to be forbidden; *Brady v Leeds Area Health Authority,* above—drunkenness on duty; *Jack v Leeds Area Health Authority,* 1978—drunkenness off duty but on premises; *Khanum v Mid Glamorgan Area Health Authority,* 1978—a nurse's misappropriation of drugs. Assaults on patients have the same effect, as does other degrading treatment of mental patients *(Retarded Children's Aid Society v Day,* above). An ambulanceman who took a patient to hospital and then returned to the patient's home to make unwelcome advances to his daughter was held rightly dismissed for gross breach of trust without, it should be noted, any prior warning or the need for reference to any particular express rule of employment *(Margerison v Yorkshire Regional Health Authority,* 1976).

It is probably true to say that since higher and more immediate responsibilities attach to medical and nursing work than to most other occupations, a generally higher standard of discipline and conduct may be insisted upon. So, where a nurse abused her senior officer in a disagreement over duties and then walked off the ward she was fairly dismissed *(Stewart v Essex Area Health Authority,* 1975). The standard of discipline in a hospital, said the tribunal, 'must be much higher than that expected of a worker in a factory . . . The conduct of the applicant in deserting her post and . . . towards her superiors destroyed we think permanently the trust, confidence and respect which must exist between those in authority and their staff if an institution such as a hospital is to be efficiently run . . . *There is no rule of law which says that a warning must always be given'* [my italics]. On the other hand, where an experienced and competent nurse near to retiring age became awkward and uncooperative because of a personality conflict with a new matron, it was held that in view of her past service she should have been moved, not sacked. The tribunal commented critically on the 'great lack of flexibility' in the service which made it difficult to post the nurse outside her district, but thought that the alternative at her age was retirement on full pay, subject to her being available for temporary work

elsewhere if so required. Since neither choice was offered, her dismissal was unfair, but her compensation was cut by half because of her own total refusal to take part in an inquiry *(Norfolk v Essex Area Health Authority,* 1975).

Incapacity

The other main reason for dismissal considered in this chapter is that of incapacity, an expression covering many widely different types of behaviour ranging from sheer incompetence to absence because of illness or injury. Incompetence is not just a matter of making a mistake. The law does not demand perfection. But in some occupations, such as medicine and nursing, one mistake may unfortunately be too many, if and in so far as it suggests an unacceptably high risk to the employer or the public at large *(Taylor v Alidair Ltd,* 1978). No selection procedure is foolproof, and employees may be taken on who prove their unsuitability almost immediately. If they do so within their first 26 weeks they are usually only entitled to one week's notice and cannot claim protection against unfair dismissal.* It is important to recognise that the first six months are indeed a probationary period, and if need be reviews or test procedures should be instituted permitting action to be taken well within that time.* If unfitness only appears later, say because of a student nurse's inability to pass examinations, dismissal must eventually be justified, but in a case like this will be hedged about by the need for interviews, counselling, second chances and the like. These are not legal requirements as such but merely aspects of the basic rules of fairness which are particularly relevant for trainees and young people generally *(Post Office v Mughal,* 1977; *Sandhu v Department of Education and Science,* 1978). The tribunal will not challenge the examining body's decision or substitute its own view of the employee's ability unless there is evidence of bad faith or irregularity in the

* The probationary period becomes 52 weeks under Conservative government proposals put forward in 1979.

conduct of the examination (*Witty v Northamptonshire Area Health Authority,* 1976). Another example of incapacity is that brought about by promoting a previously satisfactory employee beyond his abilities. Dismissal in such a case is very likely to be the employer's fault, either because of his misjudgment or from his failure to provide further training or support.

One last but particularly vexed question is that of employers' rights when employees are incapacitated through sickness or injury. The problem is equally difficult to resolve whether illness or disability leads to prolonged absence or losses of a day or two at a time over and over again. While we can say that sick or injured employees must receive every consideration, particularly if they have given long service, we cannot be at all sure what that requires in any given case. No single rule can be laid down to cover each and every employee. All we can advise—in very general terms—is that the employer must show he has taken due account of certain common-sense factors and behaved as a reasonable employer might be expected to in the light of them. These factors are notably the length or frequency of absence, the nature of the illness or injury, its likely development, and the employee's position in the enterprise—important because of the way his or her absence affects the workload. On the one hand, it may be possible to spread the load or, on the other, people may be overburdened or the work may simply have come to a standstill because the absent employee is a key figure. In any case, no employee is entitled to be absent indefinitely, and if his or her return is clearly unlikely he or she can properly be dismissed. But in the interests of good industrial relations such employees should be put in a 'holding department', that is, promised re-employment if possible should they recover. It is essential also to prove that the employee has been 'kept posted'. He cannot be warned that he must get better, but he must be informed of the employer's problems and intentions before the final decision is taken (*Egg Stores v Leibovici,* 1976). These points all stress the need for medical guidance, which in case of doubt might reason-

ably include the obtaining of a second opinion *(East Lindsey District Council v Daubney,* 1977).

A case conveniently illustrating the *wrong* approach to sickness is *Hardwick v Leeds Area Health Authority,* 1975. Here a nurse's recurrent absences through illness exhausted the period covered by her sick pay scheme, and she was dismissed immediately after the last 'day of grace' allowed by the scheme. Her dismissal was held unfair because none of the specific questions listed above was asked about her. Again, although employees are usually obliged to provide sick notes, they cannot be dismissed for any and every failure to do so. If, after recovery, an employee is fit only for lighter work the employer should try to keep him on in that capacity, but is not bound to create a new job specially for him *(Merseyside and North Wales Electricity Board v Taylor,* 1975; *McKenzie v Sheffield Area Health Authority,* 1978). All these various examples indicate the importance of some form of occupational health scheme or system which can keep check on employees' absences and discuss and, if possible, treat their causes. If lengthy or repeated absence is condoned without inquiry the employer may find it more and more difficult to say that such absence cannot be tolerated, and he may eventually and quite unnecessarily become liable for unfair dismissal or redundancy.

Conclusion

Although for the sake of brevity we have considered here only two of the five possible headings under which dismissal might be justified, it is hoped that these few examples and extracts will provide a little guidance for employers generally and NHS management in particular. Expressly or implicitly they tell us of the urgent need to lay down reasonably clear and acceptable standards of behaviour and to work out and enforce straightforward disciplinary procedures. These procedures should be wide enough in application to avoid discrepancies in treatment

which can be interpreted as inequality or injustice. This is, of course, easier said than done, and may seem very difficult to reconcile with the still more fundamental principle that each case must be dealt with on its own merits. But the contradiction can be resolved if and in so far as treatment on merit is indeed shown to be the basic rule. If it is always applied, then cases which may seem similar may properly be treated in different ways. The cases also remind us of the need to say who has the authority to take the various steps in the procedure, and to give prompt and fair rights of appeal. All this information must be communicated both to managers and to employees, with such training for each as may be appropriate. The procedures should preferably be developed in full consultation with the unions. These conclusions again are easily stated but may take months or, more probably, years to put into practice. Ultimately, however, they are only matters of common sense and not, as employers may sometimes be tempted to think, the byproducts of an unfair or unintelligible legal system.

Case references

Some of the cases noted in this chapter are discussed at greater length in issues of the *Health Services Manpower Review* and are indicated by *HSMR,* in addition to the case number and year by which the judgment can be traced through the Central Office of Industrial Tribunals. The author wishes to express his appreciation to those health authorities which have kindly supplied copies of these reports. Certain cases are also to be found fully reported in various series of law reports, notably the *Industrial Court Reports (ICR), Industrial Relations Law Reports (IRLR),* and *Knights Industrial Reports (KIR).* Some have also been reported in *The Times* newspaper.

Air Canada v Lee (1978) *IRLR* 392
Amar-Ojok v Surrey Area Health Authority, 5205/75/D

Atkin v Enfield Hospital Management Committee (1975), *IRLR* 217
Baksi v Liverpool Area Health Authority, L 10358/77; on appeal (1977), *The Times,* 10 December 1977; *HSMR,* August 1977 and February 1978
Bloomfield v Trust House Forte Ltd (1975), *IRLR* 36
Brady v Leeds Area Health Authority, 40595/76; *HSMR,* November 1977
Briggs v Imperial Chemical Industries (1968), 5 *KIR* 492
British Home Stores v Birchell (1978), *IRLR* 379
British Labour Pump Co v Byrne (1979), *ICR* 347
British Leyland v McQuilken (1978), *IRLR* 245
Brown v Hall Advertising (1978), *IRLR* 246
Bullock v Merseyside County Council (1978), *The Times,* 9 November 1978
Davis v Lancashire Area Health Authority, 9708/76
Devis and Sons v Atkins (1977), *IRLR* 315
Dolby v British Hovercraft Corporation Ltd (1972), *IRLR* 113
East Lindsey District Council v Daubney (1977), *IRLR* 181
Egg Stores v Leibovici (1976), *IRLR* 376
Ellis v Inner London Education Authority (1978), *The Times,* 7 November 1978
Futty v Brekkes Ltd (1974), *IRLR* 130
Gannon v Firth (1976), *IRLR* 415
Gregory v Liverpool Area Health Authority, 10164/75
Hardwick v Leeds Area Health Authority (1975), *IRLR* 310
Harris v Harrison (1978), *IRLR* 382
How v Tesco Stores (1974), *IRLR* 194
Huxtable v Devon Area Health Authority, 6837/76; *HSMR,* October 1976
Jack v Leeds Area Health Authority, 19707/78; *HSMR,* February 1979
Jones v Douglas Construction Ltd (1975), *IRLR* 175
Jones v London Co-operative Society Ltd (1975), *IRLR* 110
Khanum v Mid Glamorgan Area Health Authority (1978), *IRLR* 215; *HSMR,* August 1978

Lowndes v Specialist Heavy Engineering Co (1976), *IRLR* 246
McKenzie v Sheffield Area Health Authority, 23588/78
Margerison v Yorkshire Regional Health Authority, 12364/76; *HSMR,* February 1977
Marley Tile Co v Shaw (1978), *IRLR* 238
Meridian v Gomersall (1977), *IRLR* 425
Merseyside and North Wales Electricity Board v Taylor (1975), *ICR* 185
Meyer v Rogers (1978), *IRLR* 162
Norfolk v Essex Area Health Authority, 18606A/75; *HMSR,* May 1977
Post Office v Mughal (1977), *IRLR* 178
Redbridge London Borough Council v Fishman (1978), *IRLR* 69
Refund Rentals v McDermott (1977), *IRLR* 59
Retarded Children's Aid Society v Day (1978), *ICR* 437
Riley v Kirklees Area Health Authority, 24010/77; *HMSR,* February 1978
Robertshaw v Bradford Area Health Authority, 43011/76
Sandhu v Department of Education and Science (1978), *IRLR* 208
Shan v Croydon Area Health Authority, 13630/75/D; *HSMR,* May 1977
Sherrier v Ford Motor Co (1976), *IRLR* 141
South v Leeds Area Health Authority, 7853/78; *HSMR,* November 1978
Stewart v Essex Area Health Authority, 14521/75
Stewart v Western SMT Co (1978), *IRLR* 553
Taylor v Alidair Ltd (1978), *IRLR* 82
Toke v South West Thames Regional Health Authority, 4858/77/D; *HSMR,* May 1978
Wilson v Racher (1974), *IRLR* 114
Witty v Northamptonshire Area Health Authority, 24838/76
Wood v Leeds Area Health Authority (1974), *ICR* 535

3
Disputes procedures and grievance procedures

CHRISTOPHER WEST and TREVOR GOODMAN

A grievance procedure aims to provide rules for the conciliation of disputes. The older name of a 'conciliation procedure' perhaps captured the spirit better than the more modern term. It has to be distinguished from a disciplinary procedure, both in the range of issues it covers and in the way that it approaches them. A disciplinary procedure deals with questions of conduct or misconduct by the individual at work. The standard of judgment can be set by the written particulars or job specification. Alternatively, the standard can be set by the employee's normal duties under common law. The focus is, however, on the contract of employment, and the procedure for handling issues is tightly regulated by a small body of law—that relating to dismissals.

No such compact body of law provides a setting for the handling of grievances. Nor are the issues to be brought up limited. In fact, just about the only points excluded are those which have to be covered by a disciplinary procedure. Some grievances can arise from differing interpretations of collective agreements. Others again may come from the demand for revision of collective agreements. There may also be difficulties about local custom and practice. The range of issues covered is normally summarised through the distinction, made in the code of practice[38], between procedures for handling individual grievances and those for handling collective disputes. Collective disputes are then further divided into disputes of right, which relate to the application of agree-

ments, and disputes of interest which relate to claims by employees or proposals by management about terms and conditions of employment.

A grievance procedure also grows out of a part of the relationship between management and trade unions rather different from that of a disciplinary procedure. A disciplinary procedure is about the exercise of managerial prerogative, even if tightly constrained by law. Unions are involved in so far as they represent members, and their rights to information grow out of this representation. In practice, there may be an element of negotiation, but there is no expectation that collective agreements will be the outcome. Grievance procedures often deal with issues in which managerial prerogative is much less clear. They aim to provide a forum for negotiation and bargaining in which there is a much greater equality of standing.

Why should the NHS have grievance procedures? The first reason is that it is the law. It is now the duty, implied in the written particulars, of employers apart from the very small employers to have such procedures. Where the NHS does not have them, it is falling below the minimum standards set by the code of practice.[38] The second reason is that of necessity. The NHS has seen a great increase in local trade union membership and in shop steward activity. It has been going through major changes in organisation and facing new pressures from changes in service. It has also seen the negotiation of more agreements, ones which are more complex and which can involve a greater degree of local discretion. The movement towards incentive schemes for ancillary workers has provided much more scope for local negotiation. All these changes imply a greater range of issues which might have to be handled locally through a grievance procedure. Thus, the need for local procedures has grown: but so have the difficulties of their effective operation. Increased union activity has also brought increased interunion competition, which hardly creates an atmosphere favourable to successful conciliation. There is more discretion in

local agreements but, in general, the system of pay bargaining is still highly centralised. The fears of management are still those of leap-frog claims and of setting precedents. Those, too, will encourage centralisation. Can procedures aimed at local settlement of disputes work effectively where power and authority are still so highly centralised? Even with well established procedures, such as those in the engineering industry, there has been an increasing inability to resolve issues locally and more resort to the later stages of the procedure.

Current law

The Industrial Relations Act 1971[67], Code of Practice[38] and the Contracts of Employment Act 1972[60] refer to the need for effective arrangements for settling grievances and disputes. The code of practice, which conceded that its recommendations might be modified in small organisations (barely applicable to health authorities), emphasised management responsibility to 'maintain jointly with trade unions effective arrangements for negotiation, consultation and communication, and for settling grievances and disputes'. The code imposed no legal obligations in itself. However, Section 4 of the Industrial Relations Act 1971 required any relevant provisions to be taken into account in proceedings under the Act before a national industrial relations court or an industrial tribunal. Thus, an employing authority appearing before an industrial tribunal on a matter relating to an employee's grievance or disciplinary matter would be in a very weak position if no adequate procedure had been approved by the authority concerned at the time the grievance or disciplinary question arose. Similarly, an employer who, as a last resort in a dispute, involved either ACAS or some other recognised arbitration service would find his position weakened if no disputes procedure had been established.

The Contracts of Employment Act 1972[60] and the Employment Protection Act 1975[62] require employers to provide written information.

> '(i) Specifying any disciplinary rules (other than those relating to health and safety at work) which apply to the employee or refer to a document, reasonably accessible to the employee, which specifies the rules;
> '(ii) Specify by description or name the person to whom the employee can apply and the manner in which such applications should be made;
> '(a) if he is dissatisfied with any disciplinary decision relating to him, or
> '(b) for the purpose of seeking redress of any grievance relating to his employment; and
> '(iii) Where there are further steps which follow from an application under (ii)(a) or (ii)(b), explain those steps or refer to a document which explains them and is reasonably accessible to the employee.'[37]

Thus, with effect from June 1976, all employees, and, within 13 weeks of commencement of employment, all new employees, must be told of grievance, disciplinary and appeal procedures applying within each health authority.

It must be of concern that seven years after the Industrial Relations Act 1971 and the publication of the Industrial Relations Code of Practice, only a limited number of health authorities had a disputes procedure. A DHSS letter*, with an accompanying paper, showed that seven of the 14 RHAs, 13 of the 35 single-district AHAs, 27 of the 55 multidistrict areas and 68 of 168 health districts had procedures. Thus, half the RHAs, almost a third of the single-district areas, half the multidistrict areas and two-thirds of districts did not have disputes procedures. Those

* DHSS letter N/149/75, 19 October 1978.

that had, often dealt with individual grievances and disputes through the same procedure. What is the difference? As we have suggested, there is no simple answer. Some view a disputes procedure simply as a type of bargaining.[89] Others point to the origins of 'conciliation procedures or procedures for avoiding disputes'.[15]

The reality of a grievance procedure and a disputes procedure is that they are many things: 'a face saving device, a power instrument for making deals; a judicial system; or a laboratory for developing negotiating issues, leadership skills and political alliances'.[96] However, in attempting a peaceful and constructive resolution of differences at work, grievance and disputes procedures are safety valves, a means of recognising the negotiating rights of the employee and his organisation, and a means by which external conciliation can be brought to bear if necessary. One author expressed the position succinctly.

> '. . . procedures both give the workers an opportunity to express themselves, and also require the directors of their work lives to hear and consider their problems seriously.'[91]

The description of procedures for handling grievances and disputes in the code of practice[38] is very simple. Observing that all employees have the right to seek redress for grievances, the code recommends that the main aim of the procedure should be to settle the grievance fairly and as near as possible to the point of origin. The procedure should be negotiated formally with the employee's representatives; be simple, quick and be in writing. It should provide for the grievance to be first discussed between employee and immediate supervisor; for the right of appeal; at further stages for the right of the employee to be accompanied by a representative.

The code further recommends that where there are separate procedures for dealing with grievances and with disputes, the

procedures should be linked so that a grievance can be dealt with under the collective disputes procedure, particularly if it has not been resolved at an early stage in the procedure and has itself become the subject of a dispute. The disputes procedure is described in the same simple terms.

A blueprint for a disputes procedure applicable to all situations is not practicable but fundamental principles are worth exploring. The procedure should be agreed, and in writing, so that all managers, employees and unions know how it operates. It should provide for disputed matters to be referred to it and might also include examples of the types of disputes anticipated. It should

> 'provide that *all* disputes should go through the defined procedure; should identify the level at which an issue should be raised; express the intention to settle disputes close to their point of origin; lay down time limits for each stage of the procedure (including details of reference to higher management).' [38]

Preservation of the *status quo* is likely to be a key negotiating area in reaching a procedural agreement. Certainly the TUC regards a provision of this sort as fundamental if disputes procedures are to operate fairly, but a shared interpretation on this aspect is essential. The employer's and employee's interpretation of *status quo* may be quite different, so whose prevails? It is unlikely that any differences of opinion could be resolved in the middle of a dispute, so clarity is essential if a dispute is to be avoided on this issue. Additionally, the procedure may provide for external mediation, conciliation or arbitration, and should exclude other action being taken by unions or management whilst the dispute procedure operates.

Procedures in Wiltshire

Until recently, disputes procedures have emerged from the initiative of individual health authorities. The negotiated grievance/disputes procedure that applies in Wiltshire is considered to be fairly typical and has the following features.

1 It embraces all staff.

2 It provides a maximum of four stages.

3 It prescribes time limits (in days) for resolution or referral to a higher authority.

4 It culminates with the chief officer of the department concerned.

5 It allows for collective agreements to be dealt with in the same manner.

Exceptions are disputes procedures negotiated within the General Whitley Council for dealing with grievances arising from disagreements relating to Whitley matters, appeals against disciplinary action and disputes machinery set up under the National Health Service Reorganisation Act 1973.[69]

In addition, we have a fresh initiative on non-Whitley matters from the DHSS proposed regional disputes panels. These proposals provide for

1 a review of existing disputes procedures

2 early member involvement

3 referral to a regional disputes panel where resolution by the health authority is not possible.

Lack of information makes it difficult to examine the effectiveness of procedures. However, some conclusions can be drawn from press reporting and from looking at some facts which the DHSS has issued. This covers the causes of disputes and their outcome in the three years from 1976 to 1978.

Closure of hospitals or other services

Disciplinary matters

National pay policy

Local interpretations of agreements

Manning levels

Procedural defects in industrial relations

Style of managerial decision-taking

Interunion

Political issues (for example, pay beds)

Alleged assaults

Control of incentive bonus schemes

Changes in practice at work

The 79 cases in which collective conciliation action was taken in 1977 and up to July 1978 are analysed as follows.

Nature of dispute	*1977*	*1978* (end July)
Pay and grading matters	8	8
Manning rotas, duties and hours of work	13	7
Recruitment	3	2
Other terms and conditions	4	1
Recognition, demarcation, and other union matters	6	4
Redundancy	3	—
Dismissal and discipline	7	6
Others	3	4
	47	32

A further analysis of why these could not be dealt with in the NHS was made.

	1977	*1978*
No appropriate procedure	7	10
Procedure exhausted	22	8
Procedure broken down	16	11
Procedure not used for other reasons	2	2
	47	32

Whereas this information cannot be regarded as comprehensive, it raises several interesting points. First, disputes can and do arise on almost any issue, particularly locally. Second, it emphasises the need for adequate machinery to resolve the issues locally. Although a jointly agreed disputes procedure will not guarantee that all disputes will be resolved, or that there will be no recourse

numbers of beds, getting more staff and increasing participation through a new local consultative committee. There is little doubt that the length of the negotiations far exceeded what would normally be acceptable, but in this case it showed the commitment of both sides to a solution. The role of the AHA played a very important part in the negotiations, as did the length of the negotiations and the additional time available for them.

Other cases resolved without industrial action included the reinstatement on appeal of an officer dismissed for alleged theft where members of staff refused to have the officer return; the relocating of finance staff to a central office; staff reaction in support of a senior member of staff who had resigned on a matter of principle; and the centralisation of an ambulance control.

Case 4 In this case, AHA members were not involved but management chose rather to test out staff resolve. The case involved an area stores and the correction of a bonus scheme. Local consultation to reach agreement on some relatively minor changes had failed. Management declared that the changes would operate and the men went on strike. The strike lasted 11 days and negotiations, which involved full-time officers, continued daily. No agreement was reached but management gained in confidence. Full publicity had been given to the circumstances of the dispute and other unions did not support the case. Managerial staff continued to issue emergency supplies and other staff groups openly denied support. Negotiations finally concluded a settlement which covered amendments to the bonus scheme.

Case 5 In a case involving a collective dispute, an inadequacy in the grievance procedure was perceived. The dispute was a problem which all health authorities face—the need to revise a slack bonus scheme. In a laundry a bonus scheme had been in operation for seven years. About a year and a half before the dispute, a management services team started to review the scheme. Just over six months later, the team submitted its report to

management. Inevitably, there had been a change in practices and 'drift' in the scheme. If the team's review and recommendation were accepted, some employees would lose bonus. Protracted negotiations ensued, with the full-time trade union official seeming to stall negotiations wherever possible. This was seen by management as an attempt to delay the reduction in bonus earnings that some members would suffer if the recommendation were implemented. When management began to take a firm line by giving notice on the scheme, the employees went on strike for one day. The accompanying press publicity made three simple points.

1 The number of staff working in the laundry had been reduced by ten over the preceding seven years.

2 The laundry had increased its output over the same period.

3 Management was now proposing to cut the workers' wages by £6.00 a week.

Regardless of the effect these points had on the impartial reader, the absence of a clear and convincing management view undoubtedly hardened the staff's view that they had a just grievance.

Further trouble followed and by the time negotiations began again the management's position was weak. Hospitals were low on linen supplies and the staff had broadened their demands to include other issues. There was no procedural safety valve (for example, a panel of AHA members) and, thus, the district management team (DMT) had to get the best settlement it could without, if possible, conceding any points of principle which might affect other bonus reviews in the district or elsewhere in the area.

The DMT was surprised by the speed with which the dispute began to threaten services. A disputes procedure different in two respects might have helped management to resolve the situation more satisfactorily. First, the inclusion of a *'status quo'* clause would

to industrial action, a jointly agreed procedure will produce a built-in motivation by both management and unions to make it operate. Third, far too many disputes are being referred too quickly to ACAS, thus destroying any possibility of settlement near to the point of dispute.

The figures suggest two important conclusions. First, there is a high proportion of authorities which are not meeting their obligation under the law and the code of practice. Second, some procedures are working badly. Thus, many cases referred to ACAS were those in which procedure was considered to be exhausted or had broken down, rather than cases in which there was no procedure at all.

Case studies

We turn now to a second type of evidence, that from case studies of particular disputes, to see if they can help to show us how procedures operate within the NHS. In most cases, the procedures used are the disciplinary procedure and the grievance procedure relating to individual grievances. Two studies illustrate the importance of having an effective procedure, and of speed in its use.

Case 1 A woman complained to the Commission for Racial Equality that she had been discriminated against in that she had not been promoted, although less qualified and less experienced women in the same department had been. The Commission approached the AHA. Management sought to argue that the woman had not used the internal grievance procedure or raised the matter with her supervisor, and asked that the matter be dealt with by using the authority's own procedure. The Commission agreed. The procedure was used and the employee subsequently withdrew her complaint.

Case 2 A member of staff was informed when interviewed for the job that she would receive incremental credit for previous experience. Her first three pay packets did not include these increments. The woman complained but no positive action was taken. The accredited staff representative registered a matter of dispute and threatened industrial action in support—the matter was quickly settled.

A third case study illustrates how even the most well intentioned actions can result in dispute if full consideration is not given to all facets of a proposal and full consultations are not undertaken.

Case 3 In an earlier dispute, the involvement of members helped to produce a satisfactory solution. The dispute was a large psychiatric hospital where staff worked in very difficult conditions. Staffing levels, due mainly to recruitment difficulties, were particularly poor and patients were over-crowded. After some expressions of discontent, staff passed a resolution of no confidence in management and demanded the removal of a senior officer, threatening industrial action as an alternative.

Faced with this impossible demand, the district management team sought a local solution. The staff imposed a time limit. Local negotiations failed to change attitudes, and difficulties experienced by both management and staff in contacting the full-time officers involved made for a protracted period of frustration and unrest. Finally, the matter was referred to the AHA. Formal negotiations between members of the authority, full-time officers and staff representatives allowed more time for exploring alternatives. No doubt, attention by the AHA also convinced some members of the staff that both the authority and also the union were at last taking their claims seriously. Speculation about a public inquiry—a choice not generally supported by or in the best interests of either side—also increased pressure for a settlement. After some weeks, a subcommittee of the authority met all concerned and an agreement was reached involving reductions in

have discouraged staff from taking industrial action; second, the availability, as a penultimate resort, of the use of a small panel of experienced authority members would have given the DMT more support in the negotiation and more standing in dealing with the financial or policy implications of a settlement.

Case 6 This case study shows that even where a hospital management committee (HMC) had had a disputes and grievance procedure since 1972, other factors could prevent its successful application. The hospital authority in question had employed a firm of management consultants to devise bonus schemes for all ancillary staff over a relatively short period of time. The schemes were not well installed and in themselves led to friction. This source of conflict was magnified by the very strong inter-union rivalry between the branches of COHSE, NUPE and, latterly, the TGWU in the group. The industrial action taken by staff in the ancillary staff dispute of 1972–3 was relatively mild, but in the industrial action associated with the Halsbury report[47] the action taken, by COHSE in particular, was very strong.

Shortly after the industrial action taken in connection with the Halsbury report ended, a further dispute arose in the main hospital. Two members of the engineering staff were found to have fraudulently claimed bonus for items of work they had not done. The two men admitted their guilt; their union, the Electrical Engineers' and Plumbers' Trade Union (EEPTU) acknowledged their guilt. However, the men concerned, all of their colleagues in the works department and their union would not accept that the two men should be dismissed. Through the disputes procedure, the problem quickly reached the DMT who could not accept a strike by all the maintenance staff. The two managers negotiating with the staff and union were given a remit of reaching a settlement which avoided industrial action. Whilst the terms of the settlement may seem unusual, they were the best that could be achieved when both staff and their union were adamant that one course of action—dismissal—was unacceptable. The terms of settlement were

1 The trade union would follow normal grievance procedure in any future incidents.

2 The two men would receive a severe reprimand and agreed to contribute the equivalent of one week's pay to the endowment funds.

3 The disciplinary procedure would be clarified to indicate that any falsification of records leading to payment of salaries or wages would be the subject of instant dismissal.

4 The men agreed to continue to cooperate with the review of the incentive scheme.

Choices for the future

So what are the choices facing the service? What conclusion can we draw from the information we have? The first would seem to us to be a speedy and effective review of procedures by health authorities, or to establish procedures in areas where there are none, to ensure a minimum compliance with the law. Many procedures are operating effectively; our case studies reveal but a few of thousands of unreported examples where procedures have worked. But many authorities still fall short of the minimum standard required. Also, procedures must be known and available to all who require to use them, and they must be applied consistently. The speed and ease with which small individual grievances can achieve the status of large and time-consuming collective disputes emphasise the need for prompt and proper action. If the system works, confidence in it will be assured and the procedure used more readily.

Next, we must avoid the fallacy that the mere existence of a disputes procedure will totally remedy the problem. This is not so. Disputes procedures will not guarantee settlements in all cases.

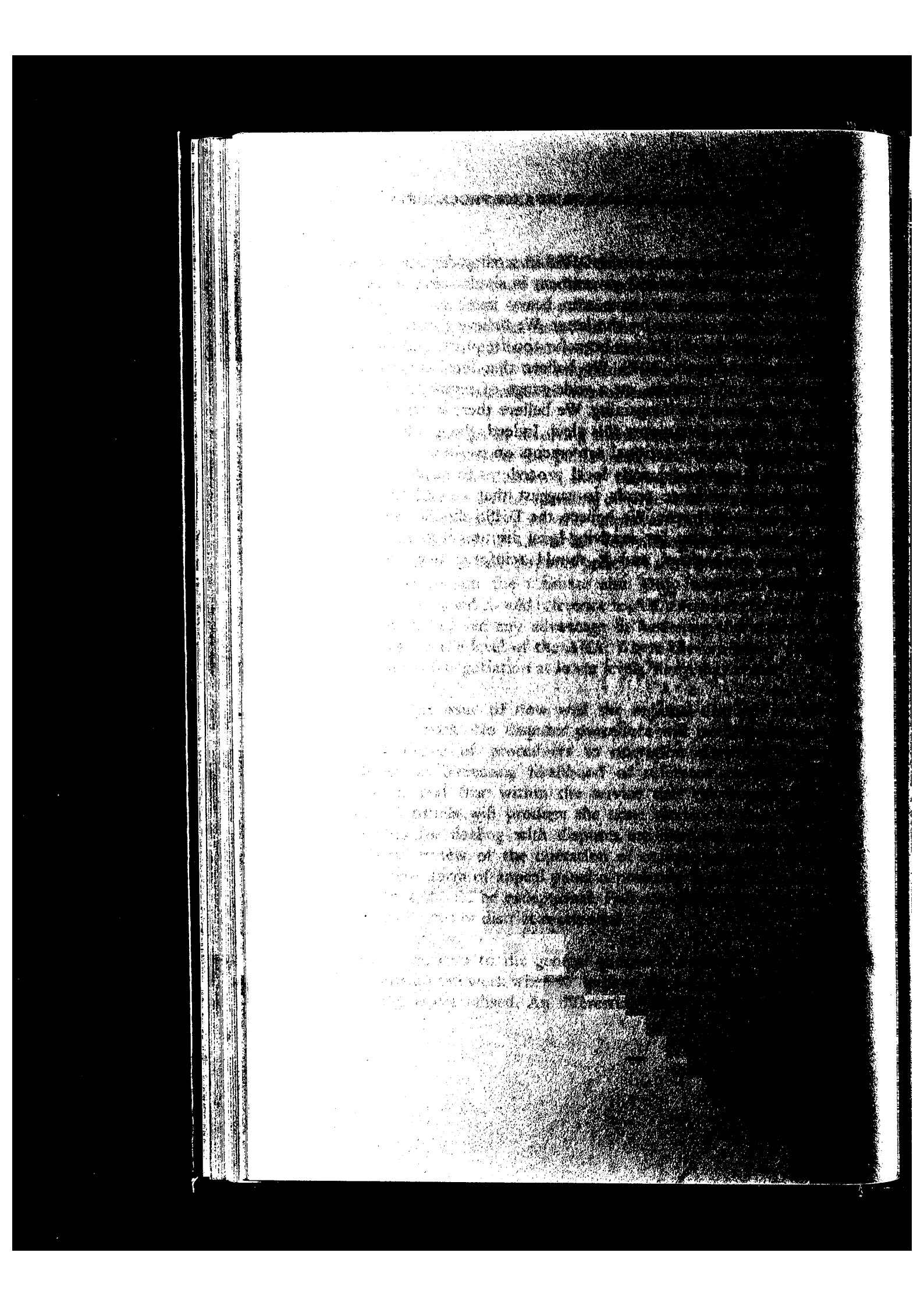
Inter-union rivalry, unofficial actions and the pursuit of national staff policies will ensure conflict, and industrial action will sometimes be taken. But sound policies and commitment to their use locally will ensure that some of the problems which result in industrial action will be resolved peaceably, some will be removed and some contained. We emphasise that this is not the total answer to all industrial relations problems.

We see advantages in involving members of the AHA. Members are there to represent the public, and their own careers do not depend upon the decisions they take. Local agreements often involve decisions on the spending of large sums of money, and the members, corporately, are the employer. But their involvement must not become a substitute for managerial decision-taking. The keystone to any disputes policy is settlement at source, and this must remain the ultimate aim. Only when all managerial efforts have failed should reference to AHA members be necessary. Neither do we see any advantage in hastening the escalation of a dispute to the level of the AHA. Where the procedure does not allow for full negotiation at lower levels, harm may result.

Next is the issue of how well the regional disputes panels are likely to work. No disputes procedure will resolve all disputes, and evidence of procedures in operation elsewhere tends to indicate an increasing likelihood of reference to higher level. There is real fear within the service that the introduction of regional panels will produce the same tendency. More effective remedies for dealing with disputes are likely to emerge from a stringent review of the operation of current procedures. In the end, some form of appeal panel is probably inevitable, but reference to it should be exceptional. Full opportunity for settlement within the area or district is essential.

Finally, we turn to the general question of whether or not local conciliation can work when so much of the bargaining, particularly on pay, is centralised. An interesting comparison is drawn here

between the involvement of the DHSS in settling disputes in the NHS and the role of central government in similar circumstances in local government. We have seen heavy involvement by the former and little or none by the latter. We believe that the direct involvement of the DHSS has been far too frequent, and far too often expected by the NHS. We believe that local conciliation is necessary, and possible, on a wide range of important issues, within centralised pay bargaining. We believe there is evidence in the health service to support this view. Indeed, the gradual move towards more flexible national agreements on pay and terms and conditions of service demands local procedures to resolve differences. Recent evidence tends to suggest that central thinking might be quite different. We believe the DHSS should recognise that the responsibility for resolving local disputes rests primarily with health authorities, and it should reinforce that view at every opportunity.



4
Consultation and negotiation

ROGER DYSON

This chapter is concerned with the formal processes of consultation and negotiation at all levels in the NHS up to and including regional health authorities. It outlines present arrangements, explains and analyses current initiatives and considers their long-term implications for the service. The chapter is limited to the formal, structured relationships between management and staff in consulting and negotiating. It is not concerned with the informal and often day-to-day consultation between managers and their immediate staff, or with any of the more sophisticated developments that are centred on that day-to-day relationship, such as staff appraisal and organisation development.

Consultation and negotiation are two distinct processes. Guest and Fatchett have defined formal joint consultation as '. . . any method of establishing two-way communications between management and workers in addition to those provided by normal day-to-day contact . . .'.[83] They see joint consultation as an '. . . integrative . . . activity for the purpose of . . . enhancing the achievement of increased productivity by involving the workers through their representatives in the planning of the production process, as providing a channel of communication thereby lessening mistrust and suspicion and as ensuring for the workers a voice in the management of the enterprise'.[83] A characteristic of formal joint consultation thus defined is that it provides only a limited opportunity for representatives to be involved in real matters of concern

to their members. By contrast, the Donovan commission saw negotiation as a means of reaching agreement upon '. . . the pay and conditions of work settled between trade unions on the one hand and an employer or association of employers on the other'.[107]

Thus, by potentially encompassing all aspects of terms and conditions of employment, negotiation is seen as less limiting to union stewards than joint consultation and, according to Lord McCarthy, joint consultation in the strict sense cannot survive the development of effective workplace organisation.[95]

It is easier to distinguish between the two processes in theory than in practice. If management outlines a problem or explains a proposed initiative, listens to the views of staff side representatives and then withdraws to make a final decision, that decision is clearly management's decision and management's responsibility. It may or may not adjust its thinking to reflect opinions and proposals of the staff. Such a procedure can be described as joint consultation. Where management has to continue in discussions with the staff representatives until the two sides reach an agreement about what will be done, management is *negotiating*. The two sides are reaching a joint agreement that is likely to be jointly signed and will be their joint responsibility.

In reality, it is possible for one practice to shade gradually into the other. Management representatives may still withdraw from the meeting before making a decision, but when they leave it is clear what their action will be, and they recognise that they cannot ignore a particular requirement of the staff. Another practice nearer to real negotiation is when management and staff representatives reach a clear informal understanding about what action will be taken, but no formal agreement is drawn up and the joint understanding simply comes into effect. It is in this way that issues which were once strictly consultative come within the scope of negotiation, whilst on a different occasion con-

sultation might begin upon issues which were previously regarded as exclusively a managerial prerogative.

This shift is occurring continually in the NHS, although in the short and medium term local situations may remain static. Those managers who insist upon consultation only, can do so in relation only to their own local circumstances, and their views, although interesting, are irrelevant to managers with an extensively developed negotiating relationship with staff. Later in the chapter the immediate reasons for this change in the NHS are considered in more detail. The important point here is that this process of change makes it totally artificial to separate consultation and negotiation in considering the formal relationships between management and staff in the NHS. There may have been a time when the formal relationships between management and staff below national level were exclusively consultative. In the NHS as a whole this is not now, and will never be, so; a comprehensive study must include both.

Present provision for joint consultation

In 1950 the General Whitley Council introduced a national model constitution for joint consultative staff committees (JCSCs) to be formed in hospitals. It required all consultative committees to conform to the model constitution and expressed the view that such committees were desirable in all hospitals except those where numbers of staff were small. The functions of these committees were strictly limited. They were to promote cooperation between management and staff and to assist in preventing friction and misunderstanding within the hospital. Their opportunity to consider hospital rules was limited by the strict requirement that local arrangements should not cut across any national or regional provision. The list of functions specifically stated that decisions reached should in no way contradict with or over-ride the provisions of the Whitley Councils. Even the general function of

considering the conditions under which work is performed was somewhat limited by the examples given: staff comfort, recreation, entertainment and diet. A further specific subject listed for inclusion in the discussion of such committees was the cloakroom facilities, and in looking at the functions provided by the 1950 constitution it is easier to understand the criticism that it was all about 'tea and toilets'.

The constitution provided for representation from five categories of staff: administrative and clerical; nursing and midwifery; technical and professional; domestic; and farm, garden and artisan. These rather dated categories still exist in today's constitution. The only change has been that the original exclusion of medical staff from participation in JCSCs was removed in 1977 when hospital medical and dental staff were included as a sixth category of staff. In reality, the JCSCs of the early days included many that operated without participation from each of these categories. A further early variation in the constitution was the requirement for member-representation on the management side of the committees.[122] This was largely ignored from the earliest days and the subject is returned to later in this chapter.

An important concession to staff side organisations was that membership of the staff side of JCSCs was limited to people who were members of nationally recognised organisations. There were to be joint secretaries with joint responsibilities for the agenda, and either side was to be free to put whatever matter it wished on the agenda. However, this concession to the staff sides was limited by the requirement that all aspiring candidates for the staff side would submit themselves for election by the various grades of staff within their grouping, and members and non-members alike were allowed to vote.

One particularly interesting feature of this constitution was that it talked of the *decisions* of JCSCs being *agreed* by both parties before submission to the area or regional health authority for

approval.[122] This curious use of language could be taken to mean that joint agreements were being reached in the collective bargaining sense of that term. That was not so, however, for many JCSCs appeared to sidestep that clause and staff side members had, in any case, not been elected in a way that allowed them to commit their constituents. Whatever happened locally, the deciding body was not the JCSC but the authority, and the authority took its decision separate from the staff side representatives and was free to take other matters into consideration. Another interesting point in this constitution was that it specifically excluded any other type of formal joint activity unless it was conducted through subcommittees of the JCSC. Today such a requirement is impossible in practice and has to be widely ignored.

The number of operating JCSCs is now small and in the main they are limited to medium-sized hospitals that have experienced no major change in workload or designation within the last ten years or so. Among managers now coping with extensive developments in collective bargaining it is possible to meet with nostalgia for the quieter days of the JCSC approach, but it must be remembered that JCSCs had been recognised as a failure in the NHS by the mid-1960s. Miles and Smith undertook a survey of 197 hospital JCSCs operating in the mid-1960s and their conclusion confirmed '. . . what has long been an open secret, namely that, so far, consultation in the hospital service must, with few exceptions, be pronounced a failure'.[101] The management side of the General Whitley Council has recognised the inadequacy of the 1950 JCSC constitution and in its 1978 proposals to the staff side it argued that '. . . because of the great variety of sizes, types and location of units the General Council do not consider it practicable to prescribe any standard pattern for joint consultation machinery nor to specify in any detail the subjects which are suitable for discussion. At each level, therefore, arrangements for joint consultation should be agreed between management and staff representatives at that level, and the matters appropriate for joint

discussion should also be agreed.'* Employing authorities are being left to go their own way.

The need for alternatives

With few exceptions, NHS managers have been seeking alternatives to the JCSC constitution as a response to pressures upon them and not as their own independent initiative. The argument is still heard in the NHS that managers should take no initiatives towards the creation of formal joint machinery because this means conceding ground to the staff side and makes their own task more difficult. In those parts of the country where external pressures upon managers are few or non-existent, this approach is logically consistent but it does not help those managers who are now facing pressure and are seeking a suitable response. The variation in experience across the NHS is understandable, but one of its less fortunate consequences is that it produces sometimes sharply differing views about the future direction of the health service, which are expressed as principles unrelated to the needs of the service in particular regions, areas or districts. The reality, which the General Whitley Council may now recognise, is that each situation needs to be judged in relation to the nature and extent of the pressures if the detailed response is to be both relevant and constructive. It follows that an analysis of the pressures is essential before determining the response.

The staff of the NHS have their own views about what is desirable and appropriate, and it is therefore not surprising that the first two pressures derive from the staff. In the last decade trade union membership in the NHS has doubled: from only one-third of the staff in 1964 to two-thirds by the end of 1975. Since then, the growth of NUPE, COHSE and the Rcn has almost certainly

* Draft agreement, headed *Joint Consultation Machinery*, presented to the staff side of the General Whitley Council in July 1978.

pushed membership above two-thirds. The decision of most professional associations to become certificated independent trade unions has also given a boost to this trend and membership is still rising rapidly. In considering the most suitable methods of consultation and negotiation, management is dealing with an organised staff, whereas the 1950 constitution was developed for a service that was largely unorganised.

The second pressure from staff side has been caused by the introduction and rapid development of the role of the union steward. At the beginning of 1968 only the craft unions, the TGWU and GMWU, had stewards in NHS establishments and the total number was very small. The major NHS unions operated exclusively through branch chairmen and secretaries whose work was often more concerned with trade union activities and administration than with industrial relations. In the last decade all health service unions have introduced union stewards or representatives. The number of stewards operating in the NHS establishments has increased dramatically. Immediately before NHS reorganisation, a hospital group was considered unusual for having as many as 30 recognised stewards.[25] By 1978, figures indicated that it was not unusual for a district to have over 100 recognised stewards and some had more than 150.[26]

The arrival of the union steward in such numbers has undoubtedly had an effect on the increased recruitment to unions, and these two developments taken together have permanently changed the relationship between management and staff. Staff have opted for trade union representation and one of the unavoidable effects of this is to require increasingly formal relationships between management and staff locally. Business that used to be handled exclusively by the manager and his staff can now, if necessary, involve union stewards as representatives of staff. This, in turn, requires procedures for handling problems and for allowing managers and stewards to come together. As the role of the steward develops,

the restrictions of the old JCSC constitution become more apparent, with the resulting search for an alternative.

There are two other reasons for the pressure on managers, which are less directly concerned with the staff. Those who are unhappy about the introduction of new formal consultative and negotiating machinery question whether there are any genuine issues for negotiation at levels below the Whitley Councils. Terms and conditions of employment are determined at national level and the JCSC constitution recognised this limitation upon any local decision-making. The truth is, however, that in the last decade there has been a veritable revolution in Whitley thinking about the appropriate levels for determining terms and conditions of employment. This revolution has taken the form of the creation of a growing number of work-sensitive contracts, by which pay can vary with individual changes in hours worked.

Towards the end of the 1960s, the NHS witnessed the introduction of incentive bonus schemes which allowed ancillary staff and ambulancemen to secure bonus schemes subject to the ground rules established nationally. These schemes were established with the aid of newly appointed work study officers and brought with them many of the aspects of local bargaining so common in industries which have these types of payment schemes. The extent of the bonus, its method of calculation, workloads, staffing levels and the implications of changes in total workload all became issues for local bargaining, with management required, in the end, to interpret their arrangements within the framework of the national agreement.

At the same time, the criteria for grading ancillary staff, craftsmen and some professional and technical staff have introduced a degree of flexibility. Judgment is often very fine between one grade and another, and it is not unknown for local management to be convinced of the legitimacy of staff side claims only after a period of industrial action. Most disputes concern the choice between the

top two grades in the ancillary and craft pay structures, and since the Halsbury report[47] greater flexibility has been extended to professional staff, particularly with regard to the distinction between Senior I and II grades.

Two of the most recent shifts towards work-sensitive contracts involved the hospital doctors, both juniors and consultants. Junior doctors were the first, with their payment for time worked. The question of the distribution of that time as between the higher paid in 'A units' and the lower paid in 'B units' was one for local interpretation and it is significant that the B units have now almost disappeared! It is not only the terms of the junior doctors' contract, however, that made it work sensitive. Junior doctors are now able to negotiate for flexibility payments* for agreeing to cover for sickness, leave and other absences, and these flexibility payments vary between districts according to the pressures upon management. The key point is that these contracts have introduced and extended local bargaining, even if often on an individual basis. The consultants' contract would appear to contain many features similar to those of the juniors'. The number of notional half-days (NHDs) will not be determined exclusively by the consultant, but he has it within his power to influence the decision in the longer term, for example, by manipulating his waiting lists, assuming that a consultant would ever do such a thing. Again this contract, whatever its other advantages or disadvantages, has introduced a degree of local bargaining into what was previously a standard contract subject only to periodic alterations in the pricing.

Of the two principal groups of staff still without work-sensitive contracts—administrative and clerical, and nursing and midwifery—the latter are involved in discussions about lieu bonuses on their Functional Whitley Council as compensation and recognition for their lack of opportunities for income measured by output. It is

* Known as units of measured time (UMTs).

these changes that more than anything have given union stewards and representatives the opportunity to influence the major terms and conditions of employment locally. In cash terms the amount of influence may be small, but it exists, and it is a focus for pressure upon management wherever the steward has a well developed role and a strong membership. One of management's responses to this pressure is to seek to regulate the collective bargaining that it engenders—hence the search for more adequate joint machinery.

The other major pressure upon management comes from the labour legislation of the 1970s. The Trade Union and Labour Relations Act 1974[80], Trade Union and Labour Relations (amendment) Act 1976[81] and Employment Protection Act 1975[62] have led to the production of the Advisory, Conciliation and Arbitration Service (ACAS) codes of practice on disciplinary and dismissal procedures[1], disclosure of information[2], and time off for trade union activities.[4] All these recommend formal procedures and encourage employers to enter into negotiation with their staff representatives to ensure practices and procedures in line with the recommendations of the codes.

The Health and Safety at Work etc. Act 1974[66], with its provision for health and safety representatives and health and safety committees, is a further requirement upon management to enter into local arrangements with staff side representatives. In all these cases the stewards of certificated independent trade unions have legal rights that are either only voluntary or do not exist for non-members and for representatives of trade unions which are not certificated. A further provision of the legislation was the introduction of the concept of union membership agreements, a form of post-entry closed shop. By giving some encouragement to the closed shop, the legislation has caused some NHS managers to have to turn their attention to enabling agreements of the type recently established in Northamptonshire AHA.

When all the major causes of pressure upon management are brought together, it is easy to see that the developments have not been temporary phenomena. It is unlikely that trade union membership will decline, and although the number of union stewards may increase more slowly, there is little or no prospect of there being fewer stewards. The switch to work-sensitive contracts has been extensive and is continuing, and the current labour legislation is unlikely to be removed from the statute book, with the possible exception of the closed shop, even with the 1979 change of government. In virtually all parts of the NHS, these pressures increasingly commit management's time to industrial relations and, in exceptional cases, the pressure of industrial relations business upon management can be said to be crucial. The 1950 JCSC constitution is inadequate largely because it was drafted to meet very different needs at a time when the health service was largely unorganised and when the Whitley Councils totally dominated the major questions of terms and conditions of employment.

Post-reorganisation initiatives

A major problem for NHS managers has been to determine the nature of the response to the pressures described above, in the circumstances of their own region, area or district. An important part of the response lies beyond the creation of formal consultative or negotiating machinery. It involves the use of increasingly sophisticated methods of informal consultation, the introduction of suitable forms of management training and general management development. The concern of this chapter, however, is with the initiatives that have been taken to develop firm consultative and negotiating arrangements.

In some districts, joint union stewards' committees have been, or are being, formed to give different trade unions a forum of their own. In a number of cases, these joint committees have approached management to seek recognition as the official bar-

gaining committee for staff in the hospital or district concerned. What makes the NHS different from other major public services or from industries is that a significant minority of its staff is organised within trade unions based upon single professions that are not affiliated to the TUC. These new trade unions are nationally recognised and are part of the Whitley Council machinery. As such, local management has a requirement to recognise them and to deal with them on the same basis as the TUC-affiliated trade unions. The implications of this split will be referred to later, but its importance here is that management is unable to respond by giving recognition to joint union stewards' committees if their constitution excludes the non-affiliates, unless it gives equal rights to the non-affiliates. Thus, where there has been a request from a joint union stewards' committee of this kind, management's typical response has been to reject formal separate recognition and to institute its own initiatives to try to establish broadly based joint committees that include, or give equal rights to, all recognised staff side organisations.

Once management has recognised the need to take an initiative of this kind, for whatever reason, it has to consider the width and extent of the joint committee's role. One option is to introduce an up-to-date version of purely joint consultative machinery, and some districts have been able to do this. Another is to separate the processes of consultation and negotiation with separate committees often operating at different levels within the service. And a further response is to create a single committee structure, possibly on more than one level, that avoids the titles of consultation and negotiation and makes the assumption that the business of such a committee will vary between consultation and negotiation according to need.

Where parallel consultative and negotiating committees exist, the supporting argument is that the processes of consultation and negotiation are different and require different structures. To be effective, formal consultation requires broad participation by

managers and staff representatives to ensure that every positive contribution that can be made *is* made, directly or indirectly. By contrast, the process of negotiation is best conducted by smaller teams of managers and stewards with clear lines of responsibility and accountability. In support of this argument, it must be added that the now defunct 1972 code of practice[38] recognised the possibility of this type of parallel committee structure.

Despite the strength of this argument, there are very few examples of parallel committees in the NHS. The concept of parallel committees raises a number of very practical obstacles. Management would be obliged to provide support for two sets of committees instead of one; the effect of this would be a heavier call upon the time of certain managers who would need to take part in both. The more serious obstacle, however, is that the boundary between consultation and negotiation is ill-defined, and the need for some issues to pass from one committee to another, in the way envisaged in the code of practice, could cause rivalry and disagreement. What evidence we have from present NHS machinery[26] suggests that there is some division between negotiation and consultation but that this is not tackled through a system of parallel committees. In a district, a popular model is one that allows for a series of unit-based joint committees that are almost exclusively consultative, with a district-based joint committee whose function is largely negotiation but which may also be used for consultation on broader issues.

Having decided the scope of the committee's activities, the next problem concerns the level or levels at which these activities take place. In the last few years initiatives have been developed in some regions, areas, districts and sectors or units (hospitals) and, inevitably, in the experimental period these initiatives have not always been fully coordinated. Developments have been simultaneous at different levels and, for convenience, consideration of them will begin with a district and single-district area and continue with area and region.

District development

The pressure for more adequate formal machinery has been greatest in the districts and single-district areas because they have the responsibility for operational services. In addition, because districts in a multidistrict area can experience varying degrees of pressure, individual districts have felt the need to take initiatives in their own time and in their own way. By far the most popular model is to have committees at two levels: one at district level and one below. Machinery below district level is most commonly found in the larger units and the community services, but there are also instances of it at sector level. The choice of the lower level depends upon a variety of factors. In some cases, sector and unit are the same; in others the sector is chosen because the individual units are too small to maintain a formal structure. The district may have a number of JCSCs functioning at unit level which appear to meet the needs of staff in each unit. In this case, the structure is built around them. The unit often provides a focus for a multidisciplinary consultative structure which is lacking in a sector. However, this argument is sometimes ignored in favour of the sector because of the need to reinforce the particular management structure of the district.

The greatest variation among districts concerns the link between the district and the lower level within the structure. Where a district has inherited a number of unit joint committees the tendency has been to create a district joint committee that is independent of the unit committees and does not draw its staff side support from those committees. Where districts created completely new machinery, the preference has been to build in a management and staff side link between the lower and higher levels. If unit committees were in existence they were almost always JCSCs or other forms of consultative committees. As the district joint committees were almost always based upon the need for a negotiating forum, the different methods of determining staff side representation made it almost impossible to create a formal link.

Area development

The initiatives at area level in the multidistrict areas were largely a response to the new labour legislation of the 1970s and were a way of exercising the areas' responsibility for industrial relations policy. In the first two years after reorganisation, some areas unquestionably took initiatives because they saw individual districts getting involved in the creation of formal machinery and wished to ensure standardisation within the area. Originally there was some friction between area and district about their respective spheres of responsibility but this has now diminished because most districts accept the need for some form of guidelines from the area.[26] However, once districts have established their own formal joint machinery, it is used to discuss and resolve industrial relations problems and to approve developments in industrial relations *within the district.* It is here that we find a certain amount of confusion of purpose. Management at area level seeks to achieve agreements with staff side representatives either on matters of general policy or, less frequently, on matters of detail. For this reason, the only committee of real value to management is one in which the staff representatives have the ability to commit their members within the whole area. In theory, management could fill the staff side of such a joint committee with faceless nominees of its own and secure agreement very easily, but that agreement would be worthless. The problem with many of our multidistrict area joint committees is that their staff side representatives have no recognisable local constituency and no right to commit their fellow employees. For this reason, decisions may be meaningless because the district staff side refuses to accept them. There is increasing evidence that the area is alive to this difficulty and the staff side is becoming more genuinely representative, but the process is slow.

Regional development

Several regions have also taken initiatives to establish formal joint machinery; for example, the Thames and Mersey regions. Regional initiatives have stemmed almost exclusively from management and their objectives have sometimes overlapped those of the areas. The distinction between the operational and the policy-making levels can be defined in practical terms, but the distinction between two different policy-making levels is harder to define! Where a regional initiative has stemmed from the genuine desire of its constituent areas to have certain common policies and objectives, there is a clear logic in the development and it is one which diminishes the role of the individual areas. Where the region takes the initiative and pushes a number of reluctant areas, the result can be either confusion or a committee operating with little reference to reality. The problem of adequate staff representation is greater for a region than for an area. As the Mersey RHA discovered, a concession made at regional level can be fairly easily forced onto a reluctant area, but a concession obtained from staff at regional level is unlikely to be accepted if it is opposed by staff representatives in a particular district, let alone a particular area.[26] It may well be that regions which have not taken initiatives have been influenced by these pitfalls for management.

Functional committees and panels

So far this chapter has considered only the formal machinery that is multidisciplinary in character, yet a significant amount of consultation and negotiation takes place within purely functional committees which are based, to some extent, upon national Whitley Council divisions. The principal characteristics of these at the moment are that they are almost entirely based at district level and confined to the larger functions. Functional committees often owe their existence to the desire of management and staff to discuss their own business separately; for example, the Nursing

and Midwifery Joint Committee in East Dorset and the Ancillary Joint Committee in Liverpool. Sometimes, however, they are formed because the district multidisciplinary committee wishes to limit its work to purely multidisciplinary issues. Many management and staff side representatives are familiar with the problems of the discipline or of the individual who dominates the committee with the minutiae of its or his own affairs, and this has been identified as a reason for earlier dissatisfaction with JCSCs.[101] Most constitutions that allow for functional committees usually allow also for six or seven functional panels. Of these, the nursing and midwifery panel is by far the most popular, followed by ancillary staffs and administrative and clerical staffs. Many medical and dental staff panels exist only on paper and few seem to function in practice. This is equally true of the professional and technical staff panels wherever the staff on PTA and PTB councils are made to sit down together. Examples of success with functional panels for professional and technical staff are almost exclusively limited to those where PTA and PTB staff have been separated. The functional panel is in its early days of development in the NHS, and reasons for its growth are described below.

Composition of joint committees

At district level there is considerable variation in the composition of the management side of joint committees. In some districts, the district management team (DMT) members are extensively involved, and the arguments in favour of this are that they alone are able to sanction concessions required to reach settlement, that their presence indicates the importance they attach to good industrial relations, and that it meets a strongly felt need of the staff side to 'talk to the top' about their industrial relations problems. In those districts with little or no DMT involvement, it is argued that the team can be kept in reserve for use in emergency or deadlock in order to provide an additional level of support for the processing of industrial relations problems. It can

also be argued that the absence of the DMT allows the senior managers to develop their industrial relations skills. Whatever the arguments, one cannot help feeling that the personalities of team members have a great deal to do with this choice and that 'enjoyment of the fray' is an important reason why some wish to be regularly involved.

The choice made by the team has a considerable effect on the role and status of the district personnel officer (DPO). When the team is involved, the role of the DPO is restricted to that of management side secretary with a more limited influence upon the outcome of discussions. Where a second-in-line team is used on the management side, the DPO may still be secretary but he has greater influence in determining the direction of management thinking. One of the reasons advanced for a second line presence on the management side is that these members are able to commit their time to this responsibility and thus to develop their team skills more effectively. DMT members often have other commitments that can lead to their absence from meetings and the extensive use of deputies which is unpopular with the staff side.

At unit level the management side is usually drawn from a much more extensive range of managers, from departmental head upwards. This wider management team can be involved more effectively at unit or sector level, but their absence at district level has been a cause of concern in some districts. A number of experiments has been undertaken in order to try to involve this wider management team in the work of the management side of the district joint committee, notably in central Birmingham*, but none has been completely successful.

There are again two distinct choices in determining the composition of the management side. One is to opt for what is basically a multidistrict management side composed of adminis-

* Personal communication from the administrator.

trators and/or personnel officers from the districts, with no more than one or two area officers present; the scheme developed in Suffolk AHA was an attempt at this model.* The other is for the area management side to be dominated by area team members and officers with a less senior presence from the districts, sometimes limited to the DPO. Whatever composition is chosen, the area personnel officer (APO) is usually the management side secretary.

One problem for area rather than district concerns the role of the authority member. There is member-involvement in virtually every area joint committee in the country and sometimes this is substantial; for example, Lothian Health Board in Scotland.* It is also interesting to note that member-involvement is greater in more recently established joint committees than in those established soon after reorganisation. Because of the initiative of the McCarthy report[94], member-involvement has been growing, but it is still rare in districts despite the terms of the JCSC constitution. There may be some reluctance amongst officers to see member-involvement at district level, and the formidable workload upon members with industrial relations experience may be another factor, but as there is already member-involvement in single-district area joint committees (for example, Oxfordshire AHA) the principle at the operational level is clearly possible.

There are more variations in the composition of the staff side than in that of the management side, and an examination of staff side constitutions indicates how inadequate a single national standard would be. The shape and size of the district, the number and sizes of its units, the pattern of trade union membership and representation, and the state of relationships between trade unions locally are factors that help to determine the shape of staff side representation. The NHS has experienced many attempts by management to delineate in precise terms the staff side composition, and the overwhelming conclusion is that such detailed

* Personal communication from the administrator.

initiatives are counterproductive. The staff side is sensitive to any attempt by management to interfere with staff representation, and management's only constitutional right is to refuse to give formal recognition to committees it considers to be inadequate or unrepresentative. The fact that management has so often been tempted to propose its own constitution for the staff side illustrates the extent to which initiatives in the creation of joint machinery have come from management.

The most important change in the terms of the JCSC constitution is that staff representation in the newer joint committees is determined by nomination rather than by election. A common practice is for staff and management to agree upon the distribution of seats between different staff side organisations and for those organisations to use their own method of determining who should take the seat or seats. This derives from the need to have people on the staff side who can commit their members in collective bargaining and who have the constitutional authority to do so; that is, branch secretaries, chairmen or senior stewards. An open election would put the outcome at risk and could result in a staff side without authority to speak on behalf of the organised staff. The most common alternative to nomination is the system whereby a panel of one or two representatives from each staff side organisation elects from amongst its own number a smaller group who will form the staff side of the joint committee. This retains the principle of nomination in that one or two representatives of different organisations are nominated by their own organisations. In these cases, it is usual for joint agreements to be referred back to the wider staff side committee before acceptance.

One of the principles established by management as a requirement before recognition is that all the major staff groups should be represented on the staff side of a multidisciplinary joint committee. This is usually accepted without question, but there have been occasions when the election of staff side members of a joint committee by a wider meeting of staff side representatives has

produced a functionally unbalanced group.[26] Staff side's defence of this arrangement has been that the ablest negotiators were chosen, irrespective of their trade union.

The biggest obstacle to the creation of effective staff side representation has unquestionably been the growing conflict between affiliates and non-affiliates. In several parts of the country there is no conflict and all staff side organisations sit down together, usually with the single exception of ASTMS which has a rigid national policy of non-cooperation with non-affiliates. However, the number of regions, areas and districts affected by this problem is continuing to grow. Different strategies have been developed to try to circumvent it but none has been completely successful. A few, like Oxfordshire AHA, have developed parallel committees for affiliates and non-affiliates. Others, like Bristol, operate with one formal joint committee limited to non-affiliates but open to affiliates if and when they wish to join, with a joint shop stewards' committee limited to affiliates that meets the management side at need but which is not given formal recognition! A further way around this problem is to place a greater reliance upon functional panels for conducting joint business. If PTA and PTB are separated, most functional panels are able to operate either exclusively with affiliates or with non-affiliates. Only the nurses and midwives panel regularly requires both groups to sit down together, and as the ASTMS is not recognised for nursing and midwifery staff it is sometimes possible to achieve this even in districts where there is conflict in the multidisciplinary discussions. In many districts, however, progress has been stopped by the inability of the sides to find a solution to the problem, and several areas, such as Camden and Islington, have had to face conflict because of the growing antagonism of the two groups of staff side representatives. It is a problem for which there is yet no adequate solution, either nationally or locally.

Another problem concerning the composition of the staff side of joint committees relates to the issue of proportional representation.

Since the publication of the McCarthy report[94], the larger trade unions have been increasingly sensitive to this issue at local level, and object to the unbalanced representation given to much smaller organisations. Strict proportional representation is almost impossible to apply at local level, given the need for an efficient and manageable joint committee and the number of staff side organisations with reasonable claims for membership. The argument in favour of proportional representation sometimes confuses the roles of the Functional Whitley Councils and the local joint committees. At national level, the staff sides are executive in the sense that majority decisions determine staff side action. At local level, there is possibly not a single joint committee where the staff side operates on the basis of majority voting. Current practice is to seek a staff side consensus before an agreement is reached, and no organisation is committed until it accepts the arrangements which have been made. In theory, management can go ahead without the agreement of a particular organisation, and in practice this has happened, but it can be argued that management is unlikely to do this if one or two major organisations are still uncommitted. Wherever this consensus system is openly recognised by both parties, there is little or no difficulty over proportional representation.

This section has outlined the major variations in management and staff side composition in the NHS today. The more joint committees are established the more local variations will be written into their constitution, and the harder it will be subsequently to introduce any detailed national formula. Some of the principal difficulties may at some stage be resolved at national level (for example, the problem of affiliates and non-affiliates) but if anything more broadly based is attempted at national level, it will have to be accepted by staff side as representing a recognisable move towards greater participation. In present circumstances, such a development is unlikely.

Conclusion

The NHS is going through a period of major change in its consultative and negotiating arrangements below national level, and the recent efforts at the General Whitley Council can only serve to speed the pace of this change. It is not possible to be precise about the outcome, but a number of developments are already clearly recognisable.

The 1950 concept of a standard formula for the NHS has gone, and it has been increasingly recognised that individual authorities have to develop in ways appropriate to their own circumstances. It is already clear that these ways involve considerable variation in structure, in operation and, more importantly, in the degree to which they formally extend and develop the role of staff side representatives. Genuine collective bargaining has now been recognised and established within the NHS at operational level. That some districts have avoided it does not detract from the fact that this is one of the most important developments in industrial relations in recent years. With it has come the increasing formalisation of relations between management and staff, and this chapter has outlined and considered the direction and principal variations in this process of formalisation.

It is too early to judge the extent to which any one pattern might come to dominate the service, and two important variables are the extent to which functional panels will come to dominate day-to-day collective bargaining, and the way in which the affiliates versus non-affiliates conflict will be resolved. In recent years, the pace of change has been dramatic, and it will continue.

5
Health and safety

GERALDINE HEALY

Health and safety have always been important parts of industrial relations, though rarely at the centre of a dispute or of negotiations. This may well change. To understand why, it is necessary to understand the nature not only of industrial relations but also of legislation governing health and safety. This chapter examines the main principles of the Health and Safety at Work etc. Act 1974 (HASAWA)[66] as they apply to the National Health Service, discusses the NHS environment and its constituent hazards and finally examines the implications for its industrial relations.

It will be argued that the objective of a safe working environment may be hard to achieve, because the Act has tremendous limitations, and because commitment to its spirit in the NHS appears to be less than wholehearted. The only way the aims of the Act will be achieved will be with full commitment of all involved—trade unions, professional associations, and management at all levels and in all disciplines. The ultimate responsibility, however, rests firmly with management.

Health and safety legislation and the NHS

Before 1974, NHS employees, along with several million others, had little or no statutory protection for their health, safety and welfare at work. Their limited protection came under the Factories

Act 1961[65], Offices, Shops and Railway Premises Act 1963[71], public health Acts, food hygiene regulations, and the Nursing Homes Act 1975.[70] There were also stringent requirements for specific parts of a hospital; for example, the pharmacy. But, if an NHS employee had an accident at work, his or her only recourse in law was to claim common law damages—an expensive and inhibiting business with little guarantee of success. It has been estimated that employees are successful in 20 per cent of cases.[90]

The origins of HASAWA lie in the concern during the 1960s about the increasing number of lives lost and injuries sustained by people at work. A committee of inquiry, set up under Lord Robens to investigate and make proposals, reported in 1972 and argued not for more law, but for less; for a system of voluntary self-regulation by industry guided by flexible codes of practice rather than slavish compliance with minimum standards.[77] These and other proposals are apparent in HASAWA.

The pre-1974 protective statutes tended to be specific. Unless there was a provable breach of them—or of regulations made under them—an accident could lead to a civil action for negligence but rarely to a criminal prosecution. Under HASAWA, there is no need to wait for an accident—even a failure to provide adequate welfare facilities could result in criminal prosecution.[102]

The Act establishes duties for employers and employees, and provides the machinery by which its provisions will operate. It is essentially an enabling Act. All previous protective statutes are still in force, but the Act provides also for legally enforceable regulations, and for codes of practice to be drawn up (not legally enforceable but which may be used in any proceedings) so that the legislation can be revised and brought up to date. This is important, given the exponential growth of technological development and the new hazards which accompany it.

Main duties imposed on employers and employees

Section 2(1) establishes the general duties of employers.

> 'It shall be the duty of every employer to ensure, so far as it reasonably practicable, the health, safety and welfare at work of all his employees.' [66]

This 'catch-all' section is crucial. Under previous statutes, an inspector may have been able to establish negligence by an employer but unable to prosecute since there had been no breach of a specific requirement. The employer must now take care of the health and safety of his employees, and their welfare. The Health and Safety Commission* interprets 'welfare' to include those aspects of industrial amenity covered by previous Acts, such as ventilation, sanitation, heat and light, a place to sit and somewhere to eat.[102]

Section 2(2) outlines the particular duties of the employer.

> 'Without prejudice to the generality of an employer's duty under the preceding subsection, the matters to which that duty extends include in particular—
> '(a) the provision and maintenance of plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health;
> '(b) arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances;
> '(c) the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees;

*The policy-making body of HASAWA; it has representation from the TUC, CBI and local authorities.

'(d) so far as is reasonably practicable as regards any place of work under the employer's control, the maintenance of it in a condition that is safe and without risks to health and the provision and maintenance of means of access to and egress from it that are safe and without such risks;
'(e) the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.' [66]

The employer also has responsibilities to other persons, as stated in Section 3(1).

'It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.' [66]

The NHS, therefore, has a responsibility to employees, patients and visitors alike. That such responsibilities may conflict indicates the special nature of health and safety in the NHS.

The phrase *'so far as is reasonably practicable'* stands out in the passages quoted above. This phrase has been strongly criticised, particularly by trade unions, as superfluous and unnecessary. Safety, health and welfare are inevitably relative concepts, but it is feared that such qualification may weaken the force of the Act. The phrase is open to a variety of subjective meanings, so it is to the law we must look for interpretation. In a 1949 judgment, the words 'reasonably practicable' were interpreted as

'A quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed on the other.' [105]

Thus, the meaning of 'reasonably practicable' in common law involves weighing the risk against the 'sacrifice' in time, money and inconvenience. This is different from 'practicable' which means 'feasible without reference to cost'.[12] Perhaps this interpretation will not surprise managers and trade unionists in the cost-conscious NHS!

Duties under the Act are not confined to the employer. Section 7 places general duties on employees, the breach of which could lead to criminal prosecution.

> '(a) to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work; and
> '(b) as regards any duty or requirement imposed on his employer or any other person by or under any of the relevant statutory provisions, to co-operate with him so far as is necesary to enable that duty or requirement to be performed or complied with.'[66]

The section places more stringent requirements on the employee than previous legislation; for example, under the Factories Act, employees were required not to do anything likely to endanger themselves or others *wilfully and without reasonable cause.*[65] It has been argued that the effect of Section 7(a) of HASAWA is quite revolutionary: an employee can become guilty of a criminal offence for failure to take reasonable care, whether or not injury results, whether or not his actions in themselves constitute a breach of some statutory requirement, and notwithstanding the fact that only he is in jeopardy as the result of his act.[106] To some extent, this reflects a changing attitude to responsibility for health and safety. Although ultimate responsibility remains with the employer, more involvement by employees, through the Regulations on Safety Representatives and Safety Committees, is accompanied by an increase in the employees'

responsibility. The particular onus put on management by Section 7 has been unequivocally stated by the DHSS.

> 'Where an employee has been given by his Authority a specific safety responsibility, either as an intrinsic part of his management function, or as a specialist safety adviser or officer, failure to discharge this responsibility where it was reasonably practicable for him to have done so could result in liability under Section 7 of the Act.'[41]

Breach of any of the HASAWA requirements and/or its accompanying regulations, may lead to a criminal prosecution: on summary conviction, a fine not exceeding £1000 may be levied; and on conviction on indictment, an unlimited fine or imprisonment for a term not exceeding two years or both (Section 33(3)). The maximum fine on summary conviction has been increased from £400 to £1000—in 1976 the average fine was only £95. The chairman of the Health and Safety Commission hopes that by raising the maximum fine, a tougher line will be taken towards offenders.[114] Section 47, however, provides no right of civil action for breach of any statutory duty contained in the Act proper, yet it specifically includes such a right (where damage is caused) under regulations made by virtue of the Act. Consequently, any claims for damages must be made under common law.

Despite criminal sanctions provided by the Act, the total number of enforcement officers now combined under the Health and Safety Executive (HSE)* has not been increased sufficiently to cope with the eight million new entrants and wider responsibilities. In the NHS, effective implementation may be further inhibited.

The NHS has to be aware not only of the Act's provisions as applied to other undertakings, but also of its own specific problems as Crown property. The position of the Crown in law is

* The enforcement arm of HSC.

still a matter of some dispute.[118] Only the reigning monarch has full immunity. If the Crown commits an offence which is a breach of a statutory duty, the Crown is liable only if the particular statute enacts that it shall be so, either by words or by implication.[116] By the Crown Proceedings Act 1947[61], the Crown may be sued in contract or tort, with minor exceptions. But there is no civil liability for breach of the HASAWA provisions. It may be argued that because the Crown as an employer has the same duties by statute under common law, the injured employee can sue the Crown for negligence. This is correct, but individual employees rarely have the money to take such a case. It is likely that such cases will only be brought by trade unions determined to make the Crown as accountable as any other employer.

While the Act provides some statutory protection for most NHS employees for the first time, this has been done with reservation. Section 48 states that the Act binds the Crown with the exception of Sections 21 to 25 and Sections 33 to 42.

Sections 21 to 25 relate to the power of the inspectors to serve improvement notices and prohibition notices, and to seize or render harmless articles or substances which they have reasonable belief will cause imminent danger of serious personal injury. Without doubt, the powers of the inspectorate have been severely curtailed with respect to the NHS and other Crown employment.

Sections 33 to 42 relate to offences and penalties. They do not bind the Crown. However, Section 48(2) makes clear that they apply to persons in the public service of the Crown as they do to other persons. Section 36(2) spells out the position precisely.

> 'Where there would be or have been the commission of an offence under section 33 by the Crown but for the circumstance that that section does not bind the Crown, and that fact is due to the act or default of a person other than the Crown, that person shall be guilty of the offence which, but for that

> circumstance, the Crown would be committing or would have committed, and may be charged with and convicted of that offence accordingly.'[66]

Crown employees are thus in a more onerous position than other workers. The main unions in the NHS are seriously dissatisfied with this. COHSE and NUPE, particularly, have pressed the TUC to use its influence with government and the commission to make the Crown as accountable as other employers. NUPE fears that the Crown as an employer will be thought to be so conscious of its responsibilities and so anxious to be a 'model' employer and a setter of standards that it will not require the spur of sanctions, and that the NHS, with the wealth of knowledge and expertise available to it, would be beyond reproach in complying with the Act. But NUPE argues that hospitals are dangerous places to work in.

The concern about Crown immunity has led to assurances from the HSE that no NHS employee will be prosecuted in substitution for his/her health authority, and that prosecutions would only be brought in cases where they would have been brought against employees of bodies not covered by Crown privilege.*

Such assurances without the force of law do not allay the fears of many interested and vulnerable parties. Consequently, the HSC intends to deal with the whole question of sanctions against the Crown under the Act. Meanwhile, the HSE has agreed, as an interim measure, to adopt a series of Crown notices in place of the prohibition and improvement notices used in industry. Though not legally enforceable, they will at least notify unions and health authorities of the hazard in question.[17]

What form might amendments to the Act take? What is certain, at present, is that the question of Crown immunity is creating

* Draft Health Circular. *Health and safety at work act 1974. Management responsibilities and organisation.* 15 December, 1976.

confusion, uncertainty and anxiety among those who feel they may be affected. Managers feel they may find themselves in an invidious position. 'It is perhaps owed to those who will be carrying this heavy new responsibility that they should feel quite free of any additional burden, concerned always that if there were a major incident of some sort somebody might decide that heads were to roll.'[36] If the sections in question are not to be used, as has been assured, it should be made clear not by assurances, but by amendments.

COHSE has advised its members in management and supervisory roles not to accept responsibilities under the Act. If members complied with this advice, health and safety arrangements could not function effectively since they depend on the cooperation of all employees, particularly those in management, to take special responsibilities. On the other hand, by complying, the individual's position is uncertain. Such inconsistencies do not bode well for the commitment necessary for effective operation.

NALGO has more pragmatically advised its members to take care they do not undertake additional duties relating to health and safety without full consultation and perhaps consideration of matters such as grading and salary. The assurances given by the HSE do not seem to be enough to allow the unions to advise full cooperation.

Perhaps the most significant part of the Act for workplace industrial relations came into effect on 1 October 1978, with the HSC's Regulations on Safety Representatives and Safety Committees.[85] The Robens committee recommended a statutory requirement dealing in general terms with arrangements for participation by employees, although it also suggested that 'There is no legitimate scope for "bargaining" on safety and health issues'.[77] The recommendations were enacted in Section 2(4) of the Act. This provided for safety representatives to be appointed by recognised independent trade unions. The regulations were due

to come into force at the beginning of 1977, but were shelved because of the estimated costs and the restraint on expenditure. The TUC saw this as a fundamental breach of the 'social contract' and made immediate protests to the government. This led to the new date of implementation.

The regulations give greater powers than perhaps any other piece of legislation to local union representatives. They firmly embody the principle of participation by trade unions in questions of health and safety. They enable the representative to initiate formal action, such as inspecting premises, plant and equipment, documents and other related information. The accompanying code of practice expands the type of information which a safety representative may demand: accident statistics, dangerous areas, technical information, proposed changes in plans and performance which may affect health and safety.

The regulations reflect the view that it would be undesirable to restrict unnecessarily the freedom of employers and trade unions to make arrangements suitable to circumstances. Nothing in the regulations or accompanying code would prevent the continuation of agreed arrangements which are satisfactory to both sides, or of alternative arrangements for joint consultation, provided that these do not detract from the rights and obligations of trade unions and employers as stated in the regulations. This has importance for the NHS where safety representatives may have been appointed by management and sit on safety committees. If the recognised independent trade unions felt that the arrangements did not comply with the regulations and were not happy about them, they could request a change in practice. These regulations were significant in the decision of professional bodies such as the Rcn to become independent trade unions. Had they not elected for certification, their members would have been deprived of many rights of representation, including the powerful rights under HASAWA.

The Act provides protection to NHS employees with such reservation that uncertainty and concern might well prejudice its effective operation. Given the immature state of industrial relations in the NHS and the nature of the hazards, the introduction of the regulations may be less than smooth.

Working conditions in the NHS

It might have been assumed that the aims of the NHS and the aims of HASAWA would not conflict; that an organisation devoted to caring would have had little to do to comply with any statutory requirements for the health and safety of its employees. As J A Lunn puts it, 'It has been a natural assumption that the Health Service, because of its commitment, would be first and foremost in ensuring that its employees had the maximum health care, both curative and preventative. Unfortunately, as is often the case with doctors' and cobblers' families, the very reverse is true.'[93] The British Society for Social Responsibility in Science (BSSRS) has been even more explicit. 'Despite its reputation as a place of healing and safety, the hospital is filled with potential hazards for both patients and workers. Constant stress, infection, exhausting shift rotas, microwaves, x-rays, bad wiring, chemicals, slippery floors, backache, bad ventilation—all take their toll on the hospital workforce.'[11]

The NHS was a 'new entrant' under the auspices of the HSE, and the HSE's knowledge of the NHS was limited, so, with the agreement of the DHSS, the HSE instituted a pilot study of working conditions in the hospital service. North West Thames RHA was chosen because it provided a suitable range of hospitals in type and age. The terms of reference were 'to examine the activity, identify the principal hazards and obtain information which would give some indication as to how these hazards were being controlled'.[86] First, information was collated at HSE headquarters from various sources, including inspectors; second, a number of

representative premises were visited; third, separate inquiries were made about particular hazards associated with the use of ionising radiations. Letters outlining the aims and purpose of the study, and asking for any relevant information went to 15 professional associations*, and to the staff side secretary of the General Whitley Council, with copies for distribution to members. If hazards came to light during a visit, they were to be drawn to the attention of the health authorities; but because the study's purpose was to advise the HSC, the local inspectors were asked to take no formal action before referring to the HSE. This is the traditional approach of the inspectorate, which prefers to rely on persuasion than to wield the big stick.

The pilot study showed that NHS buildings can be dangerous places for workers and for patients, and that the hazards are diverse and complex. In hospitals they range from those associated with conventional process machinery such as that found in light engineering and maintenance workshops, with which the HSE is familiar, to those found in operating theatres and laboratories, which were new to the HSE.

Environment The HSE argues that the most serious environmental problems come from the control of temperature and ventilation, and found it significant that such problems were not confined to older buildings but were also present in modern units.[86] It is in this area of temperature and ventilation that the special problems of the NHS begin to emerge: there can be conflict between the comfort of the staff at work and that of the patients in bed; for example, minimisation of cross-infection risks, and maintenance of high temperatures and relative humidities in the care of infants and patients with severe burns.

The HSE feels that further guidance is required on the problems in operating theatres, whether or not inspectors are to assume

*There is no indication in the report about which associations replied, except for the BMA and the Royal College of Surgeons who are specifically mentioned.

responsibilities for enforcing Section 3 of HASAWA (which requires an employer to take care of the health and safety of people other than employees). Such guidance is urgently required. Operating theatres were found to have only one to two air changes per hour (DHSS-recommended rate is 20 air changes per hour) and temperatures of up to 32.2°C (90°F). External doors to a theatre suite were left open while the theatres were in use to get a through draught of air, which is contrary to aseptic routine. The theatre suite had overall negative pressure which was again contrary to requirements for minimum cross-infection.[86]

Lifting Many accidents are associated with lifting and moving patients. Lifting hazards are of particular concern to nurses, and the HSE recognises the difficulty in applying standards imposed by HASAWA. Basic rules on lifting, which include summoning help, cannot always be obeyed in an emergency. 'The instinctive reaction of staff to put the patient before themselves is likely to contribute to the risk of personal injury. In industry there may be the alternative of dropping the load being lifted in order to avoid personal injury, an alternative not available to medical staff.'[86]

Violence Another hazard, violence to staff, is becoming increasingly serious. The study says the risk of violence could be reduced by improving patient–staff ratios, the training of staff, the degree of consultation between all responsible for treatment and the provision of alarm systems. Such action is 'relevant to the discharge of the duty imposed on the employer'.[86]

Microbiological hazards/laboratories In all medical establishments, 'normal or low-risk' and 'high-risk' microbiological hazards are recognised. More stringent precautions are meant to be taken when treating 'high-risk' patients (for example, those suffering from tuberculosis or hepatitis B infections) or in dealing with high-risk specimens. But many patients are undiagnosed, and many specimens unidentified, when they are first received by the department concerned.[86] The HSE argues that any patient, or specimen,

may subsequently be shown to have been infectious. The admission to a London hospital of a patient showing no clinical signs of the Lassa fever infection which he carried, and his initial treatment and the handling of his specimens in a routine fashion, are illustrative of such an eventuality. It will be appreciated that a wide range of events and procedures may have to be regarded as inherently potentially hazardous.[86] The HSE examined a number of potential microbiological hazards and found some procedures to be effective and stringently observed, but it was also able to show examples of poor practice with a low rate of awareness of such hazards.

Infected people and those with decreased resistance to infection after medical/surgical procedures are particularly at risk from nosocomial infections (disease associated with institutions taking care of the diseased). Many hospitals attempt to minimise the risks by carrying out microbiological surveys and by appointing medical and nursing staff to be specially concerned with the control of infection.

The HSE pilot study indicates the potentially dangerous nature of work in laboratories. A tragic example was the death of a technician from smallpox at the Medical School, University of Birmingham, in 1978. Such potential dangers were recognised by the DHSS working party which published recommendations on the prevention of infection in clinical laboratories.[48] The report has been surrounded with controversy; initially because of the apparent reluctance of the DHSS to publish it[18], but more seriously because of its content. For example, it pointed to the very serious hazards to health and safety incorporated in the design of some new laboratories and post-mortem rooms, which were caused by

'1. Lack of consultation between architect and user at the initial design stage, at intervals during building and when unforeseen difficulties require changes to be made.

'2. The failure of architects to accept the guidance of Building Note No. 15 which explains the purpose of the laboratories in some detail.
'3. The failure of certain sections of Building Note No. 15 to give guidance on safe design and the avoidance of hazards; and its ambiguity and inconsistency in several sections—notably, specimen reception, washing facilities, clothing storage, siting and exhaust facilities for safety cabinets and autoclaves, and storage and use of compressed gases and hazardous materials.

'In some laboratories large sums of money have been spent and in others large sums will be spent to rectify errors that could have been avoided had the users been consulted. In others, rectification is now impossible *eg* in some tall buildings where aesthetic considerations were over-riding, unsafe working conditions were created which may be perpetuated unless certain categories of the laboratory are transferred elsewhere.'[48]

The Howie report[48] makes recommendations on microbiological hazards in clinical laboratory equipment, on laboratory safety officers, on keeping the code of practice up to date, on advising laboratory workers and on notification of infections.

There is no doubt that full implementation of the Howie code of practice will be costly and some recommendations will be introduced gradually. However, this does not prevent local safety representatives from attempting to achieve Howie's standards in laboratories—this is certainly likely to be the case with safety representatives who belong to ASTMS.

The Howie report also points to the inadequacy of some existing standards and the failure to take up recommendations of early working parties. The smallpox tragedy at Birmingham could have been avoided had existing recommendations been followed.

Storage, use and disposal of hazardous substances The wide range of substances used in a hospital necessitates effective procedures for their use, handling, storage and disposal. Gaps or breakdown in procedures were identified by the HSE pilot study: for example, potentially infected waste was found deposited in bags normally used for domestic waste; problems were found in the storage of inflammable materials, chemicals and anaesthetic gases; carcinogenic substances were found to be in use, which would be banned or severely restricted under international regulations.[86]

The pilot study provides a great deal of information necessary for management and unions, and considerable ammunition for those safety representatives and committees committed to improving the standards of health and safety.

To understand the nature of hazards in each location, accurate reporting systems of accidents are necessary. The HSE report shows no uniformity of practice of compiling statistics on occupationally acquired injuries or sickness in the NHS. Some hospitals have fairly sophisticated analyses undertaken by the occupational health departments, others have no analysis at all. Most systems rely on the injured persons reporting the accident, and there was some evidence that they did not always do so. It appeared, however, that almost any accident involving a patient, no matter how minor, was reported by the nurses.

Neglect of problems of health and safety before HASAWA is indicated by the very few epidemiological surveys of occupationally acquired infections. A retrospective postal survey of all staff working in NHS medical laboratories, by Harrington and Shannon[84], reported a fivefold increased risk of acquiring pulmonary tuberculosis for workers in medical laboratories compared with the general population, and found that technicians, especially in morbid anatomy departments, were at greatest risk. More research is needed into the types of risks of certain occupations, and into methods to eradicate them.

Occupational health services

Such research could be done by occupational health services. The NHS has no overall occupational health service. Provision varies from one hospital to another, despite the 1968 Tunbridge report[55] which recommended an NHS occupational health service with

pre-employment and other routine medical examinations

examination and resettlement advice after sick absence

maintenance of all immunisation and staff health records

health and hygiene instruction

research into health factors, sickness patterns and wastage

initial treatment of staff injured or becoming ill at work

liaison with local general practitioners responsible for the personal care of hospital staff

counselling.

The HSE study suggests that these recommendations are in a transitional phase[86], but the more sceptical might argue they have been shelved. The main functions of an occupational health department seem to be pre-employment medical examinations, immunisations and a first aid treatment service for staff who receive minor injuries or fall sick at work. There are few occupational health departments with a more sophisticated programme.

The attitude of occupational health services to HASAWA tends to vary. Some see the Act as outside their terms of reference—their

role is narrow, something akin to what is disparagingly known in industry as the 'knitting and sticking brigade'. Others see it as reinforcing their preventive medicine role and are therefore committed to its effective operation. As the Act becomes more fully operative there are likely to be more demands on occupational health services to provide a wider service.

The relationship with trade unions is often ambiguous. On the one hand, the unions welcome occupational health services unequivocally: it used to be not uncommon for an NHS employee injured at work to have to queue in the casualty department of that hospital or be taken to another. But some trade unions suspect that the occupational health services are management-oriented and, therefore, not acting in the interest of union members. This is often how unions in industry regard the factory doctor. To maintain a position of 'neutrality' some units may refuse to cooperate in what they see as management roles—a particularly sensitive area is where a health issue becomes the reason for disciplinary action. The very names of the hierarchy in occupational health units are sometimes a source of concern: a nurse may be appointed to a senior nursing officer post because of the nature of his/her responsibilities in the unit but may find the job title, indicating a management post, inhibits effective performance because it belies the neutrality which the holder is attempting to achieve. The question of the occupational health services' link with the Act needs examination and guidance. An extension of best practice is crucial.

Standards

Thus we see that the NHS is in many cases failing to meet established standards. However, a crucial area of concern is how the standards themselves are set. This issue was raised by ASTMS in their supplementary evidence on health and safety to the royal commission on the NHS.

It has generally been the responsibility of the DHSS to set standards, through various codes of practice, technical notes, building notes and guidance notes, and through committees set up to investigate and make recommendations in specific areas. The decision to implement such recommendations invariably rests with the DHSS. Trade unions and professional bodies are rarely consulted or involved in setting standards. This is contrary to HSC practice which involves both trade unions and employers. The importance of involving the user was stressed by the Howie report. In some areas, the establishment of standards has been so neglected that management and staff are left without specific guidance. In others, standards are set without all interested parties being involved so many relevant factors are not taken into account.

A more open style of government would seem essential if the DHSS is to regain much of the goodwill already lost in the area of health and safety. However, because of the link between the establishment and enforcement of standards and economic allocation, such a spontaneous move seems unlikely.

Although in many areas, particularly the technical departments, the NHS has good procedures which are carefully followed, there are others where thought needs to be given to the effectiveness of procedures and their enforcement through supervision and training: general environmental hazards such as ventilation and temperature; storage of materials; lifting patients. The disparity of service offered at different hospitals promotes inequitable treatment of members of staff. There is little choice but to conclude from the HSE pilot study that the NHS generally is failing to comply with the duties imposed on it by Section 2(1) and 2(2) of the Act.[66]

Response to HASAWA

For the objectives of HASAWA to be achieved, commitment by top management is crucial. It is particularly important for the

DHSS to show its full support for implementation because of the Act's limitation on the powers of the inspectorate to prosecute. However, early indications of the DHSS's approach are not encouraging. The Act became fully effective on 1 April 1975, yet it was not until 26 March 1975 that a DHSS circular was issued to NHS administrators.[40] This gave them precisely five days to make ready. The circular included information on the background to the Act, the general duties, inspection, the legal position, the policy statement, safety representatives and committees, with an attached suggested policy statement which authorities might wish to use. It emphasised that section and departmental managers should be involved in formulating local policy statements—where the practise of health and safety is most significant. However, it also delegated much of the onus for health and safety to individual managers, whose own position in law is not clear. Furthermore, no urgency was implied. In practice, safety policies are generally made by the AHA or the district team, though some tend to be produced by the hospital to take account of local circumstances. Policy statements *should* vary because they should reflect local need. NHS safety policies were rarely compiled by the mandatory date of 1 April 1975 and are usually documents simply outlining the duties of the employer and employee. They rarely include a statement of intent on how the authority proposes to comply with the Act. This is changing due to greater awareness of the Act, to the introduction of regulations on safety representatives and to the interest shown in the NHS by the HSE. It is clear that the Act itself was an inadequate impetus for more than token compliance with its requirements.

The DHSS circular was explicit that no additional resources are to be provided for general health and safety purposes, and that expenditure must be considered part of health authorities' management function.[40] Some practices and procedures can be made more safe with little expenditure, but others may require major capital expenditure. In such cases, discussions between the HSE and the DHSS are likely and the question of what is 'reasonably

practicable' would doubtless form the basis of any decision. Trade unions have also been angered by the unwillingness of the DHSS to allocate extra resources to cope with the introduction of the Regulations on Safety Representatives and Safety Committees.

A further DHSS circular, in October 1978, reiterated that no additional resources can be made available, but stated that additional costs of implementing the regulations would be reviewed '. . . in the light of experience of the working of these Regulations . . .'[41] Regional health authorities have been asked to provide estimates so that the extent of demands can be assessed: to record the number of representatives, the average time they spend on their duties, the average cost of such time and the total cost of time. Similar calculations are suggested for estimating the cost of safety committees.

Although it is understandable that the DHSS should want estimates in order to assess demand, the early costs will have to be met by, and may strain, management budgets. But an unintended consequence of a control system to monitor time-costs may be a disproportionate concern with time at the expense of genuine and practical interest in safety issues. This is likely to be so in 'low trust' industrial relations climates. In 'high trust' areas, management and unions are likely to make such estimates by agreement. The control systems would have to be implemented at all levels in the NHS, and may well become a major administrative cost not included in present budgets. In theory, trade unions have always seen health and safety as very much part of their fundamental objective to improve working conditions of members. Indeed, the Webbs in 1897 wrote 'in the trade union world of today, there is no subject on which workmen of all shades of opinion and all varieties of occupation are so unanimous and so ready to take combined action as the prevention of accidents and the provision of healthy workplaces.'[117] Unfortunately, this has since not always been so. Interest in safety varies between unions, and general official interest in industrial safety is low.[103] Many in-

dustrial practices (sometimes negotiated by trade unions), such as piece-rate systems, appear to contribute directly to accidents. Unhappily it is not always in the worker's short-term economic interest to take as much care about his own safety as he should.[103]

But this has begun to change. W Anderson pointed out in 1972 that the government in 1971 spent less than £11 million on the factory inspectorate and paid out around £100 million through the industrial injuries schemes.[113] Thus, what had often been a source of trade union pride—the amount won in compensation—has become a source of concern, perhaps particularly since health and safety have rarely been at the top of trade unions' priorities.

Safety standards tend to be set by legal enactment rather than by collective bargaining, and action by unions tends to be a protest at the employer's failure to comply with legislation, or to persuade the factory inspectorate to take action on unsafe working conditions.[103] In the NHS, the unions have become a significant force in the last ten years and have spent much of their energies conducting national disputes and recruitment drives, and organising campaigns against government expenditure cuts. Health and safety have been relegated to the traditional minor role. But disputes on staffing numbers are increasing, and it is likely that unions may attempt to use the Act to improve staff ratios.

The Act makes clear that health and safety are a part of industrial relations. For many, it has only just become so. It will be particularly hard for some NHS managers who, because of the rapid growth in trade unionism and the consequent challenge to authoritarianism, have yet to see trade unions as anything but an impediment to efficient work. The Act and its regulations are firmly in the pluralist tradition of industrial relations and will fundamentally challenge authoritarian attitudes in the NHS.

In most cases, NHS management is not prepared for the introduction of the regulations. On the other hand, to ensure that

safety representatives are equipped for their role, the TUC and trade unions have implemented a fairly extensive programme of training for them, in addition to the TUC's normal training courses for shop stewards, which have increased in recent years and which include the subjects of health and safety. The courses for safety representatives are either general—that is, representatives from different industries learning together—or specific to a particular industry, which includes one course for NHS representatives.

The aim is to train representatives to identify potential hazards, and to determine whether correct procedures are being followed. The emphasis on these courses reflects the trade unions' view that health and safety can best be improved by well trained representatives.

In addition, shop stewards are given handbooks by their unions which include a section on health and safety. The section usually sets out the objectives of the Act, the main duties of employers and employees, but does not give specific advice to the steward who may also be appointed safety representative. The GMWU, on the other hand, produces a shop stewards' guide to the Act which is detailed and provides specific advice to negotiators.[30]

As a result of activity by trade unions, managers are being forced to assess their own response and, in some cases, are hurriedly arranging courses on the Act and its regulations. Where management is not carrying out training and consciousness-raising on health and safety, the introduction of the regulations may be fraught with difficulties. A new and enthusiastic safety representative and an untrained manager may well conflict unnecessarily through ignorance. The HSE chief inspector pointed to this danger when he warned that workers' safety representatives will get to know as much as or more than their supervisors and middle management with the possible result that the latter will blame any subsequent troubles either on safety representatives, who may simply be getting down to the job, or on what they see as the unreasonable demands of the factory inspectors.

Such warnings are pertinent in view of the rather *ad hoc* local response to the Act. Because of the small amount of guidance, some teams of officers have had to make their own arrangements and decisions on how they are best able to comply. This results in different emphases and different stages of compliance.

In industry a safety officer is often employed solely to achieve and maintain safety standards. In the NHS, such appointments are less likely, arguably because of the complexity of the service's safety requirements, but more likely because of economic constraint. The trend is to make the coordinating function in health and safety part of the role of an administrator. As such, it has to compete with other duties, and is not a prime concern.

Most of the activity is concentrated in AHAs and districts, with the region in some cases providing a support role in training and advice. Some AHAs are making constructive attempts to comply with the Act. Working parties are being set up, involving the relevant independent trade unions, to coordinate activities*, and training programmes based on the Act have begun. But some areas are doing nothing. What is done is left to the districts. The districts themselves are not averse to such arrangements because they demonstrate that health and safety should be dealt with locally.

Some districts have efficient and enthusiastic safety committees. Their composition does not necessarily accord with the regulations and may have to be changed on request by two trade-union-appointed representatives. However, in such cases, trade union interest has been relatively low. In yet other cases, the district committees are frustrated, like area committees, by the unwillingness of unions affiliated to the TUC to sit with non-affiliates. And, of course, there are also cases where management and unions are working out together how best they can each comply with the Act

* In some cases, representation is frustrated by conflict between independent trade unions that are TUC affiliates and those that are not.

and with the necessary changes the introduction of the regulations will make.

A question to be decided by trade unions, but also of interest to management, is who should be the safety representative—the union steward or another person who would work in cooperation with him/her. The latter has advantages. The steward in recent years has had to acquire a great deal more knowledge, particularly about the implications of recent legislation, and it eases the load if the safety functions are carried out by another union member, who could be single-minded in developing the relevant skills. But part of the steward's role has been that of 'safety policeman'. More pragmatically, there may be too few candidates for the job. There may be doubts about the technical knowledge needed and the fear (although ill-founded) of accountability. The stewards may feel their role is undermined because appointed safety representatives will have more legal power than they. There may be an argument for creating the post of assistant steward to cope with the increased work rather than adding to the present function. The GMWU, in its advice to stewards, advocates an approach suitable to the local circumstance, the main concern being that the representative should be appointed through the trade unions.[30] However, John Edmunds, a GMWU industrial officer, has argued at a GMWU conference that only shop stewards should be appointed safety representatives because safety questions are closely linked to other negotiating issues. 'Safety rules could often affect earnings and unions dare not allow these vital issues to pass out of the shop steward's control.' * This is a convincing argument: safety issues arise with almost every negotiation on working arrangements, productivity agreements, shift changes and so on. The consequence of the stewards becoming safety representatives is that more will become full-time lay officials of the union, although officially employed and paid by the NHS. Interestingly, this is the very reason why the Rcn wants the safety representative's

* Reported in *GMWU Herald*, June 1977.

role to be separate from that of the steward. The Rcn argues that to combine the two roles would reduce the professional involvement of the steward.

The tendency for more stewards to become full-time union officials, or to spend more time on union business (a frequent point of contention) might not be welcomed by those NHS managers who perceive it as a further extension of trade union power, rather than the product of a pluralist system of industrial relations relying on joint consultation and negotiation.

Safety committees

A safety committee can be set up, according to the regulations, when two safety representatives ask management in writing for one. Those set up before the introduction of the regulations vary in composition and rarely comply with the standards now laid down. Some have few or no union representatives. This may change where there is sufficient commitment. A further problem may arise in the staff side composition. Under the law, independent trade unions have equal rights, regardless of TUC affiliation, to appoint safety representatives. Conflict on this is likely to impede the harmonious setting up of committees. This may lead to parallel systems of consultation, as in the case of some joint consultative committees.

Multi-unionism in the NHS will necessitate negotiation and consultation between unions, and between them and management. The regulations and code of practice give little guidance on this. Each union will want to be seen to be represented, particularly where there is competitive recruiting. However, in the more harmonious areas, spheres of influence are likely to be negotiated, since inter-union conflict will only serve to inhibit the effective operation of the safety representative's function.

Summary

Health and safety are very much part of industrial relations. What might at first seem a simple area for analysis—health and safety in an organisation explicitly devoted to health care—has emerged as a complex pattern of inter-related and, often, conflicting elements.

The HSE pilot study confirms the hazardous nature of work in the NHS, and raises a number of questions which deserve attention. First, the potential conflict between the health and safety of the staff and the care of patients must be considered. Second, research is needed on the effect of certain kinds of work on staff. Research costs money, and the DHSS is reluctant to reassure the representatives of those who work in the NHS that sufficient resources will be provided to ensure a safer environment for working. This is particularly worrying because of Crown immunity which leaves NHS workers in a potentially more onerous position than those in non-Crown employment. Should the HSC be successful in its attempt to make the Crown as liable as any other employer, one wonders if this will affect the attitude of the DHSS.

Few would disagree with the objectives and spirit of the Act. But tacit sympathy must be translated into action by management and unions, and by sufficient resources. Despite the involvement of trade unions by law in questions of health and safety, it should never be forgotten that these are the responsibility of management in the NHS and, ultimately, the DHSS. Without management's wholehearted commitment, health and safety may become major negotiating issues.

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[illegible] and between them [illegible]
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6
Managers and industrial relations

BRIAN EDWARDS

Managers in the National Health Service during the 1970s have seen their organisation almost torn apart by conflict and turmoil. The service has moved from relative stability with modest growth, paternalistic management, an obedient and well motivated staff and high public esteem, to organisational crisis. This crisis is characterised by the instability of NHS organisational and management structures, recurrent financial problems, poor morale among staff who are constantly at odds with both their employer and each other, and mounting public unease and concern.

This chapter considers the crisis from the position of the managers and observes how they reacted to it. The crisis did not build up overnight, nor did it stem from one source. The general social turbulence of the 1970s, the Arab oil embargo, the poor economic climate and successive government pay policies are as significant in the building of the crisis as are changes and pressures generated from within. Poor pay, distorted differentials, the growth of trade union membership and power, and the hostility between the doctors and the government were all potent internal sources of conflict. The much-criticised reorganisation of the NHS in 1974 created an environment in which long established problems and grievances could gain positive expression.

The first problem any manager faces is to appreciate that he has one. Despite clear warnings, it was not until the mid-1970s that

management in the NHS began to take industrial relations seriously. The first strikes in 1972 by the ancillary staff came as an enormous shock both to management and to other groups of staff. But the shock soon wore off and managers became preoccupied with the preparations for reorganisation. But while they were busy changing the structure, the health service began to change imperceptibly around them. Trade union membership was increasing and there was a hardening of attitudes amongst staff on the issue of pay. The ancillary staff had breached the emotional barrier against strike action, without disaster either to patients or to themselves, and other groups of staff were beginning to prepare themselves to follow suit. For the first time, differentials between different groups of staff (ancillary staff, nurses, technical staff) became matters of some significance. Among ancillary staff, union power was already growing as a consequence of local productivity bargaining.

There were two basic management approaches to the changing scene in the early 1970s. The first was to preserve the *status quo*. Trade unions were powerful only if management recognised them as such—if they were kept at arm's length their members would quickly regain their loyalty to the service (and its managers) and the unions would return to their real heartland in industry. The other approach, which it must be said was adopted by a small minority of managers, was that trade unions were here to stay (if only among ancillary workers) and managers would have to adjust. Trade unions would have to be consulted before managers took decisions about union members' pay or conditions of service, and this in itself demonstrated the need for some sort of machinery for regular contact. Very few managers were prepared for the speed with which groups of professional staff would become involved in militant action or how consultation would begin to shift into negotiation.

As the NHS moved towards reorganisation, managers were reasonably confident that they had things under control. Most had

experienced some kind of industrial action during 1972 and 1973, although most of this action had been taken by staff in pursuit of national grievances and as a result they came to believe there was little point in fighting their own managers because the solution could be found only at national level. So relationships between local managers and their staff remained reasonably good, though there were isolated examples where a conflict became a bitter test of strength and sowed the seeds of many future conflicts. There are other examples of local managers and shop stewards conspiring to exaggerate the nature and strength of the conflict to their respective superiors. Both—for the shop stewards were as inexperienced as the managers at this time—used the period to test each other out and to learn the rules of the game. Shop stewards and full-time trade union officials began to get an idea of how determined their members were prepared to fight, and managers began to recognise the need to negotiate, at least with representatives of the ancillary staff. The value of the mass media during a dispute was quickly appreciated by the trade unions, but management was slow to adjust and earned itself a lot of bad publicity. Both sides began to recognise the problems of getting into win/lose situations and senior management began to look with some concern at the attitudes and conduct of departmental managers who were, of course, right in the thick of the battle. It was perhaps the departmental manager who suffered most. He suddenly found that his staff were not prepared to follow his orders and, when there was a problem, the unions dealt not with him but with his bosses. As a result, departmental heads were becoming increasingly frustrated and began to show it in the day-to-day management of their departments.

The storm clouds began to build up in the late autumn of 1973. Trade unions were by now well established in the health service and actively competing for members—itself a source of many of the conflicts during this period. The unions were increasingly taking industrial action in support of local issues and militancy was beginning to spread beyond the ranks of the ancillary staff.

Management, of course, was in the throes of NHS reorganisation. The most senior officers had left their old posts to help 'shadow' authorities prepare the ground for the appointed day, and their work was being done by more junior staff. They did very well, but in the field of industrial relations they could do no more than fight the fires as they developed. Not much positive progress could be made.

The appointed day for NHS reorganisation, 1 April 1974, passed peacefully and for a while it looked as if the service would survive the structural changes with the minimum of fuss. Two of the unexpected consequences of reorganisation were the slowness with which new appointments were made to management, and the amount of movement between jobs. Surprisingly large numbers of senior managers were new to their districts, and there was considerable movement of staff up the structure which left the key posts in units to be filled by relatively inexperienced officers. During the summer and autumn of 1974, the new service was most vulnerable. Above all, it needed time to settle down, to re-establish new processes of communication and of making decisions, and to develop proper relationships between the new managers and the staff they were managing, the key professionals in the district and the trade unions.

However, time was not on the managers' side, for by the late summer of 1974 the health service was again in turmoil. The nurses and radiographers were taking industrial action and the ancillary trade unions, in particular, were forcing the issue of removing private patients from the NHS. The consultants reacted as expected. In January 1975, they lost their patience and took industrial action themselves. They felt harassed on all sides. Mrs Barbara Castle, the then Secretary of State, had declared her intention of closing down private practice in the NHS; negotiations on the consultants' new contract had broken down; the ancillary trade unions were attempting to dictate admission policies and the consultants had lost faith in the new management

structure. The action by consultants caused the most acute problems for management. In the past, the consultants had always been regarded as part of the management structure of the NHS. Their 'action' lasted just over three months but it proved to be a watershed in the history of the service.

Once both consultants and junior doctors had been perceived as putting their own interests before that of their patients, every other group could do so with impunity. Management's trump card—the patient must come above all sectional interests—had been removed and this left local managers almost helpless. The trade unions quickly realised this and began to demand local concessions that were either at variance with or, on occasions, completely outside the national agreements—local shop stewards began to assert their authority to negotiate with their own managements. Faced with the choice of paying junior doctors over the odds or closing accident departments, management chose the former; faced with the cessation of emergency duty services by radiographers, management paid what it was being asked to pay; many of the productivity deals with ancillary staff became wholly one-sided, designed to ensure that the ancillary staff took home a reasonable pay packet.

It is easy in retrospect to be critical but the fault—if blame is to be apportioned—lies as much at the door of the Secretary of State as with the managers in the service. Whenever the politicians were tested, local management received the response 'If lives are at stake, do what you consider to be the best in all the circumstances'. Given that, most managers acceded to the demands regardless of the consequences.

It was during this period that the first evidence began to emerge of the uncoordinated approach to the problems of industrial relations by management. Even in one authority, district management teams would be negotiating separately with their local trade union officer and were so concerned to dampen the fires

raging all around them that little, if any, effort was made to co-ordinate their settlements with management in other districts or other areas. As a consequence, leap-frogging claims became common. This was hardly surprising, for the NHS reorganisation itself had created a set of circumstances where it was inevitable. All the new health authorities were amalgamations of former authorities, each of which had had its own personnel policies and, even within the national framework, there were significant variations in the generosity or otherwise with which DHSS circulars had been interpreted—particularly those about gradings. In addition, one of the new parties—the local government staff—had been part of a very different negotiating structure anyway and there were significant differences between their terms and conditions of service and those of hospital staff.

The problems are best illustrated by what happened in the ambulance service. On the appointed day, many of the new health authorities responsible for ambulance services found themselves managing a service with men drawn from up to 15 former authorities. The men were on different bonus schemes, had widely fluctuating rates of take-home pay and conditions of service. It was a personnel officer's nightmare that has still not been fully resolved. The ambulancemen, not surprisingly, sought to remedy the variation by levelling up—a process in which they were largely successful and which, to some extent, explains why the reorganisation of any structure is a very costly business. But the problems generated by reorganisation—intractable as they were—simply added fuel to the fire already burning, and eventually the management itself began to feel the strain and started to prepare itself for self-inflicted wounds.

The new management structures, which had been designed by outside advisers led by Sir Keith Joseph, had been under heavy criticism almost from the beginning. The Labour Government which had assumed responsibility for reorganisation had never been happy with Sir Keith Joseph's approach and quickly said so.

The doctors, too, had had their doubts right from the beginning (despite the fact that the whole structure was designed to give them a lion's share in the future managerial structures) and began to attack the bureaucracy even before the end of 1974. Indeed, it was not long before authorities themselves started changing the structures that were hardly in place. In Liverpool, Leeds, Manchester and Sheffield, AHAs began to ask themselves whether they ought to reduce the number of districts they had created only some few months earlier. The consequence was inevitable, and the ripples of apprehension were felt throughout the service. So, by the end of 1976 the managers, and perhaps more particularly the administrators and the personnel officers who had borne the brunt of the conflict, were under attack from all sides. They were trying to hold together a service that seemed intent on breaking itself apart, trying to support a Secretary of State, Mrs Castle, who had publicly disowned it—'We never designed this bureaucracy'—and trying to control local industrial action in circumstances where negotiations, of which they knew little, took place at the centre. As a result, they were constantly in the cross-fire, and it is to their credit that most of them stuck to their task because of their belief that the service would ride out the storm. But the storm is still with us, though by the end of 1978 it had abated somewhat. The problems remain, but it is now possible to reflect on the experiences of the mid-1970s to see what management learned from them and what can be done to ensure a calmer future.

A national framework

The centralised bargaining system of the NHS has been under increasing strain in recent years. Indeed, most of the industrial action in the service has its roots in the Whitley system. Lord McCarthy in his report, *Making Whitley Work*[94], provided an accurate and perceptive view of the way the system worked until 1976. Despite minor modifications since the McCarthy report, the system is still not working effectively and, from a

management point of view, three issues remain unresolved. These concern reconciling national agreements and local flexibility, tackling deep-rooted differential problems between various groups of staff, and identifying who are the managers and getting them to adopt a coherent and coordinated approach.

Few people in the NHS today would argue against the principle of a national pay structure. It produces a degree of equity—the same pay for the same job wherever it is performed—that has attractions to both management and staff. National agreements limit the scope for local bargaining and, thereby, it can be argued, the potential for conflict. They inhibit leap-frogging claims and competition between employers which could have the effect of pushing up the going rate for the job and, thus, distorting differentials. The only significant disadvantage for management lies in the inevitable rigidity of national agreements which can restrict management's ability to respond to local problems (or competition from other employers) and to initiate new developments.

Lord McCarthy recognised this problem and suggested the development of more flexible national agreements which would retain the benefits of the national structure but permit a degree of local variation.[94] A neat solution—if it can be made to work. The difficulty lies in picking issues where flexibility is appropriate without damaging the structure of national agreements. A simple example in which flexibility could usefully be permitted relates to starting points on nationally agreed, incremental salary scales, and this is under discussion in many of the functional divisions of the Whitley system.

Unfortunately, almost the first example of a flexible national agreement in the post-McCarthy period was that relating to the granting of two extra statutory holidays. The decision as to which days would be selected was left to local discretion. That discretion has been the cause of untold confusion and controversy. The staff themselves often could not agree which days should be taken, and

there was a good deal of conflict between local trade union officials as well as between management and staff. In many cases the ambulance service selected days different from those of the hospital staff—as a result four days' work was lost, not two. Managers are now pleading for this local flexibility to be removed and the two days either nominated nationally or added to an individual's annual leave.

It can be argued that the bank holiday problem is another illustration of managerial incompetence (and that argument would have some force) but the more likely truth is that insufficient thought was given to the practical ramifications of flexibility on this issue, and local managers were totally unprepared. Flexibility is two-edged, as NHS managers have quickly come to appreciate.

Internal differential problems are an increasing source of conflict and militancy—the maintenance supervisors' dispute in October 1978, with its crippling impact on hospital services, was a product of narrowing differentials and a rigid pay policy. The service is still coping with the nonsense whereby senior registrars often earn more than the consultants who are training them. These are two of many examples. Whilst the differential problems have been exacerbated by successive incomes policies, the real causes lie within the Whitley structure itself. There is little effort to coordinate the agreements reached by the various functional councils, which operate largely as independent bargaining units with the inevitable results. Productivity bargaining for ancillary staff has grossly distorted differentials with supervisory staff, whose salaries are negotiated in other councils where productivity bargaining is not a feature of the pay structure. The General Whitley Council, which is supposed to deal with issues common to all functional councils, does not appear to be able to exercise an effective coordinating role, and there are wide variations in conditions of service as a result.

Of all the possible solutions the 'spine' approach appears superficially to be the most attractive. This means one salary structure

for the whole of the NHS with each job allocated its place on the spine. The whole structure would move with wage awards, thus preserving established differentials. Attractive as this notion might be, the likelihood of getting everybody to agree where they ought to fit on the spine seems remote, and differentials would in any case be distorted by variable payment systems, such as productivity bonus payments. But even if the spine is an academic's dream, the service could at least develop a more coordinated approach itself by pulling together the management sides of the various functional councils in a more formal and systematic way.

But who are these NHS managers who negotiate national agreements? Following the recommendations of Lord McCarthy[94], each functional council now comprises a representative from each English region, together with representatives of the Scottish and Welsh health authorities, DHSS, SHHD and the Welsh Office. The methods for selecting the regional representatives tend to vary, but in the main the selection is controlled by the chairmen of the various health authorities within a region. The Ancillary Staffs Council is a typical example and in 1978 was made up as follows.

Chairmen of health authorities	3
Members of area health authorities	7
Regional administrators	2
Area administrators	2
District administrator	1
Area works officer	1
Area treasurers	2
Civil service officials	5
	23

It will be seen that lay members of health authorities are by far the largest group and that not a single NHS personnel officer is involved. The process of detailed negotiation in all functional councils is handled by civil servants who have no experience at all of NHS management, and few have any specialist training in personnel management or industrial relations. Some civil servants who have stayed long enough to gain the necessary experience have earned the respect of their NHS colleagues, but they are exceptions.

The whole system is astonishingly amateurish, despite the well intentioned efforts of everybody concerned, and it is little wonder that a wide gulf has opened up between those representing the NHS on negotiating committees and the managers of the service.

There have been very few attempts to develop an effective means of testing the opinions of management or of allowing people working in the health service to influence the nature of national agreements. One notable exception was the occasion when the Ancillary Staffs Council had to deal with a proposal by the unions to develop a closed-shop or union membership agreement. Because of the far-reaching implications, the council formally sought a view from NHS managers and authorities. In the event, the response was negative but it was evidence that one council was trying to reflect the views of the health service in its negotiating activities.

One possible solution to some of the problems of the Whitley system may be an independent management secretariat—independent, that is, of the DHSS. This would at least ensure that national negotiations were supported by specialist personnel officers with NHS experience. It would also provide a centre for communications and links with NHS managers and authorities. Overall pay policies would, of course, continue to be dictated by government ministers.

Problems of structure

In its evidence to the royal commission on the NHS, ACAS drew attention to what it considered to be three weak links in the organisational structure.[3] The need for clarity of policy and firm direction in multidistrict areas is so obvious that it needs action rather than elaboration, and the comments of ACAS on the need for a corporate approach to industrial relations problems by management teams are equally sound. It is their third weak link, that of the unit administrator and line manager, that deserves the closest attention, for this is where services are delivered and where most industrial relations problems begin. Far from achieving the objective of decentralising management decision-making, the reorganised structure within districts has all too often produced precisely the opposite effect. Catering, domestic and works services are commonly managed on a district basis. Nursing staff are usually organised into specialties (maternity, psychiatry, general, and so on) rather than institutional groupings. As a consequence, it has become increasingly difficult to manage the large institutions as natural entities. A unit administrator may find himself trying to cope with six or more functional heads, all of whom are senior to him in organisational terms, outside his institution, each operating separate personnel policies and each with his/her own management style, which may be widely divergent.

The usual result is that the focus for making decisions moves to district or area level in single-district areas and the trade unions also refer their problems to the district because it is usually the lowest point at which real decisions can be made. In organisational terms, the district or area management team is almost at the apex of the management structure and yet the new structure was supposed to be designed to achieve maximum decentralisation of decision-making! I believe that there is an urgent need to re-establish the larger hospitals (or geographic health sectors) as a key decision-making level. To achieve this, management teams will

have to delegate far more responsibility than they do, so that problems and opportunities for development may be readily identified and dealt with quickly by officers on the spot. The teams must encourage a shift of power (at least as far as the day-to-day application of personnel policies are concerned) away from functional managers operating at district (or area) level, in the direction of either unit administrators or multidisciplinary hospital management teams. The latter is the preferred option, but this entails a positive attempt to blend more effectively the divergent management structures for nursing and administration.

But whatever the shape of the structure, the over-riding need is to inject some clarity into the process of making decisions. The lack of clarity breeds confusion and conflict, and is as debilitating to management as it is frustrating to staff and trade unions.

Questions of conscience and ethics

A unique problem for both NHS managers and unions is the potentially dramatic, tragic and irretrievable consequence of industrial disputes. In industry the major risks of unresolved conflict for both sides are economic collapse and the loss of jobs. In the NHS, economic collapse and loss of jobs are only remote possibilities: the key issue is the extent to which patients will be inconvenienced or harmed. To deny that patients suffer during industrial action is, in my view, to deny the facts. Every time hospital services move on to an 'emergencies only' footing a whole range of patients is exposed to a new set of risks arising from delayed diagnosis or treatment. Every time standards of care are lowered due to a shortage of linen or sterile supplies, patients are at least discomforted and, on occasion, exposed to new dangers.

The staff of the health service are well aware of the consequences of their actions. The first time individual groups or professions have to face a decision to take industrial action they approach it

with anxiety and very real concern. Unfortunately, once they have faced and made the decision, it always seems easier the second time around. Whilst the problems are there for all staff, it was perhaps the medical profession, with their Hippocratic Oath, who faced the most acute dilemma.[24] However, once the doctors' leaders decided that they, too, had to take industrial action in support of their grievances, many other groups of hospital staff, which had until that time set their face against it, found themselves able to follow the doctors' lead. The doctors' action finally removed the deep-rooted ethical objections to industrial action in the NHS.

Some would argue that, because of the inevitable impact on patients, NHS staff ought not to take industrial action at all. It is, they claim, morally wrong to put patients at risk, and a direct breach of long-established professional ethics that were temporarily, and misguidedly, put to one side in the heat of battle. However, this view can be countered by the argument that, in our society today, the reward of selfless dedication to the needs of others is poverty and that in some circumstances industrial action is the only effective response left to members of staff who work for arbitrary and unjust managers. Others put the whole argument in a wider context and see the problem as one not just for health service staff, but for society as a whole. Why should NHS staff accept their meagre lot because of their sense of duty and dedication when teachers, firemen and others providing a public service reap the rewards of militancy? Whatever view is taken on this issue, the dilemma for staff and trade unions can be recognised.

However, what is not always acknowledged is that managers on the other side of the negotiating table have to face the same agonising problems. Those who claim that NHS management is weak often ignore the fact that the consequences of strength may be a battle, with patients the principal casualties. It is all very well to argue that the consequences of a battle are problems for the

staff alone to face and live with, but a sensitive manager can see for himself the impact a dispute may be having on patients. He has to ask himself whether the point of principle he is seeking to uphold, or the demands he is resisting, are worth the risks to which patients are being exposed. He also has to be acutely aware of the extent to which his stand will be supported by both his authority and its political masters. All too often managers in the NHS have found that in the face of fierce industrial action (regardless of the justice or otherwise of the claim), their superiors will accede to the demands rather than risk the political or other consequences of danger to patients.

But what should a manager do? Give way to every demand; stand aside and push the problem up the managerial hierarchy; pass the problem to the politicians; or do what he thinks is right and live with the consequences? Attitudes on this issue amongst managers appear to be changing quite significantly. During the first examples of serious industrial action in the early 1970s by ancillary staff the attitude of most managers was to resist union demands and to protect the health service and the patients from the consequences of militancy. Thus management volunteers were recruited to run laundries and deliver goods and services round the hospital. In taking this action, managers were supported by other staff—particularly doctors and nurses.

However, as militancy became more widespread and began to involve a wider range of staff, and in particular doctors and nurses, it became increasingly difficult for managers to maintain services against the wishes of staff. As this happened, the approach began to shift to one of doing whatever was necessary to preserve the lives of patients—which in practice usually meant conceding the union demands.

More recently, managers have started to take a rather different line. They have begun to recognise that, on some points of major principle, the interests of the health service and its patients will be

best served by a firm stand. No pay during strike action is one principle. Another is the need to preserve a proper degree of clinical freedom for doctors and their patients. Managers must not permit shop stewards to dictate which patients will be admitted to hospital unless, in exceptional circumstances, the doctors concerned accept such a policy (as is sometimes the case in psychiatric hospitals when the admission of violent, or potentially violent, patients is being considered). Faced with industrial action on a major point of principle, managers are beginning to say to trade unions 'If your members can live with the consequences of the industrial action they intend to take, then so be it—it is not for me to protect you from the consequences of your considered actions'. This approach, which now appears to be gaining ground rapidly, may be seen by some as new tactics by management in calling the bluff. It is more usually a wholly realistic acceptance of the fact that a manager's power to preserve services against the wishes of militant staff is slight. Ironically, it may well be that this recognition of the limits on a manager's power, belated as it is, will have a beneficial effect in that, as staff and trade unions begin to see that they do indeed have the power to bring the health service to a halt, they may use that power more responsibly. It remains to be seen how events will develop, but no one should under-estimate the enormous moral and ethical problems that face managers in the conduct of industrial relations, and this distinguishes them in a sharp and a clear way from their counterparts in industry.

The possibility of a general acceptance by staff that they should give up their right to strike seems remote, despite the stand taken by the Royal College of Nursing. In these circumstances the only solution is to create an organisational environment in which problems can be solved without the need for staff to resort to industrial action.

The need for a strategy

Most NHS managers recognise the urgent need for a coordinated national and local strategy for coping with industrial relations problems and for developing a healthy organisational climate in which conflict is contained within acceptable limits, staff receive what they regard as fair rewards in relation to their neighbours within the health service and outside it, where all sides recognise the needs of the patients, and in which the energies of managers, staff and unions are channelled into improving, invigorating and sustaining the service.

That no strategy exists reflects the general state of a service that lives from day to day and, seemingly, from crisis to crisis. There is no clear lead from the top of the service. The national negotiating machinery is uncoordinated and few authorities have been able to invest the time and energy required to lift their heads above the problems of the moment.

Those authorities which have attempted to develop a local strategy have found it very difficult to sustain because of the activities of management at national level and the actions of neighbouring health authorities. For example, the national decision to pay back the money PTB staff lost as a consequence of arbitrarily reducing their hours of work cut the ground from under many authorities who had taken the line that in no circumstances would they reimburse staff for income lost during industrial action. Equally irresponsible is the attitude of some authorities who, albeit under duress, concede additional payments that had been resisted by the management side at national level. Those health authorities who agree to give doctors four sessions' pay for two sessions' work in accident and emergency departments may keep their service open today. However, next time round they will be asked to pay six sessions, and then eight, until eventually the whole structure will become anarchic and these departments everywhere will begin to close.

The need for a coordinated national and local strategy does not imply a prescriptive, standard solution to the problems of every health authority. It implies, however, managerial discipline within an agreed framework. To be effective, any national strategy must concentrate first on coordinating the national negotiating processes, defining the areas and limits of local bargaining, and establishing effective management links between the centre and the periphery. Locally, authorities must first establish a sufficiently sensitive information system to enable them to know what is going on in their own organisation. They can then begin a systematic process of injecting equity and clarity into their personal policies, of training line managers to manage effectively, and of evolving a structure that will facilitate a constructive relationship between managers and trade unions.

Both local and national strategies must identify what response management is going to make to industrial action. What do managers do when staff work to rule? Send them home, stop their bonus payments or pretend nothing is happening? How do managers cope with disputes such as that of works officers in 1978 when the officers concerned simply refused to do one of their duties? Do managers accept the situation, or do they send the men home and put all emergency services at risk?

The issues cannot be thought out in the middle of disputes. Managers must know what action they will take (and so must the staff concerned) before the event and they must coordinate their activities with those of their neighbouring authorities. The need for a coordinated approach by management suggests the need for some regional machinery to coordinate policy. I am not suggesting the establishment of regional Whitley machinery, which in my view is a wholly misconceived approach to the problems, but a forum for the evolution of managerial policy.

Matters of pay and conditions of service are not, of course, the only ones about which authorities need to have a strategy. They

need to develop and sustain the means of allowing the ideas and talents of their staff to contribute to planning and the making of policy. They need to develop an effective programme of managerial training as well as a decision-making process which allows first line and middle managers to *manage.*

Above all, there is a need for managers at all levels to get off the treadmill of daily crises, if only for a short time, and to concentrate their minds and energies on deciding what sort of organisation they want to see in the future and how they will create it. It is time the health service itself took charge of its own destiny.

[redacted]

7
Professional associations

ROGER DYSON and KATHERINE SPARY

In recent years almost all the professional associations with Whitley Council status in the NHS have been rapidly developing their industrial relations activities at every level in the service. There are also associations without Whitley status which have been developing in this way. This chapter considers this development, its validity and its implications for the NHS.* The chapter is not intended to analyse the concept of professionalism, nor to assess the professional activities of the associations concerned. It accepts at face value each organisation's claim to be a professional association simply as a means of determining which are to be included within the analysis.

Despite this open-ended definition, there is considerable similarity in the stated objectives of the different professional associations operating in the NHS.* They aim to promote the development of the profession, to maintain professional standards, to uphold the status of the profession and to provide representation upon and protection for the interests of the profession as a whole, and the welfare of its members. They also set out to provide the human and financial resources necessary for fulfilling these objectives.

*This information comes from that published by the associations or from the authors' personal communication with them. It was correct at the time of going to press, though some of the details may require bringing up to date quite shortly. Developments in some associations are proceeding rapidly, and readers are asked to bear this in mind.

To achieve this, they provide educational facilities, research grants and scholarships (within the limits of their funds) and almost half of them have examining-body status and provide postregistration courses of various types.

Almost without exception, they publish journals or newsletters to facilitate a national exchange of information about research and developmental activities within the profession. However, it is arising from their objectives to protect the interests of the profession and the welfare of its members that their activities in industrial relations have grown. It is clear from constitutions and charters that they see themselves as the watchdogs of the profession on all legislative and administrative proposals and it is this, as well as their responsibility for the welfare of members, that has caused them to maintain and develop Whitley Council activities. They seek to influence, and even to lead, staff side representations to the Secretary of State upon matters of professional concern, and to protect the status and interests of the profession by participation in Whitley Council business. It was in recognition of the growing importance of this activity that the Rcn extended its objectives to include more specifically the promotion of '. . . the professional standing and interests of members of the nursing profession'.[108] It is as a result of this way of interpreting and developing their objectives that most professional associations became involved in industrial relations and are extending that involvement.

The professional associations included in this analysis are those with full voting rights on the staff side of the appropriate Whitley Council and, as such, are involved in collective bargaining at national level. Most of these professional associations are now certificated as independent trade unions under Sections 8 of the Trade Union and Labour Relations Act of 1974[80] and of the Employment Protection Act of 1975.[62] As such they can be regarded as single-profession trade unions, in contrast with the multi-occupational trade unions such as NUPE, COHSE, NALGO

and ASTMS, which either recruit among all occupations of the NHS or among several industries and services. This chapter also considers those single-profession trade unions in the NHS which, as we write, have no Whitley Council status; for example, the Hospital Consultants and Specialists Association (HCSA) and the Guild of Medical Secretaries (GMS). There are some professional associations operating in the NHS which do not have voting rights on the staff side of the Whitley Councils or which have chosen to merge with multioccupational trade unions. Two of these associations will be considered in order to compare their experience with that of the single-profession trade unions.

The following section identifies the professional associations involved, their size and Whitley Council status, and their industrial relations staffing resources. There follows an analysis of the validity of their recently acquired status as single-profession trade unions and its immediate and longer term implications for the NHS. The professional associations are considered in five different professional groupings: medical and dental, nursing and midwifery, professional and technical, administrative and clerical, and optical. The only organisations with Whitley Council status not to be included are the joint committees of one type or another which are not associations in their own right.

Medical and dental

The British Medical Association (BMA) and the British Dental Association (BDA) are the oldest professional associations considered in this chapter (see Table 1). Only the BMA was recognised as involved in negotiation before 1948 and that recognition continued with the creation of the NHS. The BDA's negotiating status was not formally recognised until 1950. Since then the BMA and the BDA have been the only professional associations fully recognised by the DHSS as eligible to negotiate on behalf of doctors and dentists. The more recently formed HCSA and

Table 1 DOCTORS AND DENTISTS

	Year established	Number of members	Certificated independent trade union	Whole-time officers	Representatives or stewards		Examining body	Involved in pay negotiations before 1948
					Number	Year introduced		
British Medical Association	1832	52 859[a]	Yes	84	–[b]	–[b]	None	Yes
British Dental Association	1880	12 027[c]	Yes	8	0	–	None	No
Hospital Consultants and Specialists Association	1944	4 300	Yes	4	180	1976	None	No
Hospital Doctors' Association	1966	4 852	Yes	3	0	–	None	No

a Includes retired members but excludes overseas members
b No precise numbers of place of work accredited representatives (POWARs) are available
c All categories of membership

the Hospital Doctors' Association (HDA) are not so recognised, but individual members are eligible to participate on the staff side of the joint negotiating subcommittees because the election process does not distinguish between the associations. However, the staff side of the negotiating machinery is financed and serviced via the BMA, in the case of doctors, and for this reason both the HCSA and the HDA have sought a more independent forum in which their status and independence could be recognised.

All four associations are very aware of their trade union role. The associations representing doctors were among the first to obtain certification as independent trade unions, and the HCSA and the HDA have formed the British Hospital Doctors' Federation (BHDF) as a means of strengthening their unity and commitment to trade union responsibilities. All the associations are proportionately well supported in terms of the ratio of whole-time administrative and industrial relations officers to membership. The BMA has undertaken an extensive series of appointments to industrial relations officer posts, including the appointment of a chief industrial relations officer with considerable professional trade union experience.

In the appointment of lay officials, the more recently formed HCSA took the initiative and its representative–member ratio is now as low as 1 : 25. Spurred on by the prospects of the new work-sensitive consultants' contract, the BMA moved in the same direction with the appointment of place of work accredited representatives (POWARs). So far the BDA has not chosen to move in this direction. In the appointment of local representatives, the HCSA acted first and subsequently went so far as to ballot members on the desirability or otherwise of seeking affiliation to the TUC. The decision to ballot, and the favourable majority achieved, indicate how extensive has been the shift in attitudes towards the trade union role.

Nurses and midwives

All the professional associations on the Nurses and Midwives' Council were established before 1948, and five were involved in pay negotiations before the NHS was established (see Table 2). Four associations, the Royal College of Nursing (Rcn), Royal College of Midwives (RCM), Health Visitors Association (HVA) and Association of Supervisors of Midwives (ASM), were members of the Rushcliffe committee*, and the Association of Nurse Administrators (ANA) was involved, under its former title Association of Hospital Matrons, in regular consultation with the former Ministry of Health. Between these associations there is a certain amount of dual membership, although its extent is not fully known. It is probably most extensive between the RCM and the ASM, but there is also some between the Rcn and the RCM, and between the Rcn and the HVA.[7,20]

One or two local studies of dual membership between the professional associations and the multi-occupational trade unions in nursing have produced different results. There is so far no published work on the extent of dual membership nationally. Membership of all these associations is voluntary and two, the Rcn and the RCM, have examining-body status, though the Rcn's is more limited in that it is non-statutory.

The Rcn, RCM and HVA have all expanded their full-time officer support to the membership, particularly with regard to industrial relations work. The Rcn has made a substantial number of additional appointments in the NHS regions and the RCM has extended its central labour relations staff. All three associations have established steward/representative systems, and the Rcn and the RCM were amongst the first NHS organisations to appoint union stewards. The Rcn's training programme for stewards is

*The negotiating body on salaries and conditions of service for nurses and midwives before 1948.

unquestionably the best developed of any NHS professional association and may be considered to compare favourably with that of the long established multi-occupational unions. Despite the HVA's status as a TUC affiliate, the proportion of its full-time and part-time resources for upholding its industrial relations responsibilities is very similar to the two royal colleges.

Of the smaller professional associations on the Nurses and Midwives Whitley Council, only the ANA has moved beyond certification to undertake the systematic development of a framework of lay representatives throughout England and Wales. The RCM has the lowest ratio of stewards to members, 1 : 25; the HVA and Rcn have a ratio very similar to one another, 1 : 50 and 1 : 55.

Of the 29 seats on the staff side of the Nurses and Midwives Council, the professional associations hold 18 and the secretaryship of the council is held by the Rcn. However, this council has a negotiating subcommittee of 12, with power to settle pay issues without reference back to the full council. Here the division between single-profession and multi-occupational trade unions is much narrower, for the two groups each hold half of the seats. The distribution of seats on the negotiating subcommittee is a closer representation of membership support than that on the full staff side of the council.

The HVA affiliated to the TUC in 1924, and there is a feeling that in the past this caused some alienation between the HVA and the other professional associations. In recent years, however, the interests of the HVA and their fellow professional associations have come much closer: they are now all certificated as independent trade unions, they have all appointed local stewards and representatives, and even the TUC may not divide them in the future.* But for competitive recruitment between the Rcn and the HVA, these associations might be even closer than they are.

* As we write, the Rcn is preparing a public debate on the question of TUC affiliation.

Table 2 NURSES AND MIDWIVES

	Year established	Number of members	Certificated independent trade union	Number of Whitley Council seats	Seats on negotiating committee	Whole-time officers	Representatives or stewards		Examining body	Involved in pay negotiations before 1948
							Number	Year introduced		
Royal College of Midwives	1881	17 465	Yes	3	1	14	500	1972	Yes	Yes
Health Visitors Association[a]	1896	11 300	Yes	2	1	5	200	1975[b]	No	Yes
Association of Hospital and Residential Care Officers	1898	1 200[c]	No	1	0	0	16	—[d]	No	Not known
Scottish Association of Nurse Administrators	1910	approx 400	No	1	—	0	0	—	No	No

Royal College of Nursing of the UK	1916	122 420	Yes	8	3	80	2 000	1972	Yes	Yes
Association of Nurse Administrators	1919	approx 1 000	Yes	1	1	0	14	1977	No	Yes
Scottish Health Visitors Association	1919	820	Yes	1	–	0	35	1977	No	No[e]
Association of Supervisors of Midwives	1912	190	No	1	–	0	0	–	No	Yes

a Affiliated to TUC 1924
b Date of formal acknowledgment
c Compulsory membership of NALGO
d Not known
e Not applicable

Professional and technical staff

With the exception of the Association of Clinical Biochemists (ACB), all these associations were formed before 1948 and were involved in the negotiation of terms and conditions of employment before then (see Table 3). On the PTA Whitley Council, most associations have very strong membership amongst eligible NHS staff, particularly the five smallest associations, and the variations in size between organisations largely reflect variation in the size of the profession. The distribution of seats on the PTA Council makes some recognition of these differences but is, nevertheless, weighted in favour of the smaller associations.

Membership of all these associations is voluntary. Some associations have examining-body status and hold postregistration examinations which may be necessary for advancement beyond basic grade appointments. This role *may* assist in maintaining membership numbers, but professional associations without this responsibility, such as the British Orthoptic Society (BOS) and British Dietetic Association (BDiA), seem to recruit as successfully as the others.

Almost all the associations are certificated as trade unions. Certification has been followed by increases in the number of full-time officers, and the Chartered Society of Physiotherapy (CSP) and Society of Radiographers (SR) have appointed industrial relations officers. Most important in strengthening the industrial relations role of these associations has been the rapid development of a local steward/representative system. On the PTA Council, this has affected every association, even the BDiA which as we write is uncertificated*, and only the British Association of Occupational Therapists (BAOT) has yet to get the ratio of members to stewards below 50 : 1. Three associations have a ratio of less than 10 : 1

*The association appears to be awaiting the outcome of moves towards TUC affiliation by some other NHS professional associations before deciding its future course.

and, as stewards of these associations become trained, the local service to the members is likely to be impressive by ordinary trade union standards.

The one obvious weakness of many associations on the PTA Council is their size, and in 1977 this was recognised to the extent of establishing a confederal structure of all nine associations known as the Committee of Professional Organisations (CPO) of the PTA Council. Its principal objectives were to encourage similar local groupings of their stewards for mutual support, and to organise a more effective national service to the stewards in providing research facilities, policy guidance and training.

Administrative and clerical staff

All nationally recognised professional associations on the staff side of the Administrative and Clerical Whitley Council were formed before 1948, and two of them, the Institute of Health Service Administrators (IHSA) and the Association of National Health Service Officers (ANHSO), were involved in pay negotiations before that date (see Table 4). The Guild of Medical Secretaries (GMS), the most recently formed professional association, is listed as a trade union and wishes to obtain recognition on the staff side of the Council.

Membership of all these organisations is small in relation to the total staff covered by the Council, although ANHSO has a substantial membership within its limited area of recruitment. There appears to be considerable dual membership between associations and with NALGO. Membership of NALGO is a condition of membership of the Society of Administrators of Family Practitioner Services (SAFPS) and the Association of Hospital and Residential Care Officers (AHRCO), and is believed to be very high amongst IHSA members. It is also estimated that three out of every four members of GMS are also members of the exclusively

Table 3 PROFESSIONAL AND TECHNICAL STAFF

	Year established	Number of members	Certificated independent trade union	Number of Whitley Council seats	Seats on Whitley sub-committees	Whole-time officers	Representatives or stewards		Examining body	Involved in pay negotiations before 1948
							Number	Year introduced		
Chartered Society of Physiotherapy	1895	14 619[a]	Yes	4	6 (Comm C)	14	400	1976	Yes	Yes
Society of Radiographers	1920	8 050	Yes	2	4 (Comm D)	3	200	1977	Yes	Yes
British Dietetic Association	1935	1 650	No	1	2 (Comm D)	1	93	1974	No	Yes
British Orthoptic Society	1937	665	Yes	1	2 (Comm C)	1	243	1973–4	No	Yes

Hospital Physicists Association	1943	873	Yes	1	2 (Comm A)	1	91	1974 and 1977[b]	No	No
Society of Chiropodists	1945	4 408[c]	Yes	1	2 (Comm D)	2	150	1978	Yes	Yes
British Association of Occupational Therapists	1945	6 139	Yes	2	2 (Comm C)	6.5	106	1977	Yes[d]	Yes
Society of Remedial Gymnasts	1946	551	Yes	1	1 (Comm C)	0	60	1977–8	Yes	No
Association of Clinical Biochemists	1953	1 998	Yes	1	2 (Comm A)	0.5	187	1961 and 1976[b]	Yes[e]	No

a In addition there are 3243 non-practising members
b Different grades of representative
c All categories of membership
d College of Occupational Therapists is a subsidiary company
e Membership of a joint examining board

Table 4 ADMINISTRATIVE AND CLERICAL STAFF

	Year established	Number of members	Certificated independent trade union	Number of Whitley Council seats	Seats on negotiating committee	Whole-time officers	Representatives or stewards		Examining body	Involved in pay negotiations before 1948
							Number	Year introduced		
Association of Hospital and Residential Care Officers	1898	1200[a]	No	1	0	0	16	–[b]	No	Not known
Institute of Health Service Administrators	1902	2900	No	4	1[c]	9	0	–	Yes	Yes
Association of National Health Service Officers	1919	5500	Yes	2	1	0	(8)[d]	Not known	No	Yes

Society of Administrators of Family Practitioner Services	1919	96[a]	No	1	–	0	0	–	No	–
Guild of Medical Secretaries	1967	413	No[e]	0	0	0	0	–	No	No

a Membership of NALGO compulsory
b Not available
c This is the current position. No organisation has a seat as of right
d Appeals committee representing all members at local level
e Listed, seeking certification

professional Association of Medical Secretaries (AMS).

In common with the Nurses and Midwives Council, the Administrative and Clerical Council has a smaller joint negotiating committee and the only professional association to have a seat on it is the ANHSO. An officer of the IHSA also has a seat on this committee but he currently holds that for reasons other than his membership of the IHSA.

Of the associations recognised within the Whitley Council machinery, only ANHSO has so far decided to become certificated as an independent trade union. The eight members of its appeals committee undertake all the industrial relations representation of the membership.* It is perhaps significant that ANHSO is the only professional association on this Council that can claim a significantly large membership within its area of recruitment, and this may have influenced its decision to become a trade union.

By contrast, the IHSA and the SAFPS have decided not to become trade unions. The former is giving more attention to its role as an examining body and has decided to relinquish to NALGO its industrial relations responsibilities on the Whitley Council. A ballot showed clearly that the members of the IHSA believed that NALGO could provide more adequate trade union representation for all levels of adminstrative and clerical staff than could the IHSA itself. The Administrative and Clerical Whitley Council is the only one with professional associations on the staff side in a minority to the multi-occupational trade unions. This factor may have contributed to the greater willingness to concede the trade union role, certainly in the case of the IHSA.

* The Association intends to appoint a full-time officer sometime during 1979.

Optical staff

The Optical Staff Council does not meet in full session, as do the other Whitley Councils, but only as a negotiating committee. All the associations listed in Table 5 were established before 1948 but only one was involved in pay negotiations before the establishment of the NHS. Membership of all these associations is voluntary and only the Association of Dispensing Opticians has examining-body status.

The Ophthalmic Group of the Socialist Medical Association and the Society of Opticians are not of the same standing as other professional associations considered in this chapter. The latter is an employers' organisation rather than an association of professional staff. Only the Association of Optical Practitioners Ltd (AOP) is certificated as an independent trade union. It has whole-time officers and an established representative system, and clearly wishes to develop along similar lines to the other single-profession trade unions.

Validity of their role as single-profession trade unions

The concept of the single-profession trade union is by no means unusual. There are many such in education, the civil service and public entertainment. Most of these trade unions are affiliated to the TUC and the number of such affiliations grows year by year. The NHS has one single-profession trade union affiliated to the TUC (the HVA), and its status as a trade union and as a TUC affiliate has been accepted without question in the British trade union movement. The Rcn, with more than 122 000 members, and the BMA, with more than 52 000 members, are the third and fifth largest trade unions in a service that employs over five per cent of the country's labour force, and the membership of single-profession trade unions extends to at least a quarter of the NHS staff. Despite the nationally established position of single-

Table 5 OPTICAL STAFF

	Year established	Number of members	Certificated independent trade union	Number of Whitley Council seats	Seats on negotiating committee	Whole-time officers	Representatives or stewards		Examining body	Involved in pay negotiations before 1948
							Number	Year introduced		
Association of Dispensing Opticians	1926	3 280	No	1	Yes	2	0	—	Yes	No
Association of Optical Practitioners Ltd	1946	4 022	Yes	4	Yes	4	10	1978	No	Yes
Socialist Medical Association (Ophthalmic Group)	1930s	—[a]	No	1	1	0	0	—	No	No
Society of Opticians	1937	70	No	2	1	1	0	—	No	Not known

a This association would not divulge its presumably very modest membership

profession trade unions and despite their size in the NHS, the view still survives that they are an anachronism, a remnant of a past age that will wither away, leaving trade union representation in the hands of a small number of multi-occupational trade unions. It is because of this view that it is particularly important to examine the validity of the professional associations' trade union role.

Before 1948, nearly three-quarters of the professional associations were involved at some level and in some way in negotiating terms and conditions of employment for their members. This was regarded even then as a legitimate pursuit of their objectives, and when the NHS was established their involvement on the staff side of the Whitley Councils was not challenged in principle, though there were difficulties over many points of detail. Participation in the Whitley Councils involved the associations in collective bargaining of terms and conditions of employment as equal partners with the recognised trade unions. Only the medical and dental staff developed a different method of determining pay through the independent pay review body, but even their associations have always been involved in the direct negotiation of the shape of their contract and other matters. They negotiate direct with the DHSS and, although the BMA's and the BDA's scope for negotiation is less than that of the other professional associations, they have been involved in collective bargaining in relation to an important part of the terms and conditions of employment.

For the first 25 years of the NHS, the industrial relations activities of the professional associations were concentrated centrally within the Whitley Councils, and it is only since the early 1970s that they have established their status as trade unions and have developed local involvement in industrial relations. This move has been challenged on two main grounds: that it would distract attention from their professional role, and that they were, in any case, too small and under-resourced to achieve adequate representation. Both these views are considered below.

Within the professions, the small minority groups which argued that trade union status would distract attention from professional responsibilities were overwhelmingly defeated. The justification for the defeat rested upon the claim that the collective bargaining and legislative developments of the early 1970s made any distinction between professional and trade union responsibilities unrealistic.

For the first 20 years of the NHS, terms and conditions of employment were determined exclusively at national level. There was no local collective bargaining, membership of trade unions and professional associations was modest (except for the medical and dental professions) and there were virtually no union stewards or representatives to encourage such development. Constitutionally, only the joint consultative staff committees established by the General Whitley Council in 1950 were operating at local level and, although members of professional associations participated equally with members of trade unions on the staff side, there was only a limited number of such committees, their influence was modest and they were in decline by the mid-1960s.[101]

This began to change in the late 1960s. The first step was the introduction of bonus schemes for ancillary staff, craftsmen and ambulancemen at the prompting of the National Board for Prices and Incomes.[57] This enabled these staff to influence earnings locally and helped to stimulate the development of the role of the union steward in the ancillary and craft unions.* Soon after this, the Code of Practice[38], linked to the 1971 Industrial Relations Act[67], gave positive support to the role of the steward, and recommended agreed procedures for discipline, dismissal and grievance matters, and the establishment of joint committees to establish procedures where necessary.

* See also Chapter 4, Consultation and negotiation, pages 73–95.

This legislation was replaced by the Trade Union and Labour Relations Act of 1974[80], and, under the provision of the Employment Protection Act of 1975[62], three new codes of practice[1,2,4] were introduced to replace the 1971 Code. These new codes extended local collective bargaining to cover procedures relating to the role of union stewards and the disclosure of information. Subsequently, the provisions of the Health and Safety at Work etc. Act 1974[66] further extended the role of representatives of trade unions in local decision-making.*

Despite these developments, the General Whitley Council failed to establish new procedures for collective bargaining at national level. Successive attempts to establish a national disciplinary and dismissal procedure have so far failed, as have attempts to establish a new national framework for local joint committees. Because of this failure, and because of the need for employing authorities to fulfil the requirements of the codes of practice, there has had to be greater activity at local level to establish the necessary procedures. In some employing authorities, management has merely introduced procedures of its own, in others there has been consultation with representatives of local trade unions and professional associations, whilst in a further group of authorities the introduction of procedures has necessitated genuine negotiation.

The decision to introduce work-sensitive contracts for hospital medical staff has further increased industrial relations activity at local level. Both the junior doctors' closed contract in 1976 and the consultants' contract in 1979 allow income to be determined by workload, and leave workload to be determined by local circumstances. In the case of junior doctors, the NHS has already seen that this leads to opportunities for individual and collective bargaining, and the same may well happen in determining the number and timing of the consultants' notional half-days. It is perhaps significant that the BMA chose this time to introduce

* See Chapter 5, Health and safety, pages 105–106.

their POWARs to act as the union stewards of hospital medical staff.

Since 1968, a combination of work-sensitive contracts, labour legislation and codes of practice, the requirements of NHS reorganisation in 1974, and the disappointing performance of the General Whitley Council, has contributed to a significant shift of industrial relations activity away from the Whitley Council machinery to the NHS areas and districts. Ancillary staff were the first major group of NHS employees to be involved because of the introduction of incentive bonus schemes, but other developments soon extended this involvement to professional as well as non-professional staff. The professional associations faced a choice. They could either follow these issues down to local level in order to maintain their involvement in all collective bargaining activities concerning their members, or they could limit their role to the national Whitley Council and accept a diminishing position in NHS industrial relations that would rapidly lead to a challenge to their continuing Whitley Council status, as the evidence to the McCarthy inquiry has shown.[94] Explained in this way, it is easier to understand why many professional associations came to the conclusion that their involvement in industrial relations was an all-or-nothing question and that Whitley Council membership alone would rapidly become pointless. It is interesting to note that this conclusion was reached by the IHSA and its decision not to develop a local industrial relations role was followed by an agreement to let NALGO take over its Whitley Council responsibilities.

Incentive bonus schemes gave ancillary staff's trade unions the first opportunity to develop the role of union stewards and, for that reason, there has been a tendency for these unions to adopt a somewhat proprietorial attitude to local representation. But the fact remains that in the last ten years trade unions and professional associations alike were presented with the need to develop their local involvement in industrial relations as responsibilities and opportunities moved down the NHS structure.

Having taken the decision to maintain a comprehensive involvement in NHS industrial relations, the professional associations were required to obtain the status of certificated independent trade unions if they were not to be at a serious disadvantage to the multi-occupational trade unions. Section 8 of the Trade Union and Labour Relations Act 1974[80] established the need to be listed as an independent trade union, and Section 8 of the Employment Protection Act 1975[62] established a certification officer whose responsibility was to issue certificates of independence to trade unions whose activities met the legal requirements of the definition of independent trade union. As a result of those two Acts, any organisation which was involved in industrial relations but which was not a certificated independent trade union was at a significant disadvantage in undertaking its work when compared with trade unions which had a certificate of independence. Its union stewards did not have the same legal rights, its status in health and safety representation was questionable and it was not eligible to participate in any development of union membership agreements. With one or two minor amendments to their rules, most NHS professional associations were able to satisfy the certification officer about their *bona fides* as independent trade unions and, having obtained their certificates of independence, their status as single-profession trade unions was established.

Despite the apparent logic of the direction outlined above, some professional associations decided to turn their back upon the trade union role. The decision of the IHSA to abandon its Whitley Council role only serves to emphasise the difference between administrative and clerical staff and other professionals. One reason for the IHSA's decision may be that, in contrast with other traditional multi-occupational trade unions, NALGO has a strong professional ethos. But whatever the reason, the direction chosen by administrative and clerical staff in the NHS indicates that there is a workable alternative to certification as a trade union.

The experience of other professional associations with n independent trade union role is discouraging. The Institute of Medical Laboratory Sciences (IMLS) is one example. It has three seats on Committee A of the PTB Council and acts in an advisory capacity without voting rights. The IMLS feels that it enjoys good relations with the trade unions and officially supports the concept of dual membership. In the past, the IMLS has been able to advise management and staff sides alike, although in recent years the closeness of the contact has varied. In the past, this argument about contact with both sides has been used for standing back from a trade union role, particularly by the IHSA, and it is interesting to see that the IMLS, which has held this third-party status since 1948, believes that without attendance at the Whitley Council there would not be an opportunity for direct participation.*

The Guild of Hospital Pharmacists is a professional association which chose outright merger with a multi-occupational trade union, ASTMS. The guild considered both ASTMS and NALGO, and found that ASTMS offered the better terms. In was felt by some members of the guild that ASTMS would prove more sensitive to the anxieties of professional associations than would NALGO. At the time of the merger, support was very strong (89 per cent) but since then there have been difficulties. An insurance protection scheme for pharmacists was lost almost immediately after the merger and their independent journal was closed, whilst subscriptions rose from £11 to £18. An ASTMS publication has replaced the old journal of the guild, but in some parts of the country this experience caused guild-membership within ASTMS to drop quite sharply. However, it must be emphasised that the insurance scheme seemed likely to be lost and the guild had financial difficulties at the time of the merger. The gain has clearly been the expertise brought to the task of negotiating on behalf of pharmacists. Finally, one effect of the merger has been that the Pharmaceutical Society has developed its professional

* Personal communication with IMLS.

role on behalf of pharmacists and is now becoming more involved in hospitals.

The second challenge to the role of single-profession trade unions within the NHS was identified in the McCarthy report[94], although it has been much more widely voiced. The argument is that, irrespective of the validity or otherwise of their claim to be trade unions, they should not develop this role because they are too small and lack the resources and expertise to provide adequate representation for their members.

This argument does not apply to all single-profession trade unions. The tables show that those with memberships in excess of 10 000— such as the BMA, BDA, Rcn, RCM and CSP—have a significantly high ratio of full-time officers to members and have been rapidly and successfully developing the role of their lay officers. These figures compare favourably with many established trade unions affiliated to the TUC, and in several cases the financial resources of these established single-profession trade unions are considerable. With one exception (IHSA), they are all appointing full-time industrial relations officers and where, in the short term, they need to buy expertise they can afford to do so.

Organisations with between 5000 and 10 000 members would justify their involvement on similar grounds. The HVA has been accepted as a viable trade union for many years, and the Society of Radiographers and the British Association of Occupational Therapists have whole-time officers and a rapidly developing steward and representative system that compares with that of the HVA. Only the Association of National Health Service Officers would appear to have failed so far to develop an effective industrial relations capability, though the association intends to appoint a full-time officer as an indication of determination to stay with the field.

The appointment of full-time officers is difficult for organisations with fewer than 5000 members. Few can afford them, and this, it is argued, must be a major drawback in attempting to undertake effective trade union representation. However, they all possess one vital asset upon which their future independence completely depends. This is the determination of their membership, against the odds, to maintain their independence and to develop the most effective form of trade union representation possible in the circumstances. One of the characteristics of many of these small organisations is the low ratio of members to stewards, in several cases less than 10 : 1. These stewards are being trained on day-release and residential courses which match those of the multi-occupational trade unions. The high ratio of participation in the role of steward helps to ensure a very effective form of representation at local level and makes for a highly motivated membership with many activists. To overcome their lack of full-time officer support, they are increasingly involved in collective activities at national level in order to pool their resources and manpower.

Their financial resources enable them to hire specialist research support from universities in the way, for example, that some TUC-affiliated trade unions use the resources of Ruskin College. Their stewards and representatives are encouraged to cooperate at local level, and resources could be pooled to employ whole-time officers to give support to those stewards. Whether or not this constitutes viability as a trade union is, however, secondary to the determination of their membership to succeed. Whatever their resources, and whatever the number of whole-time officers or union stewards, viability as a trade union will last as long as the determination of the membership to support it.

Implications for the National Health Service

We have noted above that some professional staff hold dual membership—of a traditional multi-occupational trade union and

of one of the professional associations which has now become a single-profession trade union. Dual membership was accepted without challenge as legitimate for professional staff with a strong sense of trade union commitment at a time when the multi-occupational trade unions were the only alternative. The idea of dual membership was fostered by the trade unions, particularly COHSE, because it stressed the separateness of the professional and the trade union function. This concept implied a complementary relationship within which satisfactory co-existence was possible. As the professional associations have come to develop their trade union role, peaceful partnership has become more difficult, and the single-profession trade unions have increasingly come to challenge the concept of dual membership. Some, including the Rcn, do not wish their stewards to hold dual membership in order to ensure that there will be no conflict of loyalties and, in defence, some multi-occupational trade unions have been developing their own interests in professional matters. Both these trends have emphasised the overlap of interests and have resulted in growing competition for membership, as both groups seek to establish themselves as the representatives of the professional staff concerned.

The medical and dental professions are, so far, largely free of this type of competition, and so are the smallest professions represented on the Professional and Technical Whitley Councils. It is among nurses, midwives, radiographers, physiotherapists and scientists that the competition is most intense. The success of the single-profession trade unions in expanding their membership has emphasised this competition. For example, the progress of the Rcn since July 1977 has been little short of phenomenal. It has increased its membership by almost 30 per cent and has had particular success among students and pupils. One reason for this has undoubtedly been the decision of the Rcn to introduce deduction of contributions at source (DOCAS) as a means of collecting subscriptions. The Rcn's success will undoubtedly lead to the adoption of DOCAS by other single-profession trade unions.

Their attention was drawn to the opportunities of DOCAS by by Lord McCarthy[94], and it was his threat that union membership figures should be assessed exclusively by reference to DOCAS that influenced the Rcn's decision to begin using this method of collection.

An indication of the growing competition between the two groups of trade unions, which the NHS has witnessed in recent years, is the growing number of local conflicts where some stewards of TUC affiliates (all multi-occupational trade unions, with the exception of the HVA) have refused to sit on the same joint committees with stewards and representatives of non-affiliated trade unions (all single-profession trade unions). As both groups strive to obtain recruiting advantage, the logic of this move by the TUC affiliates is quite clear. As they are the larger, stronger and more militant group at local level, their committee can be expected to receive more attention from management in local collective bargaining. If they are seen to be in control of local collective bargaining arrangements, they can, and do, turn this to recruiting advantage by arguing that they are the only effective trade union force at local level. The importance of this development is that it indicates the extent to which competition has replaced coexistence, with the decline of the concept of dual membership, and although the conflict is being expressed in terms of TUC versus non-TUC, the question of TUC affiliation seems to be merely a cover for the conflicting ambitions of multi-occupational trade unions on the one hand, and single-profession trade unions on the other.

The position has now been reached where at least some of the single-profession trade unions are considering taking the ultimate step in establishing their trade union status by seeking affiliation to the TUC. In September 1978, the HCSA, with over 4000 consultants in membership, decided to ballot their members on the question of whether to seek affiliation, and at almost the same time the Rcn decided to open a public debate on the question of

whether or not to seek TUC affiliation. There seems little doubt that several other single-profession trade unions, especially those with over 5000 members, will follow suit. An application to the TUC does not automatically mean acceptance, but it is hard to contemplate mass rejection of the associations concerned. When the single-profession trade unions sought and obtained certificates of independence as trade unions, the only challenge came from ASTMS to those organisations on the PTA Council which had recruited in areas where ASTMS was seeking to extend its own membership. The same opposition can be expected to be voiced within the TUC, and associations with a very small membership may be regarded as inappropriate for affiliation. However, it is hard to see any justification for excluding the major single-profession trade unions, other than the overt self-interest of a small number of affiliates. If the TUC had made its decisions in the past on the basis of consulting the self-interest of its affiliates, it would never have reached its present size. Far from being opposed to the concept of the single-profession trade union, it has many such unions within its ranks.

It should be recognised, however, that affiliation to the TUC will not end the competition between multi-occupational and single-profession trade unions in the NHS. The trade unions may begin to work together, in the sense of being on the same side of local joint committees, but alarms and excursions arising from their competition seem bound to continue until such time as the staff in the NHS make up their minds which type of trade union they will support. Whatever happens, the concept of dual membership seems doomed. There are many staff whose only reason for their dual membership is as a form of insurance until they see which association is going to prevail.

The decline of dual membership, and the resulting competition, has fairly immediate implications for the NHS, but the emergence of the single-profession trade union has longer term implications as well. The extension of formal trade union activity and

representation among virtually all groups of professional staff will add to the workload of personnel departments and create formal responsibilities in industrial relations for managers who have had little or no contact with trade unions. Personnel work among medical staff is likely to become more important and to require more senior and experienced staff, and the value of a nurse in the personnel team will grow. As with so many other developments, these changes will have implications for resources, manpower and training.

Summary and conclusion

Most NHS professional associations have decided to become single-profession trade unions and to develop their industrial relations role. Arguments about whether or not they should are now largely academic. This chapter has attempted to explain the reasons why they were drawn in this direction and to comment upon its validity. Opinions differ sharply about the wisdom, as well as the validity, of the move and those who oppose it depend to some extent upon the assumption that there is a clear distinction between professional and trade union activities. The sad fact is that cash limits and the report of the Resource Allocation Working Party (RAWP), together with government incomes policy, have helped to blur this distinction in practice. The maintenance of professional standards involved radiographers in a struggle to establish an adequate period of training for students, physiotherapists in a struggle to remove a pay anomaly for teachers that threatened to dry up the supply at a time when the profession was (and still is) grossly under-staffed, and nurses in disputes about staffing levels on wards where it became impossible to maintain minimum standards of nursing care.

All those issues stemmed from a lack of resources in the NHS and involved the professions concerned in direct negotiation, at national and local levels. Now and in the future the maintenance

of professional standards will require wholehearted participation in the debate about the allocation of scarce resources. Events in the NHS have amply demonstrated that participation without trade union status is an increasingly futile activity. The job can be done exclusively by the multi-occupational trade unions, or by the single-profession trade unions, or by both, but the task no longer seems capable of division into professional and trade union components.

Whether or not the single-profession trade unions will succeed is another question. There is a long list of variables that could affect the outcome. The smaller organisations are at risk in any future reform of the Whitley Council machinery, whether voluntary or imposed. They would be at risk in any major change in labour legislation that aimed at tightening the rules about certification. They are constantly at risk in any shifts of opinion and support that in the past have arisen during temporary periods of frustration in prolonged and difficult salary negotiations. At any time, their membership can be offered attractive and tempting terms for merger. It is these smaller organisations that are most at risk because their one major strength lies in the determination of the members to maintain their independence. As we write, their position is strong but they depend upon a continually active and involved 'lay' leadership and, in some important respects, they are not able to influence events that could be crucial for their future. The position of the larger organisations is much more secure, not only because of their size but because of their increasing skill and professionalism in the conduct of their trade union activities. It is their increasing strength and success that, given the mutual support of the single-profession trade unions within the NHS, could well be vital in determining the future independence of the smaller organisations.

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8
Special industrial relations problems in nursing

CHRISTINE HANCOCK

Nurses are the largest occupational group in the NHS, numbering approximately 400 000 altogether. The past ten years have seen a considerable increase in conflict and tension affecting nurses at work, and this had far-reaching implications for the health service. This chapter considers the industrial relations structure in nursing and the growth in industrial conflict, and then discusses a number of key issues which affect nurses. It will be argued that in the same period a number of issues, some local and some national, has led nurses into the arena of industrial relations in a new and developing way.

Industrial relations structure in nursing

Figures of membership are notoriously unreliable, but can be considered as indicators of a trend. In 1978 the three staff organisations representing the largest number of nurses claimed a total membership figure (rounded to nearest thousand) of 312 000: COHSE and NUPE (which include nursing auxiliaries in their numbers), 110 000 and 80 000 respectively; Rcn, 122 000 qualified nurses and nurses in training. Two years before, the respective figures were 80 000, 70 000 and 90 000. These figures are made more unreliable by the difficult question of dual membership, usually of both a professional association and an affiliated trade union—a practice often thought to be widespread among

nurses. In their evidence to McCarthy[94], the TUC-affiliated trade unions challenged the size of the representation of the professional associations on the Nurses and Midwives Whitley Council. The unions suggested that many members of professional associations had joined only for 'professional purposes' because they had also joined trade unions for collective bargaining purposes. This argument has been harder to sustain since 1977 when many professional associations became independent trade unions.*

A 1978 survey of membership among general hospital nurses showed dual membership to be as low as 3.8 per cent.[20] The survey also showed, in a sample of qualified nurses working in a northern region, that a majority (62 per cent) were members of a staff organisation: 37 per cent belonged to a professional association and 25 per cent to a trade union. The largest group of nurses (38 per cent) did not belong to an organisation. The non-members were younger, part-time and were usually female staff nurses; the professional associations contained more women, full-time and senior ward staff, while the unions were found to contain a larger number of men, enrolled nurses and older staff.

Membership of staff organisations in psychiatric hospitals has traditionally been very different from that in general hospitals. Psychiatric hospitals have been thought of as highly unionised organisations, and large numbers of psychiatric nurses are members of COHSE and NUPE. Membership has been large but not very effective in improving the lot of the psychiatric nurse. Some local union branches have often been very effective, however, with strong joint staff consultative committees at many hospitals. Collective representational bodies are simpler in psychiatric hospitals: in a general hospital the theatre sister would not consider herself adequately represented by a midwife, nor the casualty nurse by a medical ward nurse; it is harder for general nurses to

* Further discussion on these issues appears in Chapter 7, Professional associations, pages 152–153 and 171–174.

speak with one voice even if they belong to one organisation. In general hospitals, nurses are more likely to belong to a number of different staff organisations, local branches may be weak or non-existent and membership is often seen as an insurance in case of a grievance, a disciplinary matter or a clinical accident. General hospital nurses are becoming more militant, but it seems likely that there will emerge a pattern different from that in psychiatric hospitals because the nature of the work is different.

The pattern of industrial relations in nursing is changing, and this is reflected in the large and rapidly growing numbers of nurses who are now members of one or more staff organisations, the competition for members by the staff organisations and the increasing antagonism between those which are affiliated to the TUC and the independent trade unions. There are 40 different organisations to which nurses may belong; 12 of these are represented on the Nurses and Midwives Whitley Council, the three affiliated unions sharing ten seats and nine professional bodies sharing 19, of which the Rcn has the largest block of eight seats.

The growth in membership and the fierce rivalry followed the growth in legislation on employment and trade union matters. The Rcn's successful recruitment drive after the 1971 Industrial Relations Act, and the appointment of stewards, led to clashes with the trade unions. It was soon after 1971 that the pay claim, eventually settled in 1974, began. Whitley Council negotiations had failed to enable nurses to keep pace with the cost of living or to achieve a wage increase of any note. In January 1972—a time of staff shortages and economic inflation—a major claim was made for the revaluation and restructuring of nurses' pay. The pay freeze and a general election ended further consideration. In February 1974, the government refused an independent inquiry, and two months later COHSE launched its campaign, followed within a month by the Rcn, whose president demanded an inquiry into nurses' pay within three weeks or the Rcn would privately employ all its nurse members and offer them for hire to the NHS.

At this time, a hospital ward sister took home about 60p an hour for a 40-hour week which excluded all meal breaks. Later that month, COHSE threatened strike action and then implemented a work-to-rule, and inter-union rivalry increased when the NUPE secretary called the COHSE action 'the irresponsible act of amateur adventurers'.[92] Militancy reached a peak in May and June: demonstrations, strikes and meetings of nurses and other trade unionists were organised, and public support for the nurses' claim was expressed in the mass media. In June, the membership of the Halsbury committee was announced: it included no trade union representative. By July, militant action had declined and in September the committee reported and its proposals were accepted.[46]

These were national events. A local event some four years later was that which occurred at Brookwood Hospital, the large psychiatric hospital in Knaphill, Surrey, with 860 patients and over 1000 staff, of whom 700 were members of COHSE. In May 1978, the COHSE branch was instrumental in setting up a workers' council of 30 members to bypass the management, particularly the senior nursing officer, divisional nursing officer and sector administrator. Their list of 20 grievances contained many which were not new; in fact, the main one concerned the effects of NHS reorganisation four years earlier which had established the remote management of a district management team based 12 miles away. The final straw was a proposal to increase the charges for the créche by 35p to £1.10 per day. This is an interesting example of a new form of industrial action which has attracted attention without putting patients at risk or interrupting their care.[88]

Growth in membership has not been the only change in the staff organisations. The appointment of stewards by the professional associations brought them conspicuously into that part of industrial relations which had previously been dominated by the trade unions, and when, in February 1977, the Association of

Nurse Administrators became recognised as an independent trade union, followed in June of that year by the much larger Rcn, the rivalry intensified. Later, the Rcn decided to open up the debate about affiliation to the TUC. There has been increasing tension between the affiliated health service unions and the Rcn at local level, most publicly in Camden and Islington Area Health Authority, but also elsewhere, particularly in the Wessex and Oxford regions. Many people consider that affiliation of the Rcn will repair the divisions, but the union members are suspicious of the concentration of senior nursing management in the Rcn and refer to the college as 'the bosses' union'. The Irish Nurses' Organisation has already affiliated. Affiliation to the TUC will bring the Rcn within the protection of the Bridlington agreement* and reduce the membership-poaching by COHSE and NUPE. It is likely, however, that those unions at least will try to see that affiliation of the Rcn is conditional upon some restructuring of the staff side of the Nurses and Midwives Whitley Council to reflect their few seats in relation to their membership.

Alongside the growth in membership of nursing staff organisations has been the growing concern of nurse managers about what is seen as worsening industrial relations in nursing. Since the 1974 reorganisation, many senior nurses have achieved rapid promotion, or have seen their immediate managers change in quick succession, and, through job moves, may also have lost the support of trusted administrative colleagues. At the same time, politicians have brought about considerable change in the NHS, and have seen fit to pour out an almost continuous torrent of new legislation affecting it. No wonder that many nurse managers have felt overwhelmed by events and have reacted defensively.

Some refer wistfully to some golden era when the matron's word was enough to ensure the instant dismissal of a wilful and erring nurse. Yet it is hard to find the evidence for this: the health

* This agreement limits transfers of membership among unions affiliated to the TUC.

service was always considered secure employment for all its employees, and unemployment among nurses was not seriously discussed until the middle of the 1970s. There are advantages and disadvantages for nursing in the recent legislation, but it provides a logical framework for employment. In the growth of staff representation there are also advantages and disadvantages. When managers describe their industrial relations as 'good' they often mean that all is quiet. This may be because the staff is uninterested and apathetic. And this reflects inefficient industrial relations. Healthy and efficient industrial relations may not be quiet at all! Efficient industrial relations are the joint responsibility of management, employees and staff organisations, but the initiatives must come from management. Management must make it clear to employees that it welcomes their membership of an appropriate organisation and their participation in its activities. This requires fundamental changes for many in nursing who are still inclined to regard it as disloyal if staff take problems and grievances to an outsider.

Since the publication of the first document on priorities in 1976[45], the NHS has been committed to the notion that prevention is better (and cheaper) than cure. This clinical analogy could certainly be transferred to industrial relations. Tracing back the events which led to the many examples of poor industrial relations, it is possible to see how staff and management had been set on collision courses for some while, or that poor situations had been left to fester, to erupt if the appropriate action was not taken.

Main nursing issues

The fact that industrial relations problems affect nurses and nursing is to some extent amazing. The nurse's art and skill is surely in human relations; all nurses have been trained to be kind and compassionate, to understand and respond to others' needs and difficulties. The special industrial relations problems of

nursing are in part a crisis of confidence in nursing itself. Too many nurse managers seem remote from the practise of nursing and lack credibility with their junior colleagues. Too many practising nurses have lost sight of the main objective of nursing in their struggle for much needed improvements in their own conditions. Nurses themselves can influence and determine the future pattern of industrial relations at both local and national levels. Much will depend on government policies but much will also rest on the commitment to nursing and to nurses by staff organisations, by management and by health authorities.

Nurses, like other groups working in the NHS, have experienced an upsurge of conflict and unrest in their work. Though concern about pay has been the reason for much of the industrial action, other reasons have been, and are becoming, increasingly important and are often at the root of local industrial problems. The problems peculiar to nursing arise from their work and their working conditions: lines of accountability are often not clear, particularly for student and pupil nurses; all NHS staff who have to provide a continuous service face similar problems; basic facilities are frequently poor and any improvements have to be obtained by competing for resources available for services to patients. Standards of care have become of more concern to staff, their organisations and the public; criticism has often come from inquiries, politicians and community health councils. Concern about standards of care and employment legislation have led to more formalised disciplinary action being taken against some nurses; this and concern about discriminatory practices are other sources of industrial conflict.

Conditions at work

Salaries and conditions of service are determined at national level by the Nurses and Midwives Whitley Council; because of this, the most important local issue in working conditions for nurses often

becomes the off-duty pattern. Off-duty systems vary widely throughout the service, and often among the hospitals of one employing authority. Inflexible systems may give rise to fewer expressed grievances but will not necessarily suit the nursing service. Flexible off-duty arrangements usually allow considerable discretion to the nurse in charge, who has the difficult task of attempting to reconcile the needs of the ward or department with the needs of the individual nurses. The fairness with which off-duty time is arranged will determine its acceptance by staff. Similarly, the opportunities to work overtime and to work the hours for which extra payment is made must be available to nurses in a way which is accepted by them as fair.

The conditions of nurses' residential and changing accommodation are often poor and below the standard of those for staff working in other organisations. Resident staff in many hospitals still complain of petty restrictions.[112] Nurse managers in district and area teams are often seen to support those decisions of administrators and finance officers which remove benefits from nursing staff. Benefits concerning residences, dining rooms, transport, créches and recreational facilities are not usually the responsibility of nurse managers, but any reduction in these benefits leads to unrest and possible militancy among the nursing staff. And any industrial action will most likely be directed at the nursing work. If nurse managers support administrative decisions to reduce the facilities for nursing staff, they must not be surprised if the nurses turn to trade unions for support.

The lack of adequate occupational health services in the NHS, described in Chapter 5 (pages 113–114), is another potential source of unrest.

Staff organisations' opposition to the closure of hospitals is, in part, a concern about increased work elsewhere, in part a natural concern about their members' jobs and, in some cases, political. District, area and regional officers have often naively expected

that staff organisations would understand their problems and would support closures with little more offered to them than some guarantee of alternative employment. Staff need to see more obvious benefits for them in cooperating over closures; also, they need more opportunity to participate in making decisions about rationalisation schemes. Too often nurses, like other staff, are invited to comment on a plan which does not offer any real choices at all. Alarm about unemployment among nurses has probably heightened the nurses' hostility to closures.

One event which seriously harmed relations between junior nurses and their management was the treatment of nurses who completed their training in 1975 and 1976. At the time, the economic pressure was on, labour turnover dropped and recruitment of trained nurses improved, assisted no doubt by the drive to put an end to the nursing agencies. In many hospitals, for the first time in many years, more nurses qualifying at the end of their training were wanting to stay and work as trained nurses and there were not enough jobs for them. Suddenly, the nurse managers who years earlier would have pleaded with nurses to stay, were rushing to their personnel departments to be reassured, where it was pointed out that they had contracted only to *train* the nurses, not to employ them once their training period was completed. As many predicted, the panic was short-lived, but many district, area and regional nursing officers failed to tell their health authorities how important it was to make sure that jobs were available to these young nurses who provide so much service during their so-called 'training programme'. The financial cost would not have been great.

No staff group in the health service works in isolation and the work of nurses can be affected considerably by other staff groups. Disputes between staff groups may mean disputes between unions and, increasingly, disputes between the affiliated unions and the professional organisations. Problems often arise over the nature of the authority of one group (usually doctors or nurses) over other

groups which have quite separate management structures (usually ancillary or technical staff). Two interesting disputes were those between operating theatre nurses and operating department assistants at Dulwich and Greenwich hospitals. The Greenwich dispute was the first official nurses' strike by NALGO members. Theatre nurses have reacted defensively to the challenge of ODAs instead of clarifying the very real role of nurses in operating theatres, which they alone can fill.

Standards of nursing care

Industrial relations in nursing have been influenced by many factors: growth in trade unionism, concern about pay and, more recently, concern about staffing levels. In spite of official statements about the growing numbers of nurses employed in any one area or within the NHS as a whole, nurses are concerned about the actual number of staff on duty to give a particular amount or period of nursing care. A reduced working week, increased annual leave and changed shift patterns have all affected the number of staff actually on duty at any one time. Changes in the nurses' training programme have made nurses less available for service. Added to these are a much quicker throughput of patients, the less dependent being cared for at home, and the increasing numbers of elderly patients being nursed in general and mental hospitals and in the community. The nursing organisations' concern about shortages, whether local or national, cannot be brushed away. Militant action on this issue has been taken in some areas by members of the Rcn, and in others by nurse-members of COHSE or NUPE.

All nurses face a major dilemma over this issue. If one is considering only the patients in one hospital, it is easy enough for the staff and management of that hospital to agree on the number of beds which can be staffed adequately and to close all other beds.

It is, however, rarely that simple: many ward nurses are only too aware of patients on waiting lists, in the A and E department or ill at home. Rarely can one hospital restrict its services without affecting groups of nurses elsewhere. For example, if a psychiatric hospital restricts admissions, pressure will be felt by neighbouring institutions, local general hospitals, community nursing staff and even the prison nursing service. The Rcn seems to be supporting many of the general hospital militants. Its survey of standards of care in the four Thames regions showed the Rcn to be questioning staff shortages as a matter of professional concern.[115] COHSE and NUPE are the organisations usually involved in militant action in psychiatric or mental subnormality hospitals. The action can have greater impact when the union branches of neighbouring hospitals refuse to accept the patients, who may have to be sent many miles from home. Some local branches of both COHSE and NUPE have also refused to accept certain patients whom they consider to be too violent to be cared for in a particular hospital.

The management of violent patients is an issue which was dealt with differently by the two largest nursing staff organisations. In March 1976 the DHSS published a circular, *The management of violent, or potentially violent, hospital patients*[43], which followed discussions held with the Rcn and others. COHSE did not accept the document, advised its members not to follow it, and in September 1977 produced its own document (similarly titled), which gave much more detailed and realistic guidance.[19]

In many instances of staff action over nursing staff numbers, senior nursing management has played too passive a role. If standards of nursing care are threatened or patients are unsafe, these are the very situations which require nursing management, and senior nurses should be leading the demand for more staff. If, on the other hand, patients are not at risk, nurse managers should state this quite clearly. Senior nurses need to discuss regularly with their colleagues on the wards what is a safe level

of staffing and what action should be taken if this cannot be achieved. Increased resources from districts, areas, regions or even from the DHSS itself have been seen to follow militant action, and no other. So, more and more nurses are regarding militant action as the only effective way to improve staffing levels.

Discipline and dismissal

Section 24 of the Trade Union and Labour Relations Act 1974[80] states that one of the *fair* reasons for dismissal would relate to misconduct. It is over this matter that concern is expressed by nurses and doctors about alleged difficulties in taking disciplinary action. The difficulties in fact come from the definition of 'misconduct' rather than the disciplinary procedures.

Nursing is not a job which is easy to measure or to evaluate: there is no quantifiable output. It is vital to the safety and welfare of patients that high standards are maintained. Gross misconduct, such as drug abuse or assaults on patients, can, with adequate evidence, be dealt with in a straightforward manner. It is very much more difficult to deal with a nurse or nursing auxiliary whose performance is generally poor or whose attitude to patients is uncaring. This can only be dealt with by nursing management, who first have to make clear what standards of care they expect.

Nurses, like any workers, need to know clearly what is expected of them at work. Too often, senior nurses, including those in the ward, reprimand nurses for errors and mistakes but do not spend time explaining what type of good nursing care is expected. Standards of work must be set for nurses formally or informally according to their seniority and level of expertise. Standards must be seen to be applied fairly; a ward sister cannot expect support if she reprimands a nurse for a standard of behaviour or performance which she accepts from another nurse of similar seniority. Where agreed nursing procedures and policies have

been worked out, they must be followed consistently. If other practices have become customary, a nurse cannot be disciplined for failing to follow the approved procedure. Nurse managers cannot expect good working relationships if they make a sudden decision that it is time to improve standards, make a surprise onslaught onto wards reprimanding those nurses caught following the customary though not approved practice.

There are many instances of nurse managers and teachers issuing procedures for nursing care and then failing to provide the necessary conditions in which such procedures can be carried out. Examples of this may include chaperoning male nurses with female patients, checking drugs, managing violent patients, lifting patients.

Nurses of all grades have the right to expect their work to be continually evaluated and appraised. Poor behaviour or performance should be corrected on each occasion when the fault occurs, the error explained and the correct way shown. Too often, a nurse first learns of a shortcoming from an official report or formal interview. The nursing and midwifery professional advisory committee to the Essex AHA has produced guidelines for nursing staff working in various clinical specialties. This is an idea which other nursing advisory committees could follow.

There are rare times when firm evidence of low standards of care cannot be obtained. This is particularly so with incidents concerning mentally ill or handicapped patients or the elderly mentally infirm. On such occasions, it is important that the nurses involved discuss the whole matter fully with the AHA. The AHA has great powers over dismissal. An industrial tribunal can decide that a dismissal is unfair and recommend re-instatement; if re-instatement is refused, compensation will be recommended and it is the AHA which decides whether such compensation will be paid. The AHA at an appeal can choose, on the other hand, not to uphold a nurse manager's decision and can order the re-instatement

of the dismissed nurse. These rights of appeal are just and necessary. The industrial tribunal will be concerned that the dismissal was fair according to the law and that the procedure was followed correctly; the AHA will be concerned with the circumstances because its responsibilities are not only to its employees but, particularly, to its patients.

Most AHA members have had little or no training in industrial relations, yet they have a most important role. AHAs came into existence at a time of growing trade union militancy, not just in the NHS, and at a time of new industrial legislation. Like many people, AHA members often think it is almost impossible to dismiss anyone nowadays and they have a natural anxiety about possible industrial disputes. Nurse managers are not the only nurses who care about standards. Where industrial relations are good and management is seen to be just and fair, staff organisations will also be committed to maintaining a good service to patients. Nurses in the district and area teams have to support more junior nurse managers in this: first by ensuring that agreed policies are known and followed, and second by putting strongly to the AHA any implications for patients which will follow a re-instatement. It is important for all nurses to remember that in every major inquiry into standards of care in a hospital, it has been found that one or more junior nurses had brought examples of serious malpractices to the attention of nurse managers—who had taken no action.

The general health and behaviour of a nurse at work may also lead to disciplinary action. General problems of attendance are not difficult to manage although they demand that nurse managers are both fair and conscientious.* Absenteeism rates for nurses are lower than for many other groups of staff, but the subsequent disruption to the service is probably greater. Nurse managers need

* *Hardwick v Leeds Area Health Authority*, 1975, *Industrial Relations Law Reports*, 310.

See also Chapter 2, Discipline and dismissal: legal aspects, pages 29–33.

to be encouraged to spend less time in disciplining the absence-prone and more time in considering the individual and environmental factors responsible. A nurse's state of health has an effect on the care of patients and that is why it is important that all NHS staff have access to an occupational health unit. Nursing, like other professions concerned with the sick and distressed, attracts and produces a small number of people who react to the very demanding nature of their work or to domestic stress, and become mentally ill or addicted to drugs or alcohol. This produces a dilemma for nurse managers between the need for compassion for the nurse and the responsibility for the safety of patients. And it may be difficult to prove anything in a way that would satisfy an industrial tribunal. Nurses and doctors often protect their colleagues for fear of disciplinary action being taken. Where it is possible, the nurse, her representative and her manager may be able to agree a safe and supported working situation while medical treatment is sought. MIND (the National Association for Mental Health) criticised nursing management for dismissing nurses with mental illness.[110]

The General Nursing Council of England and Wales

Procedures for disciplinary matters are common to all NHS staff, but there are certain issues of particular relevance to nursing. Trained nurses provide a professional nursing service, and pupil and student nurses are in training to obtain a professional nursing qualification. Nursing standards are not, therefore, matters only for local management discretion. The General Nursing Council has the duty and the right to monitor standards so that the general public may know what standard is to be expected from a professional nurse.[31] Confusion arises between disciplinary matters which should rightly be decided by the employing AHA (usually by nurse managers acting on behalf of the AHA) and those which require the *collective professional* judgment of the GNC.

The GNC is required by law to exercise a professional disciplinary function to protect the vulnerable public, to maintain professional standards and, when possible, to rehabilitate the nurse concerned. Matters are reported to the GNC either as findings of guilt in criminal courts or as allegations about performance at work. The latter are usually made by nurse managers but can be made by other people. Criminal convictions are, of course, accepted. Allegations remain so until found otherwise by the GNC's disciplinary committee. The GNC has a responsibility in law to investigate those matters brought to its attention from any source, to decide whether allegations are proved beyond reasonable doubt, whether there has been professional misconduct and, if so, what is the appropriate collective professional judgment. *This judgment must be exercised without reference to an employer's decision about the nurse.* It is not about dismissal but about whether the individual is an appropriate person to have the right to practise as a qualified nurse. Misconduct that an employing authority decides justifies dismissal will not necessarily be considered by the GNC to be professional misconduct. If the GNC considers it to be professional misconduct, and the nurse's name is removed from the roll or register, the nurse will have to be dismissed from a post as a trained nurse because he/she no longer has the appropriate qualifications, although the employing authority would in theory have the discretion to employ the nurse in some other capacity. Most often an incident that leads to consideration of a nurse's dismissal as an employee will also lead to consideration of the nurse's right to practise. Nurse managers have a responsibility to draw to the attention of the GNC any matters they consider to be of professional concern.

To be present as an observer at a GNC disciplinary committee hearing is an impressive and valuable professional occasion for any nurse. The hearing is conducted with the utmost compassion and professional integrity, and every offence is considered in its context.

The GNC is concerned with the training of pupil and student nurses, and has issued guidance to training schools about the application of the Trade Union and Labour Relations Act 1974 together with the Employment Protection Act.[33] In a contract of employment, the basic principles of the disciplinary rules applicable to the employee must be specified. For student and pupil nurses, this must include the disciplinary rules of the GNC: that examination requirements must be met, the specified period of training completed, a certificate of good conduct obtained, and that the student must reach the standard required.

Each training school has to specify for its nurses what is meant by 'good conduct' and 'standard required'. Local rules should also be laid down to state that training will be discontinued after a certain number of unsatisfactory ward reports or after failure in certain internal examinations. The legislation on unfair dismissal does not apply to those who have been in continuous employment for less than 26 weeks. For a nurse who has not had previous and continuous service before starting training, the GNC recommends some form of assessment of a learner's progress at 22 weeks, but in practice this is often much too early for an accurate assessment, particularly of a nurse's practical ability.

The case of a student nurse caused quite a stir in nurse education circles. She was dismissed after failing her practical assessment for the third time. The Bedford Industrial Tribunal dismissed her claim that she had been unfairly dismissed, but the Employment Appeals Tribunal reversed this decision when it was shown that one of the practical examiners who failed the student nurse had not taken a course in examining as laid down in GNC regulations. Although the appeals tribunal warned that the case should not be regarded as setting any sort of precedent, it illustrates the extent to which tribunals insist that regulations and procedures designed to protect the employee are observed to the letter.[32]

Another case involving a student nurse shows how important it is for nurse managers to behave logically: a student nurse failed her practical assessment on aseptic technique once and was given an oral warning; she failed a second time and was given a written warning; after her third failure she was given notice and her training terminated, but during the period of her notice she was put on a busy surgical ward, at night, where she was regularly undertaking major surgical dressings![32] All AHAs should have a local appeals procedure so that nurses can appeal against the technical aspects of practical assessments, but there is no appeal against the *professional* judgment of the examining nurse.

Discrimination

Other legislation of importance to nursing is that on discrimination. Discrimination in employment on the grounds of race or sex is unlawful. Nursing is one of the few occupations where discrimination against men is probably more likely than against women. The need to obey the law is made difficult by demands by staff and unions for staff of both sexes to be on duty in mixed wards, by the objections of patients and community to mixed wards, by the staffing implications of having to provide chaperones, and by the anxiety which some female patients have about the presence of male nurses.

The racial mix of nurses reflects not only the ethnic origins of the local community but also student and pupil nurse recruitment patterns. Nursing has a great debt to the staff from overseas who were prepared to work in less attractive hospitals when local people would not. The general difficulties about employment mean that many of these staff now have trouble in obtaining work permits so that they can continue their careers. Immigrants and nurses of non-caucasian origin are under-represented in posts of charge nurse and above, and nurse managers have to make sure that opportunities for promotion are fair.

Nursing industrial relations and the needs of the NHS

The service needs good working relationships among all its staff, but among nurses it is of particular importance. Their direct involvement with the care of patients makes them the group of workers whose presence and performance at work are vital. Poor industrial relations threaten this. How can improvements in nursing industrial relations be brought about? Continued change and improvement in the style of nursing management are required, and the competition between staff organisations needs to become less of a source of rivalry and conflict.

The Employment Protection Act 1975[62] was passed at a time when the membership of nurses in staff organisations was growing and the stewards of those organisations, whose main concern had once been recruitment, began taking on staff grievances and, then, negotiations over individual disciplinary action. Nurse managers often found themselves ill-prepared to follow the disciplinary procedure, and ill at ease faced by a union steward who, though often a junior member of the staff, sounded more knowledgeable about employment legislation. Many nurse managers must have echoed the comment in the *British Medical Journal* which concerned the Dulwich theatre incident: 'One of the important and dangerous consequences of the Employment Protection Act is to make management reluctant to dismiss even persistent trouble makers'.[21] This 'consequence' is not a result of the Act but of the poor procedures available to many nurse managers and, even more, of their inadequate training. Things have improved enormously, but the many years of comments such as those expressed in the *BMJ* have created a fearful and negative attitude. It is not unusual to hear comments among senior nurses that: 'You can't even tell a nurse off these days without her bringing in the union', or 'We know how bad she is, but these days there's nothing you can do about it'. One of the greatest challenges facing nurse managers is to remove such pessimistic and defeatist attitudes, so that good industrial relations come to mean happy and

efficient staff providing a high standard of nursing care—not merely the freedom from trouble with the unions.

Much negotiation on nursing is undertaken at national level. The nursing and remedial professions will soon be among the only ones in the NHS who are not negotiating a major part of their salary at local level. The implications of this must, at the moment, be speculative but it would seem that one will be that local trade union activity will have to be directed at issues other than pay. Local negotiation over arrangements for a nationally negotiated reduction in the working week may provide an interesting challenge.

The future

How are nurses going to determine the future course of industrial relations in nursing? The most important needs are to improve the quality and style of management at all levels and to create one which is strongly founded on a commitment to nursing and to nurses and not one based on an administrative model. June Clark, a member of the council of the Rcn, has said that it is a fallacy to apply to nursing the distinction which applies to industry between the 'shop-floor' and 'management', because every qualified nurse is a manager.[14] Management is included in the basic training of student nurses and the key grade in clinical nursing, that of the charge nurse or ward sister, is specifically designated as a management grade. However, Mrs Clark is wrong to blame trade unionists as solely responsible for making such distinctions. Nurse managers refer too rarely to their own roots in clinical nursing and often create the 'them-and-us' feeling among the staff. Some nurse managers should bear in mind the comment of an American nursing administrator after the strike of 4400 registered nurses had affected 41 hospitals and clinics in San Francisco that 'the high degree of respect which existed between nurses in administration and nurses in direct patient

care, and their mutual concern for patient welfare formed the basis for very sound decision making throughout a tense period of negotiations'.[10]

There are many styles of management, but all nurse managers require the qualities of fairness, firmness and compassion, and need to be accessible to their staff. John Greene's presidential advice to the annual conference of the Association of Nurse Administrators in 1977 was that they should 'walk the wards of their hospitals—see and be seen'.*

Nurse managers need also to be well versed in all the conditions of service and policies which affect their staff, and must be informed promptly of important changes. The management side was far less efficient than the staff side at providing information over the interpretation of the Halsbury pay award.[46] Many middle managers felt then that their positions were undermined because junior nurses had received information much more quickly through their staff organisations.

Management is not, of course, responsible for all the industrial relations problems affecting nursing. A major problem for the whole nursing profession is that representation is weak, shared by 12 staff organisations, and such fragmented representation is further torn apart by the conflicts and fights, locally and nationally, between the staff organisations. The antagonism is presently greatest between those bodies affiliated to the TUC and those which are not. Earlier it was between the trade unions themselves, and between the professional organisations. Nurses could have a powerful voice in industrial relations in the NHS if they united. The scattered and discordant voices now heard will be cause for regret in the future.

* Noted by the author at the conference.

Union far outweighs the issue of affiliation or non-affiliation; the Health Visitors Association has been affiliated to the TUC since 1924 but is a highly professional and non-political organisation. In some other countries, nurses have a far stronger voice because their professional organisation is much stronger. In Denmark, for example, over 90 per cent of registered nurses belong to their professional organisation; the president is democratically elected and the organisation is the sole body with whom the government negotiates nurses' salaries and conditions, and it has a strong voice on matters affecting health policy.

Nurses have found that a trade union cannot supply all their requirements for a staff organisation, so many want to belong to a professional organisation. The Rcn has worked hard to become more representative of the views of all nurses and not only of those in more senior posts. Trade unionists still refer mockingly to the Rcn as 'the voice of management' but this is no longer a true description. At the end of 1978, the Rcn's net gain of 2000 new members a month was evidence of their strength. That it is a staff organisation of strength is recognised by personnel officers and senior nursing staff throughout the NHS. Many other thousands of nurses have opted to join a trade union, perhaps because as Albert Spanswick, general secretary of COHSE has said, the unions have a reputation for getting things done.[109] It is difficult to see these different organisations uniting in any way. The matter must rest with the nurses themselves. If they want nursing to speak strongly and with one voice they must work together to achieve it. In the author's opinion, the present position harms nurses, harms nursing and thereby harms patients.

9
Dilemmas of medical representation—a view

STUART DIMMOCK

The confrontation between the BMA and the post-war Labour government demonstrated that the introduction of the NHS was principally a matter of agreement between government and the medical profession. In the years that followed, the operation of 'state medicine' fostered a highly interdependent bargaining relationship between the profession and government, and enlarged the agenda for joint determination. Subsequently there was a number of confrontations between the parties over marketplace issues, such as remuneration and the size of the profession. While the doctors were able to exert considerable influence over these issues, it would be unwise to depict the profession as a united collectivity. The BMA's structure exemplifies the traditional divisions between doctors which can engender the pursuit of professional sectionalism.* Nevertheless, the BMA's awareness that its bargaining powers derived from its members' monopoly of certain knowledge and skills meant that it was generally able to treat with government on a more or less equal basis, even when representing sectional interests within the profession.

*The BMA has a number of executive committees. The central executive body is the BMA Council whose members are elected annually by the Representative Body. In addition, there are three principal committees (sometimes referred to as 'craft' committees) which negotiate for the main interest groups within the profession: General Medical Services Committee for GPs, Central Council for Hospital Medical Services for consultant medical staff, Hospital Junior Staffs Council for junior hospital doctors.

This encouraged the BMA to regard the bargain with Aneurin Bevan as an agreement on certain fundamental principles of the doctor's status in the NHS, and to concentrate more on representation at national level. On local matters, doctors were adequately placed to oversee their own interests. Medical power had shaped the structure to ensure that doctors were strategically placed within each administrative level. Locally, in hospitals, the composition and operation of the medical advisory committees and the hospital management committees enabled senior medical staff to achieve many of their objectives in the detailed daily running of the service.[111] The dominance of medical staff was largely based on four closely related factors: their prerogative in both the definition and the taking of medical decisions; their position within the administrative structure; the absence of other staff pressure groups; and the concept of 'responsibility for the patient', which required that the paramedical, investigative and nursing staffs were directly or implicitly under the doctors' control. As a result of both their relations with other health care occupations and their involvement with hospital administration, the BMA and the doctors tended to adopt an approach similar to that of British foreign policy in the latter half of the nineteenth century—which has been aptly characterised as 'splendid isolation'.*

The fundamental principles that the profession perceived as the bedrock of the NHS were, however, a product of the circumstances of 1948 and, as such, they had always been susceptible to renegotiation and adjustment as circumstances changed. The developments that led, in the 1970s, to the demise of the old 'colonial system' of administration in hospitals have also undermined the BMA's splendid isolationist stance. The consequences of these changes were most evident in industrial relations and, moreover, their greatest impact was felt within hospitals—the part of the NHS to which the BMA had paid least attention. National

* A phrase first used by George Joachim, first Viscount Goschen, in a political speech at Lewes on 26 February 1896.

and local industrial action among other occupations seemed to stimulate growth in membership of the TUC unions. In contrast, the medical staffs' disputes between 1974 and 1976 accentuated the traditional divisions and tensions within the profession, and served to exacerbate the potential disintegration of their collective organisation.

It could be legitimately argued that, when observed from the outside, the position of medical power and influence in the NHS remains unchanged. This view, however, can easily miss trends in hospitals over the past ten years. This chapter examines the position of hospital doctors against the seeming inexonerability of these trends, although some of the implications, to a certain degree, will be deliberately over-emphasised.

The chapter will, first, briefly outline some of these developments in hospitals—the rise of managerialism and the concomitant desire for professional identity and independence among many health care occupations and their achievement of effective trade union organisation; second, it will explore the ways in which these linked developments have undermined the splendid isolation of the BMA; third, it will discuss possible alternatives available to hospital doctors, and their collective organisations, within the changed circumstances of the NHS.

Managerialism and the quest for professional independence

The 1974 reorganisation of the NHS marked the confirmation of managerialism and the death of the hospitals' system of making decisions determined by the medico-Bevan agreement. Although, in the later stages of its gestation, managerialism had been gradually challenging the place of medical prerogatives in hospital administration, its elements can be traced to the years immediately after 1948. By the early 1950s it became evident that the Beveridge concept of a finite sum of morbidity[79] was false and

that the NHS was likely to be an increasing burden on the Exchequer. The health service was criticised for its supposed waste of resources and, although it was largely exonerated by the Guillebaud report[74], an air of disquiet persisted among some politicians and the mass media. As is often the case over this type of issue, conventional wisdom proved stronger than empirical investigation.

The return of prosperity ushered in a general mood of expansion. In the NHS, the new era was reflected by the 1962 White Paper on hospital building.[82] Although a growth in both the absolute numbers and the specialties of hospital staff had been a continuous trend, it quickened in the 1960s. To achieve maximum utilisation of large hospitals and staffs required effective administration: methods which leant towards the institutions of the 'family firm' centred on the consultant now seemed inappropriate.

The need to reassess traditional methods of organising and administering resources was part of the notion that scale and efficiency were inextricably linked. The Salmon report[56] reasoned that the complexities inherent in the organisation of nursing in large hospitals could be met by an extended nursing hierarchy with specific *managerial* functions. The Salmon proposals were echoed in a series of reports on the organisation and structure of other health care occupations.[49, 50] From another direction, the Prices and Incomes Board reasoned that productivity could be improved by the techniques of industrial management.[57] The hospitals' services, too, would be more effective after their rationalisation[53], and even the organisation of medical work was exposed to the new managerial philosophy.[51] A further element in the reports on health care occupations was their concern to lay the foundations of professional autonomy after the medical precedent. The Salmon report noted that earlier proposals[54] had not in reality given nursing an equal place in hospital administration, and argued for the right of the profession to be accorded full status by elevation to the counsels of doctors and lay adminis-

trators. The other reports followed the same path and the connection of managerialism with professionalism provided occupations with a new career structure and a prestigious escape route from medical control.

On NHS reorganisation, while managerialism received government's imprimatur, the rights of these professions were also recognised: consensus management on district management teams underlined the new equality between them and the medical profession. Functional management tended further to diffuse managerial responsibilities and to make them less amenable to medical influence. Thus, although the 'four fundamental principles' identified in the second Green Paper[39] remained unchanged on the surface, in hospitals the position of doctors had been subtly undermined. Superficially, the number of doctors on DMTs could be seen as the continuation of medical dominance. In effect, however, the differences in their medical orientations, that had bedevilled the BMA's ability to weld a united collectivity, were projected in microcosm onto the DMT. Furthermore, since the reorganisation, medical committees have not played the part in consensus management that had been originally envisaged.[13] Thus, the position of the elected consultant working temporarily in the DMT with four permanent officers and, in consequence, denied continuous access to all the flows of information, became more analogous to the role of a worker-director on a management board in private industry. Moreover, the absence of consultants from area teams in multidistrict areas added to their isolation from the management decision-making. With hindsight, the cumulative effects of these developments can be seen more clearly; at the time, their very gradualism obscured the eventual destination. The erosion of medical privilege in making managerial decisions removed one pillar of 'splendid isolation'.

Professionalism tends to emphasise the importance of individual attitudes, at least to job and workplace. In a trade union sense, the notion of individualism presented the BMA (in common with

other organisers of professional workers) with barriers to the formation of effective organisation and representation in the workplace. The BMA's ambivalence towards espousing trade unionism, though reflecting the general attitudes within the profession, added to these difficulties. The BMA's relative absence from the workplace may, in part therefore, have failed to alert it to the loss of medical influence inherent within the new structure. Its ambivalence to trade unionism and the consequent lack of organisation in the workplace were highlighted more starkly in subsequent industrial disputes.

Impact of trade unionism

The realisation of effective trade unionism among other staff groups was significant for hospital doctors in two principal ways. First, it presented yet another challenge to the exercise of medical prerogatives and, second, the use by trade unions of direct industrial sanctions provided a practical guide to alternative methods of pursuing the profession's objectives. Hospital doctors were not alone, however, in encountering this new challenge. The emergence of trade union organisation in hospitals was also, in part, due to successive introductions of managerialism. Ironically, those who had benefited most from the acquisition of managerial authority soon found that its exercise was limited by trade union aspirations.

In the 1973 ancillary workers' dispute, the need to decide what constituted an emergency admission brought manual workers' union stewards into direct negotiations with hospital doctors.[97]

Following this, some of the ancillary workers and their unions moved on to assault what many in the medical profession perceived as one of the NHS's fundamental principles. The acknowledgment of doctors' rights to private practice within the NHS had been one element in the 1948 bargain, and in the 1974 pay

beds dispute it was even claimed to be central to the principle of 'clinical freedom'. The action taken by ancillary workers in 1974 at Charing Cross Hospital was a powerful reminder to TUC unions of their declared policies towards private medicine: national and local disputes of the immediate past suggested that these could be translated into action. The issue of private medicine showed up the gulf in doctors' thinking, not only between themselves and ancillary workers but also between themselves and other emergent professions. In the dispute, the approach generally adopted by professional associations was either open antagonism or guarded neutrality. The BMA, therefore, stood alone. This was not new. In the past, as the only organisation capable of withstanding government initiatives, it had never needed support. Indeed, support would not have been readily available. The development of trade unionism threw up other, more cohesive, pressure groups, who were more or less unsympathetic to the BMA's position. In short, the second pillar of 'splendid isolation'—the absence of other powerful staff groups—was swept away.

It was, therefore, vital for the BMA's leadership to present a united front to the government, similar to that which confronted its post-war predecessor. Despite the difficulties of balancing its internal sectional interests, the BMA had managed to retain the sole right of speaking for the profession. There were competitors, but these were relatively weak and, more importantly, they had not received recognition from the employers. Now, however, the traditional divisions within the profession reasserted themselves as the JHDA and the HCSA, in competition with the BMA, presented more militant postures. Thus, the third pillar of 'splendid isolation', a more-or-less united profession, fell away. The BMA emerged facing a war on two fronts over private practice with government and the unions, and on a third front with junior doctors over their pay—all of which threatened widespread secession. In this situation, the BMA undertook the handling of its first direct industrial action.

The details of manoeuvres in the consultants' and the junior doctors' disputes have been adequately charted.[34] The ostensible triggers to the disputes were primarily economic: successive incomes policies; general inflation and its effects on doctors' earnings; insufficient rewards for long hours; and the threatened loss of private income. However, ideological and internecine issues emerged within the profession which were pursued with a public ferocity unparalleled since 1948. The events of the hospital doctors' diputes suggest it was really their monopoly of medical knowledge and skill, rather than their effectiveness in the skills of collective bargaining, that was instrumental in determining the eventual outcomes. When the environment that supported 'splendid isolation' changed, it revealed the reality of ineffective collective organisation among doctors. Thus, internally, the BMA faced, at best, publicly aired differences of opinion within its membership in letters to *The Times,* at worst, sections of its consultant membership taking precipitate industrial action. Externally, it vied with the HCSA and the JHDA as each attempted to outwit the other and, thereby, retain or increase their respective memberships. Nevertheless, both the consultants and the junior doctors achieved their main objectives. The 1977 Health Service Act meant, in effect, that pay beds within the NHS would be retained in those areas of the country where the demand for private medicine was insufficient to support alternative facilities.[68] The junior doctors received large pay increases in the subsequent local settlements with AHAs. In terms of wage settlements, the battle was won, but at the expense of further fragmentation of the doctors' collective bargaining organisations.

In 1948, the royal colleges played a key role in mediating between Bevan and the BMA. The traditional function of the colleges was largely to advance the profession's prestige through the pursuit of excellence. The colleges consist of the consultant élite, and their educative and examining roles have enabled them to move into the arena of professional standards. As such, their interests in professional matters overlap those of the BMA, and both they and

the BMA felt they had a responsibility to represent the consultant section of the profession. However, the colleges' desire not to become involved in the 1974 pay-beds dispute removed the possibility of conciliation from within the profession. It may also mark the end of the colleges' presence in collective industrial relations.

The circumstances of 1974 and 1975 reflect the contradictory issues faced by hospital doctors and their several collective-bargaining organisations. Many of these are not recent in origin. Their roots are located in the history of the profession, and in 1948 they were transferred to the NHS.[104] Since then, new problems have emerged and, together with the historical issues, have become interwoven with the health service's own destiny. It is in this context that the developments in hospitals in the 1960s are of special importance. In effect, the developments which undermined the BMA's splendid isolation have presented the doctors with a number of options; but they have also created a new environment in which to choose the options.

The options can be briefly described: professionalism or trade unionism, individualism or collectivism, continuing emphasis on national representation or a new interest in the affairs of the workplace; homogeneous or heterogeneous representation. It is important to emphasise the consanguinity of the options. The choice of one may close off either one or all of others. Although some doctors, in choosing their options, have already joined other collective-bargaining organisations, the BMA remains the lynchpin of medical representation and action. As such, its attitude towards these options is critical.

Professionalism or trade unionism

The BMA has the longest experience as the profession's principal bargainer. The agreement with Bevan was the culmination of a

series of negotiations with the State over this century, which gradually built up the ingredients within the debate over professionalism versus trade unionism. However, it was the government's desire to establish an ordered machinery for collective bargaining, as a corollary to the introduction of the NHS, that emphasised the ambiguities of the BMA's representative role. The continuous rule-making processes which constitute collective bargaining[28] are different in kind from the spasmodic *ad hoc* negotiations that tended to characterise the BMA's previous relations with the State. Thus, the BMA's subsequent collective-bargaining activities tended to belie its public statements, which consistently rejected both the form and the substance of trade unionism on emotional and ideological grounds. The BMA's adherence to the independent Salaries Review Body is an example of its desire to maintain the form of professionalism. Third-party arbitration was a means of demonstrating to its membership that they were on a different plane from the trade unionist. If the review body's reports were unacceptable, the BMA could adopt trade union methods and collectively bargain with vigour. Moreover, it would have the support of its membership. A paradox of the BMA is that while it presented the form of professionalism, it often achieved more for its membership, particularly over earnings, when it adopted the stance of trade unionism. Given its members' antipathy towards trade unionism, this sustained piece of legerdemain is a tribute to the skills of the BMA's leadership.

It may be observed here that the BMA may have unconsciously retarded the development of genuine trade unions among other hospital occupations. Thus, the quest for professional independence as a means of emulating the power and status of doctors may have led some occupations to identify form rather than substance as the key factor in medical power. Form may also have been pursued in its own right, however, as a concomitant of self and public esteem. In this context, it is interesting to note that when the BMA entered the Special Register under the 1971 Industrial

Relations Act[67], it was followed by other NHS professional associations.

Both the BMA and its principal protagonist in hospitals, the British Hospital Doctors Federation (BHDF)*, have legal status as certificated trade unions under the 1974 Trade Union and Labour Relations Act.[80] This appears, as in 1971, to signify a desire for self-protection rather than a commitment to trade unionism. The issue which above all seems to decide the conflict between professionalism and trade unionism is membership of the TUC. As with the earlier debate over special registration, the BMA's initial attitudes towards TUC membership also suggested a sense of insecurity; if the BHDF were to achieve affiliation before the BMA, would it then attempt to preclude the latter's entry? Alternatively, if the BMA approached the TUC before the BHDF, could it be sure that it would not be publicly rebuffed? While the BMA maintained informal relations with the TUC, its annual representative meetings decisively rejected proposals for affiliation; entry to the TUC appeared to signify, for the doctors at any rate, the irrevocable rejection of professionalism. However, affiliation does not necessitate automatic rejection of the professional tenet. Many professional organisations have entered the TUC. The Association of University Teachers, whose members cherish academic freedoms analogous to the medical profession's values, is one example.

To a degree, the BMA's past legerdemain has fostered the emotional overtones of the debate over membership to the TUC. Thus, many BMA members confuse form with substance. Affiliation can be viewed equally as an ideological commitment or a business transaction. The corporeity of trade unionism is founded on elements largely outside the narrow issue of TUC affiliation.

*This was formed in 1977 through a merger between the JHDA and the HCSA. As it is not recognised by the DHSS for collective bargaining purposes, its acceptance by the TUC must be in doubt.

work-sensitive contracts, which necessarily involve an element of local negotiations, may mark a fundamental change in attitude among consultants, in so far as they may promote an increased awareness of interdependency among colleagues. In this sense, the service need look no further than ancillary staff to consider the possible effects on doctors of the notion of work-sensitive arrangements negotiated at local level.

There are broader ramifications to collectivism. The doctors' emergence from splendid isolation may prompt them to seek alliance with other groups. In hospitals, ancillary workers and medical staff, while of different status, are both likely to experience an increased intrusion of managerialism in their everyday work. Doctors have not, in general, welcomed the activities of the ancillary workers' trade unions. In terms of medical practice, however, the unions have not threatened a dilution of medical knowledge and skills. The threat of dilution, inherent in the concept of the health care team[119], is one expression of the quest for professional independence among other hospital occupations. In hospitals, ancillary workers and their trade unions, therefore, may appear as more natural allies. Nationally, collectivism, if achieved, could lead to closer ties with the TUC lobby, in attempts to exert greater influence on public spending. The possibility of the emergence of local collectivism cannot be viewed in isolation, however, because it is closely bound to the development of organisation among doctors in hospitals.

National representation or workplace organisation

The changes in hospitals that precipitated the demise of splendid isolation emphasised the void in medical representation in hospitals. The BMA's relative non-involvement in decision-making at local level before 1974 rested on the assumption that medical staff could look after their own interests. One indication of this was the doctors' decision not to take part in the 1950s form of

staff consultation. The organisational changes in hospitals, together with the new threat of competition for membership among the doctors' collective organisations, have created a radically different environment. In following other NHS professional associations, which have established steward systems, the BMA has perceived the advantages offered by this instrument of the trade unions as a means of encouraging collectivism. A local system of organisation based on shop stewards is a key element in the corporeity of trade unionism. It serves trade unions in at least two important ways. First, it provides the union hierarchy with a reasonably accurate picture of the membership's concerns and aspirations. Second, the representative activities of the stewards enable the union to be seen as an important influence on immediate issues in the workplace. The establishment of a steward system*, together with its network of local industrial relations officers, is of special importance to the BMA. It is also a further example of the BMA's ability to weave the form of professionalism with the substance of trade unionism.

In the past, the BMA's leadership has often appeared to be contemplating action which its members have not been prepared to support. The use of ballots can be two-edged: not only as a means of assessing support but also as an alibi for not taking, or not continuing, a particular course of action. Therefore, care should be taken in identifying the reasons for balloting members in any collective organisation. In the BMA's case, however, ballots are one of the few indications of the membership's views on major issues. The history of the BMA's ballots highlights a difference between the leadership's course of action and views of the members on, for example, entry to the NHS in 1947–8, pay issues and private practice. The gap between central negotiators and local constituents, noted by Stevens[111], could perhaps be bridged by

* The term adopted by the BMA for its stewards is 'place of work accredited representative' (POWAR).

It is the choice that the doctors make, from the options, that will determine the issue of professionalism versus trade unionism, and the choice between collectivism or individualism is central.

Individualism or collectivism

Many professions place over-riding importance on the notion of members' first obligation to the client. In medicine, this is further supported by the belief in clinical freedom. These together have done much to encourage the doctors' antipathies towards trade unionism. The alternative concept of 'trade union solidarity' with its over-riding emphasis on obligation to one's peers is, in consequence, often regarded as entirely alien to the practice of medicine. Moreover, the doctors' attitudes towards the principles and methods of the trade unions' collective action have been hardened by the environment that formed the pillars of splendid isolation.

Under the old structure, the consultants, unhindered by managerial prerogatives, alternative pressure groups and government cash limits, competed with each other for greater resources. In addition, the distinction awards system underscored the benefits of competition. The traditional suppression of junior doctors was carried into the NHS. Consequently, although it was now the NHS that provided them with insubstantial earnings and long hours, many of the exploitive aspects in their relationships with consultants remained; in particular, the consultants' general indifference to these conditions while expressing concern for the junior doctors' careers. Even the system of medical organisation promoted fragmentation between hospital doctors.[51] Therefore, the hospital setting tended to militate against collectivism. By comparison, a significant aspect of recent developments (managerialism, emergent professionalism and heightened activity of trade unions) is their propensity to foster collective action among doctors in hospitals.

As the reorganised NHS structure matures, the consultants' elected representative on management teams may come to feel the 'worker-director role' more acutely. In the extreme, it is the consultants who may have formally to invoke sapiential authority as a justification for their involvement in the making of organisational decisions in a manner similar to that currently adopted by nurses. The introduction of management hierarchies into other occupations may further diminish medical influence. The gradual erosion of medical prerogatives over nursing matters, which followed the Salmon report, may be repeated with other occupations. The debate on the future structure and management of scientific services is one such indication.[124] Managerialism is, therefore, an aspect of hospitals which senior medical staff will come to mistrust and oppose. Furthermore, opposition to management, if it is to be effective, must be collective, as the ancillary workers have demonstrated to the medical profession.

A primary element which may discourage collectivism by encouraging competition for resources is the continued restraint on public spending. This appears to be likely whichever political party is in government. However, the formation of the BHDF suggests that in at least one respect, pay bargaining, the activities of the government have already pushed hospital doctors towards collectivism. Some consultants and juniors have jointly identified that the 'employee role', which for many hospital doctors is the essence of their relationship with government, requires a reappraisal of their traditional separation in the profession. A further aspect of pay bargaining is the method of determining the consultants' contract. In the past, individualism received support from the arrangement whereby the number of weekly sessions was negotiated direct between an individual consultant and his employing authority: a consultant's contract was a private affair over which he had unilateral control. Moreover, the unilateral control (over the contract) previously enjoyed by the consultant may be eroded by health authorities deciding to scrutinise the details of the consultants' workload. The movement towards

the advent of a steward system and information provided by the BMA's local industrial relations officers.

Another value that trade unions derive from stewards is their closeness to the issues in the workplace: stewards' representations on both individual and collective issues are a constant reminder of the necessity of union membership at the workplace. Since 1973, hospital ancillary workers have shown that their collective views on local issues are expressed more forcefully through trade union representation. The decline of medical influence in decisions made by local management (for example, it is not unknown for a DMT to approach TUC unions, in advance of any other interested parties, on the broad outline of the district's plan), in addition to encouraging collectivism, may also provide the BMA and its competitors with a platform for the expression of local discontent. Negotiations with AHAs over the implementation of the 1976 junior doctors' settlement have already provided one such opportunity. The hospital doctors' need for representation within AHAs' grievance procedures and disciplinary procedures provides another.

The concept of collective action based on trade union representation is still relatively novel for all hospital and medical staff, and particularly the consultants. It should be borne in mind, however, that a few years ago this would have been equally novel to ancillary staff. The major issues which swept away splendid isolation also encouraged the growth of trade union consciousness and workplace organisation among ancillary staff. By comparison, the significant element missing from the doctors' experience of industrial relations so far is an effect similar to the locally negotiated incentive bonus schemes for ancillary staff. The existence of work-sensitive contracts and the likelihood of managerial surveillance of consultants' workloads may prove to be the essential spur to the formation of workplace organisation among hospital medical staff.

The BMA's establishment of a steward system is an indication of its awareness of the need both to encourage a greater sense of

collectivism among hospital doctors and to move more openly towards the form of trade unionism. However, the BMA is not alone in this. The BHDF and the Medical Practitioners Union (MPU) are also concerned to channel the streams of collective power into their own ranks. The emergence of workplace organisation among hospital doctors, fragmented between different trade unions, would pose major problems, not least for local management.

Homogeneous or heterogeneous representation

The last vestige of splendid isolation—the appearance of a united profession—was dispelled by the hospital doctors' disputes. Alternative organisations to the BMA had been formed some time before 1970. The disputes merely brought matters to a head. The principal representatives of the hospital doctors are now the BMA, the BHDF and, latterly, the MPU.* The fragmentation among the comparatively small group of hospital doctors can be broadly ascribed to the exercise of individualism.

The MPU's membership (predominantly general practitioners) is distant from the BMA by the commitment to socialised doctrines in health care. The JHDA and the HCSA (now merged as the BHDF) broke away from the BMA because it did not appear to provide adequate representation of their interests. The JHDA was formed in 1966 to act as a 'ginger' group within the BMA. In 1969 the JHDA became a separate organisation leaving a 'junior rump' in the BMA. In contrast, the HCSA (formerly the RHCSA) was formed in 1948 as a counter to the London-dominated BMA. After 1970 it grew rapidly by pursuing a militant line on behalf of the hospital consultants. The BHDF now claims a membership of approximately one-third of all hospital doctors.[34] The absence of a sense of collectivism among hospital doctors as a group was

* The MPU, a part of the Association of Scientific, Technical and Managerial Staffs (ASTMS), has, since 1970, claimed increasing recruitment of junior doctors.

further reinforced in 1977 when the BHDF applied, albeit unsuccessfully, for separate recognition by the DHSS as a negotiating body. The choice between individualism and collectivism has significance for hospital doctors beyond their relationships in hospitals. It also relates to the nature of their collective organisation.

The heterogeneity of medical representation in hospitals demonstrates a central dilemma of the BMA. The JHDA's secession from the BMA, and the acrimonious comments uttered by both during the junior doctors' dispute, are superficially explained by the BMA's inadequate representations on the juniors' behalf. However, these events also suggest that the juniors are concerned to achieve greater status within the profession and, hence, negotiating power. The HCSA's growth in the 1970s was, similarly, an expression of discontent by some consultants who saw the BMA as being primarily concerned with representing the GPs.[27] Given the respective rationales of the two constituents, the establishment of the BHDF is curious. For the juniors, the issue of professional recognition must logically be linked more closely to the attitudes of consultants rather than of the BMA. As such, the consultants' attitudes towards their juniors have been shaped over centuries, and the historical gulf between them may not be easily bridged. A merger of any two organisations that encapsulates this type of relationship would be difficult to sustain. This is doubly so if the principal purpose of the organisation would involve it in the type of conflict inherent in wage bargaining. Conflict would not be limited to the clash of expectations between employer and employee; it may also involve conflicting aspirations between employees. The degree of homogeneity required to sustain the BHDF against this conflict may be severely limited by the traditional gulf between its constituents, particularly if, as it appears, the essence of the merger is a shared dislike of the BMA.

The problems faced by the BHDF in achieving internal unity duplicate the BMA's position as the profession's sole recognised representative. Thus, in representing the GPs, who form the bulk

of its membership, the BMA is almost predestined to be criticised by the hospital doctors for its failure sufficiently to meet their collective aspirations. In representing the hospital doctors, the BMA leans naturally towards the interests of the consultants who are the most powerful group. The BMA's apparent neglect of the junior doctors is, thereby, balanced by ensuring that the privileges attached to consultant status, to which they aspire, are maintained.

The causes of fragmentation are not to be found in the representational activities of the BMA, but in the traditional and distinctive forms of medical practice. The internal structure and internal government of the BMA acknowledge this. The central BMA council, together with the largely autonomous 'craft committees', mirrors the heterogeneous nature of the profession. Moreover, membership of these bodies is by election, in which BMA membership is not a precondition for candidates. It has been rumoured that it was this element in the BMA's constitution that was an important factor in the failure of the BHDF to obtain recognition from the DHSS. The BMA's structure replicates the experiences of some industrial craft unions who have amalgamated in order to subsume demarcation disputes within one single trade union, thereby reducing wearisome inter-union rivalry. An important element in the BMA's strength as a collectivity has rested on the notion of a single organisation whose structure provides for the pursuit of sectional interests. Heterogeneity outside the BMA is likely to prove a weaker alternative, in both trade union and professional terms.

The formation of the BHDF, as an alternative representation among hospital doctors concerned to pursue more militant lines in pay bargaining (from within a smaller and, supposedly, more cohesive body), may have an effect different from that intended. First, it could merely encourage the formation of other, smaller, collective organisations which would see the dissipation of medical strength in competition for membership. This would hold back the more general trend towards trade unionism. Second, large

numbers of hospital doctors recruited to the BHDF could precipitate the dismemberment of the BMA and the creation of separate organisations, maybe irrevocably demarcated, like some of the craft unions. In either of these events, the stimulus given to the emergence of yet more collective organisations would be counterproductive because many of them would still face the same four main options: trade unionism versus professionalism, individualism or collectivism, national or local representation, and homogeneous or heterogeneous organisation.

Summary

The development of managerialism, professional independence and trade unionism has undermined the twin bases of medical influence and splendid isolation in hospitals. The consultants' and junior doctors' disputes gave impetus to the trend towards fragmented medical representation. The difference between professionalism and trade unionism had been gradually emerging throughout the 1960s and, within it, the BMA had maintained the form of professionalism while practising the substance of trade unionism.

The combined effect of these developments and the disputes was to make more immediate the choice between the two. This, therefore, became the subject of open debate, in which TUC affiliation was mistakenly perceived as the essential determinant of trade unionism. The misperception obscures the fact that the managerial developments which changed the hospitals' organisational structure may also encourage the development of trade unionism among hospital medical staff. The encouragement they provide to the growth of collectivism and workplace organisation among doctors may be seen at its strongest in hospitals.

The BMA is anxious to encourage the notion of workplace collectivism as shown by its establishment of a steward system.

In this respect, the BMA is following the path of other professional associations, in a general trend towards the acceptance of trade unionism. Alongside this, the choice taken by hospital doctors between homogeneous and heterogeneous representation is a critical factor in the determination of the form of medical trade unionism. The option appears to be either strong trade unionism among hospital doctors within the 'craft structure' of the BMA or a weaker and fragmented profession.

10
Reform plans and priorities

NICK BOSANQUET

Is there hope for improved industrial relations in the NHS? At first sight there seem to be reasons for pessimism. In principle, two kinds of causes might have worked to bring about a deterioration. There might have been objective changes in the problems facing the service; on the other hand, there might have been subjective changes within unions. The 'subjective' theory at its crudest would assert that the easygoing Dr Jekylls who had dominated the unions and the BMA in the past had been transformed into a new race of Mr Hydes. The main recommendation would be for a course of therapy at the end of which the unions would 'behave' better. Press coverage of unpleasant incidents gives the subjective theory even greater currency.

Usually views of industrial relations are highly 'subjective'. This is partly because the subjective elements are so much more dramatic. Thus it is much easier to report the arbitrary and unreasonable behaviour of a shop steward than to report on the deficiencies of agreements or in the internal 'rule of law' which provides a culture for such behaviour. It is much easier to report the details of strikes and disputes than the reasons for them. Even on the subjective plane, the balance of reporting may well show a bias in favour of management, partly because management's sayings are rarely audible.

We hope that our book will help to increase public discussion of the 'objective' reasons for deterioration of industrial relations in the NHS. At national level, the largest 'objective' difficulty has been that of pay. This problem has three parts to it: one is the question of low pay, the second is that of pay in the NHS relative to pay elsewhere and finally there is fairness in differentials within the health service. In the last ten years very little progress has been made towards smoother ways of resolving these difficulties. The system can operate in ways which will turn the most peaceful and herbivorous union into a manager-eating and minister-eating carnivore. The objective problems are still there. Some workers in the service are paid at basic rates which are too low to maintain a reasonable standard of living. They must either survive on the basic rate or work many hours of overtime to raise their pay. There is still no way of adjusting relativities between the pay of staff in the NHS and staff outside. The need for a mechanism can be seen clearly from the four-year cycle in the pay of nurses. The cycle begins with a large catching-up increase and continues with a decline in relative pay. This creates the imperative for extreme action to win another large catching-up increase. Finally, it is mainly a matter of luck as to whether the service avoids gross inconsistencies in pay structure. Sometimes it does not, as when the agreement on pay for maintenance craftsmen raised their pay above that of the men supervising them. All these underlying 'structural' problems are with us still, and it remains to be seen whether the new commission on comparability can resolve them.

Industrial relations at local level have become much more complex also because of 'objective' changes. One of them has been new labour legislation. The effects form the theme of a number of contributions within this book. Whether we look at issues of discipline and local conciliation through grievance procedures or at health and safety matters, there has been an upheaval. In addition, there have been major changes in management structure and greater financial stresses for the NHS. All this has come on the service while it was in transition to a much higher level of union

membership and (even though apathy still predominates) of member interest.

A more optimistic view would start from the unusual features of this time of transition. It could argue that the NHS has existed since 1948 in a peculiar seclusion. It lived in seclusion from public opinion. It was not usually faced with harsh budgetary choices. Its industrial relations ethic was exotic, even if admirable. In a short time the NHS has had to face an enormous change. There has been the growth in interest from public opinion. Public opinion used to take as much interest in the NHS as in the water boards during a wet year—but now public opinion echoes through community health councils and through local press reporting. There has been the change in the budgetary context with more choices to be made. There has been a decline in wider loyalties to the health service and a strengthening of loyalties to occupational groups. Finally, there have been the changes in management structure. It could be argued that the NHS has gone through an inevitable period of turbulence—but that after the period of transition matters were likely to improve.

This theory of spontaneous cure, however, seems implausible as long as the objective issues are still present. There is also evidence that troubles in industrial relations can become endemic. They become part of the culture of an industry or a workplace. Thus a few industries and plants are consistently strike-prone. The NHS is unlikely to be strike-prone in terms of the normal measures of days lost or numbers of stoppages. These measures were developed for traditional forms of action in industry and cannot do justice to the stresses which have become common within the NHS. But without scoring highly on the traditional measures, the NHS could still have a case of chronically bad industrial relations.

This unpromising future might include malaise in many places: a smaller fluctuating number of incident-prone districts and battles over pay and pay differentials. Are we doing as much

as possible to avert these unpleasant possibilities? The two main lines of reform until now have been the McCarthy report[94] and the proposal for a regional disputes procedure. The McCarthy inquiry was hobbled by its terms of reference, limiting it to the Whitley Council system rather than allowing inquiry into *industrial relations* in the NHS. It had to rely on *ex parte* evidence from management and staff representatives. Thus it depended on allegations rather than on research evidence. It was not able to get behind the veil of institutions.

Lord McCarthy's recommendations had two main themes. One was about representative standing for Whitley Council members. On the management side, members were to be nominated by regional selection committees and to be accountable to them. There were also proposals, which have foundered, for increasing the representational quality of the staff sides. The other main thrust of the McCarthy report was towards local agreements. The aim was for decentralisation except in the key area of pay. The suggested system would have been rather like that of local government, except for the lack of an independent central secretariat. The plans for a regional disputes procedure have similar aims towards decentralisation. It is difficult to see how these plans will alleviate the main 'objective' problems: pay determination at national level and a much more intense *local* life in industrial relations arising from new legislation and inter-union competition, together with more financial and social stress. The main effects of the two lines of reform are on the Whitley Council machinery and on setting up new intermediate tiers. These plans are likely to have minor effects on the actual situation. The plan for an industrial charter or pledge against industrial action is also cosmetic. Furthermore, they ignore the most distinctive and important feature of the health service—its direct control by the secretary of state. No minister is similarly answerable to parliament for industrial relations in local government, in education or in the nationalised industries. Such political control makes it inevitable that difficult issues will travel upwards, particularly when they are

about incomes policy. Any reform plan is likely to have severe limitations from the nature of political control centrally and from the tangled management structure locally. The limitation will hamper particularly schemes for 'intermediate' tiers. They will tend to deal either with issues which ought to have been resolved locally or with issues which are so sensitive that they will soon involve the secretary of state. Within these limitations, what would seem to be the most promising lines of approach?

It is vital to deal at national level with the problem of pay and pay differentials. Unless this 'objective' problem is reduced in scale, there is little chance of a major improvement in industrial relations in the NHS. One step would be to synchronise most agreements under the various Whitley Councils so that they had a common starting date. This would not avert all conflicts over pay but it would concentrate them. In addition, we badly need a new method of assessing 'relativities' between NHS pay and other people's. These proposals would in effect be an index of pay in the NHS with pay movements elsewhere, together with a means of deciding on relative changes on behalf of those who were low paid in absolute or relative terms. This new scheme for comparisons may well be dependent on wider decisions on incomes policy—but synchronisation of settlements does not have to wait for such an agreement.

At local level, the most important reform would be for management to take more initiative in industrial relations. Management up to area level has generally been passive—it has reacted to unions and to the DHSS. It has rarely taken the initiative. Yet there are many issues on which the NHS would seem to be well away from best practice. How many districts or areas have policies on equal opportunities either for women or for employees from minority groups? How many have shown interest in training and in career development whether for young staff or for others? How many areas and districts have shown energy and interest in fulfilling their duties under the Health and Safety at Work etc Act? The

NHS record in all these areas is far from glorious, particularly as it is one of the largest employers in the country. The key work locally in the past few years has been in establishing procedures. The work of the next few years must surely be less defensive, towards positive policies in the employment field. This must also involve a great strengthening of the personnel function and a widening in the scope of its work. The most immediate priorities must be in staff training, in equal opportunities and in health and safety. The NHS must go out and win a reputation as a good employer. This new sense of initiative would not have sudden or magical effects on industrial relations locally but in the medium term it would help to change an atmosphere charged with exasperation, and affected by loss of respect. At worst, it would mean that management could face disputes from a position of greater confidence.

These proposals concentrate first on the objective problems of the NHS and on those where management has the main power of initiative. The implication is that, in the long run, management gets the industrial relations it deserves. However, the events of the last six years—and not least the industrial action of 1978–9—also present problems of choice to trade unions within the service. What kind of trade unionism do they want to create for the future?

An initial period of growth in membership and local activity would now seem to be over. For the purposes of Whitley Council membership, there are some 43 organisations recognised for collective bargaining but, excluding those bodies which are both professional associations and unions, there are some six unions which have a major stake in the NHS. Representation of ancillary workers is shared between NUPE, COHSE, the TGWU and the GMWU, with NUPE and COHSE having most of the membership. NALGO has an important membership among clerical and administrative staff, as does ASTMS among scientific and technical staff. COHSE and NUPE share representation of nurses, although outside the psychiatric field they probably have fewer members

than the Rcn. In addition, there are the craft unions which negotiate for craftsmen in building, engineering and electrical work outside the Whitley structure. The period 1974–8 saw rapid growth in membership. Just in these years alone the membership of NUPE rose from 165 000 to 250 000; of NALGO from 64 500 to 84 000, and of COHSE from 143 000 to 212 000. There was also a rapid increase in the number of shop stewards. Partly because of the lack of agreement on their size, constituencies are now smaller among ancillary workers in the NHS than in other parts of the economy: inter-union rivalry may also have contributed to this growth in the number of stewards. Of the main unions, only COHSE has a membership entirely within the NHS. For the others, rising NHS membership has meant some shift in the balance of power within their unions as a whole.

Over these years of growth, the public image of trade unionism in the NHS has shown a considerable change for the worse, helped no doubt by somewhat unbalanced reporting in the mass media. Public attitudes shifted even though the problems did not. Thus a 'militant' could reasonably claim that working conditions in the service were often poor. The Health and Safety Executive in its pilot study argued that 'In a general assessment, numerous examples of poor environmental conditions were found throughout the hospitals involving extremes of temperature and/or inadequate general ventilation. It is significant that these problems were not confined to older (Victorian or pre-war) buildings but were also found in modern units.'[86] In many places little money had been spent over the years in improving working conditions or staff residences. Even if unions were now to press strongly for such improvements, they would often have to be made from money that would otherwise be spent on services for patients. The picture of a service seething with militancy also seemed wide of the mark outside a few 'incident-prone' districts. Apathy was the more common mood, particularly among part-time workers.

By early 1979, the unions seemed to be in a dead end. The years of rapid growth in their membership had been also years of inexorable reduction in the growth of NHS spending and even the longer-term plans offered little hope of improvement. In 1974 the unions had had some success in winning large pay increases and, through them, in raising the share of the gross national product going to the NHS but this was not to be repeated. The unions within the NHS had, by 1979, failed utterly to influence the wider allocation of resources in favour of the NHS. Locally there were some successes in pressing for better working conditions—for example, by COHSE in psychiatric hospitals—but often this was a desperately frustrating business. The avenue of industrial action was closed to all but the very foolhardy both by wider public opinion and by change of opinion among NHS staff. The unions remained divided and had not shown any sort of constructive concern for the problems created by inter-union rivalry. The difficulties of low pay and comparability in pay were as great in early 1979 as in 1974, and some of the nation's leading protagonists of free collective bargaining were left in the undignified position of pinning all their hopes on Professor Clegg's comparability commission.

By 1979 the unions were faced with a choice: they could either remain chronically divided and particularist—or they could become a more effective force in influencing the development of the NHS. Could they be a more effective presence locally? Some agreement on reducing inter-union competition would have been useful here. Most unions and the TUC would accept that it is better to have one union representing one grade of workers in a particular plant. Most people inside and outside the trade union movement would accept that inter-union competition is wasteful, particularly where membership is already high. It was surely time for the unions themselves to take some initiative on this issue. It also seemed time to give greater priority to the development of local negotiation and local agreements. Constant friction with bodies not affiliated to the TUC may have been understandable

but it had certainly inhibited the growth of local negotiation. It was surely time for a rapid development in effective local representation. Constant bickering seemed to be achieving little. It was fair to pin some of the responsibility for delay on management—but hardly all of it. Nationally, too, the unions had to look for new ways to influence health service policy and, particularly, the crucial decision on spending.

By 1979 the first rush was over. There was little extra membership to be had. The danger was that unless aims were redefined disillusionment would gradually set in and the trade unions would become one more hierarchy, producing yet more explanations for why nothing could be done. The change in public opinion was only one small part of the dilemma. How were the trade unions to do an effective job for their members in a hostile world? The problems of style were apparent enough: but underneath were the problems of role. The first phase of development was threatening to end in a new *status quo* in which the general note was one of passivity with an occasional lurch inspired by rhetoric at union conferences.

It remains to be seen whether active trade unionism can achieve more within the NHS in the 1980s than it did in the first phase.

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Service
ACB	Association of Clinical Biochemists
AHA	area health authority
AHRCO	Association of Hospital and Residential Care Officers
ANA	Association of Nurse Administrators
ANHSO	Association of National Health Service Officers
AOP	Association of Optical Practitioners Limited
APO	area personnel officer
ASM	Association of Supervisors of Midwives
ASTMS	Association of Scientific, Technical and Managerial Staffs
BAOT	British Association of Occupational Therapists
BDA	British Dental Association
BDiA	British Dietetic Association
BHDF	British Hospital Doctors' Federation
BMA	British Medical Association
BMJ	*British Medical Journal*
BOS	British Orthoptic Society
BSSRS	British Society for Social Responsibility in Science
CBI	Confederation of British Industry
COHSE	Confederation of Health Service Employees
CPO	Committee of Professional Organisations
CSP	Chartered Society of Physiotherapy
DHSS	Department of Health and Social Security
DMT	district management team

DOCAS	deduction of contributions at source
DPO	district personnel officer
EEPTU	Electrical Engineers' and Plumbers' Trade Union
EPA	Employment Protection Act 1975
GMC	General Medical Council
GMS	Guild of Medical Secretaries
GMWU	General and Municipal Workers Union
GNC	General Nursing Council of England and Wales
GP	general practitioner
HASAWA	Health and Safety at Work etc Act 1974
HCSA	Hospital Consultants and Specialists Association
HDA	Hospital Doctors' Association
HMC	hospital management committee
HSC	Health and Safety Commission
HSE	Health and Safety Executive
HSMR	*Health Services Manpower Review*
HVA	Health Visitors Association
ICR	*Industrial Court Reports*
IHSA	Institute of Health Service Administrators
IMLS	Institute of Medical Laboratory Sciences
IR	industrial relations
IRLR	*Industrial Relations Law Reports*
JCC	joint consultative committee
JCSC	joint consultative staff committee
JHDA	Junior Hospital Doctors' Association
KIR	*Knight's Industrial Reports*
MPU	Medical Practitioners Union
NALGO	National and Local Government Officers Association
NBPI	National Board for Prices and Incomes
NHD	notional half-days
NHS	National Health Service
NUPE	National Union of Public Employees
ODA	operating department assistants
PAYE	pay-as-you-earn (tax-collecting system)
POWAR	place of work accredited representative (of BMA)
PTA	Professional and Technical Staffs Whitley Council A

PTB	Professional and Technical Staffs Whitley Council B
RAWP	Resource Allocation Working Party (report of)
RCM	Royal College of Midwives
Rcn	Royal College of Nursing of the United Kingdom
RHA	regional health authority
RHCSA	Regional Hospital Consultants Staff Association
SAFPS	Society of Administrators of Family Practitioner Services (National Health Service)
SHHD	Scottish Home and Health Department
SR	Society of Radiographers
TGWU	Transport and General Workers Union
TUC	Trades Union Congress
UMT	unit of measured time

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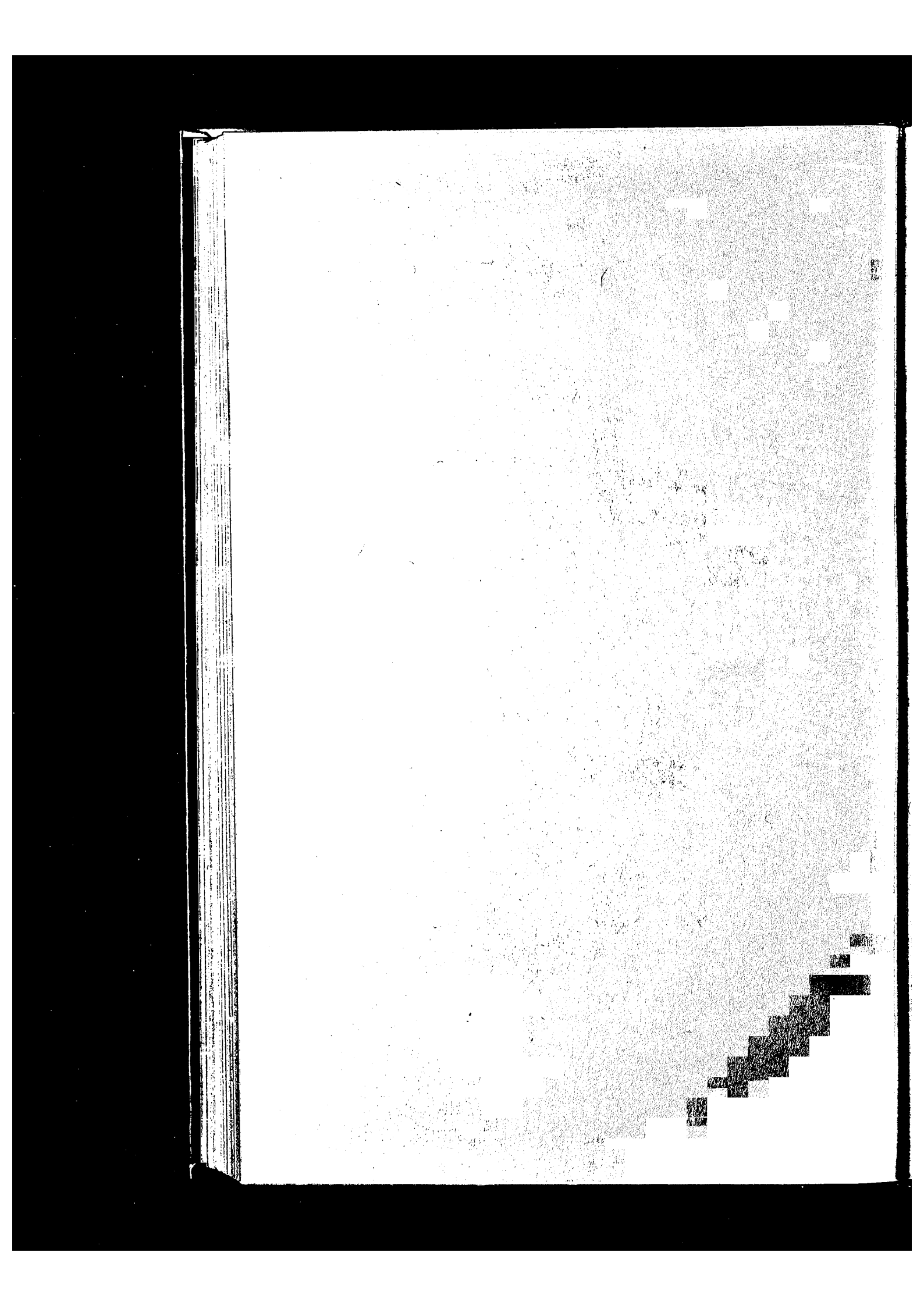

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