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Mersey Regional Health Authority 1974-1994

Edited by Michael Lambert, Philip Begley and Sally Sheard

Department of Public Health and Policy
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wellcome

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Mersey Regional Health Authority
1974-1994

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Introduction

It is a 'well-known fact', says Nicholas Timmins, that 'the NHS (National Health Service) is not one organisation but many hundreds of organisations', each with 'its own history, culture and local circumstances'.[1] Locally, these histories and their organisational memories, have all too often been forgotten. This organisational amnesia has worsened in recent years due to the frequency of reforms to the NHS, including the abolition of tiers within the organisation's structure along with their spheres of activity. Yet these histories are essential to understanding the past, present and future of the NHS at both national and local levels.

Regional oversight of local services has been a consistent feature of the NHS until the 2012 Health and Social Care Act which abolished the intermediate tier. This tier had served as both a buffer and a conduit between local services and central government decision-making. Region itself has been reinvented, with transformations accompanying successive reorganisations: beginning in 1948 with 14 Regional Hospital Boards (RHBs), increased to 15 from 1958 with the creation of Wessex, and 36 Boards of Governors (BoGs) of teaching hospitals, largely concentrated in London (1948-74); as 14 Regional Health Authorities (RHAs) (1974-94) later reduced to 8 (1994-96) as a result of the internal market reforms; then as 8 regional offices of the NHS Management Executive (1996-2002) which were briefly cut to 4 before being abolished (2002-03) through planned markets in health; as 28 Strategic Health Authorities (SHAs) (2002-06) briefly coexisting with regional offices, later diminished to 10 SHAs (2006-12) before becoming defunct. Each of these regional bodies has had their own imprint on the current shape of health services.

Mersey Regional Health Authority (1974-94) was one of fourteen RHAs established in 1974. It replaced Liverpool Regional Hospital Board which had been one of the smallest regions in terms of both geography and population, and had produced a unique configuration of hospital and health services as a result.[2] The increase in the population for which Mersey RHA was responsible with the inclusion of Cheshire provided change, rather than continuity. Historically the region also experienced significant inequalities which shaped the health of the population, patient use of health services and hospital beds.[3] This meant that Mersey RHA was an overall beneficiary in financial terms through the Resource Allocation Working Party allocation formula, introduced in 1976, because although it was 'over-bedded' due to its inheritance and distribution of hospitals, it remained 'comparatively deprived' throughout its existence.[4] This regional gain was not reflected across the districts, with Liverpool in particular compelled to introduce swingeing cuts to meet requirements.[5]

These health service configuration and population issues provided the local context for those responsible for strategic planning and decision-making in Mersey RHA. The different people, personalities and others who led Mersey RHA had an equally profound impact on the character

[1] N. Timmins (2016) *The chief executive's tale: views from the front line of the NHS.* London: King's Fund, 10.
[2] R. F. L. Logan, J. S. A. Ashley, R. E. Klein & D. M. Robson (1972) *Dynamics of medical care: the Liverpool study into use of hospital resources*. London: London School of Hygiene and Tropical Medicine.
[3] J. R. Ashton (1994) *The changing health of Mersey: 1948-1994: report of the Mersey Regional Director of Public Health*. Liverpool: Mersey Regional Health Authority Information Unit.
[4] M. Gorsky & G. Millward (2018) Resource allocation for equity in the British National Health Service, 1948-89. *Journal of Health Politics, Policy and Law*, 43:1, 92.
[5] R. Dyson (ed.) (1978) *Report of a committee of inquiry established by Mersey Regional Health Authority to examine the management and deployment of health service resources and the conduct of industrial relations in Liverpool Area Health Authority (Teaching)*. Liverpool: Mersey Regional Health Authority.

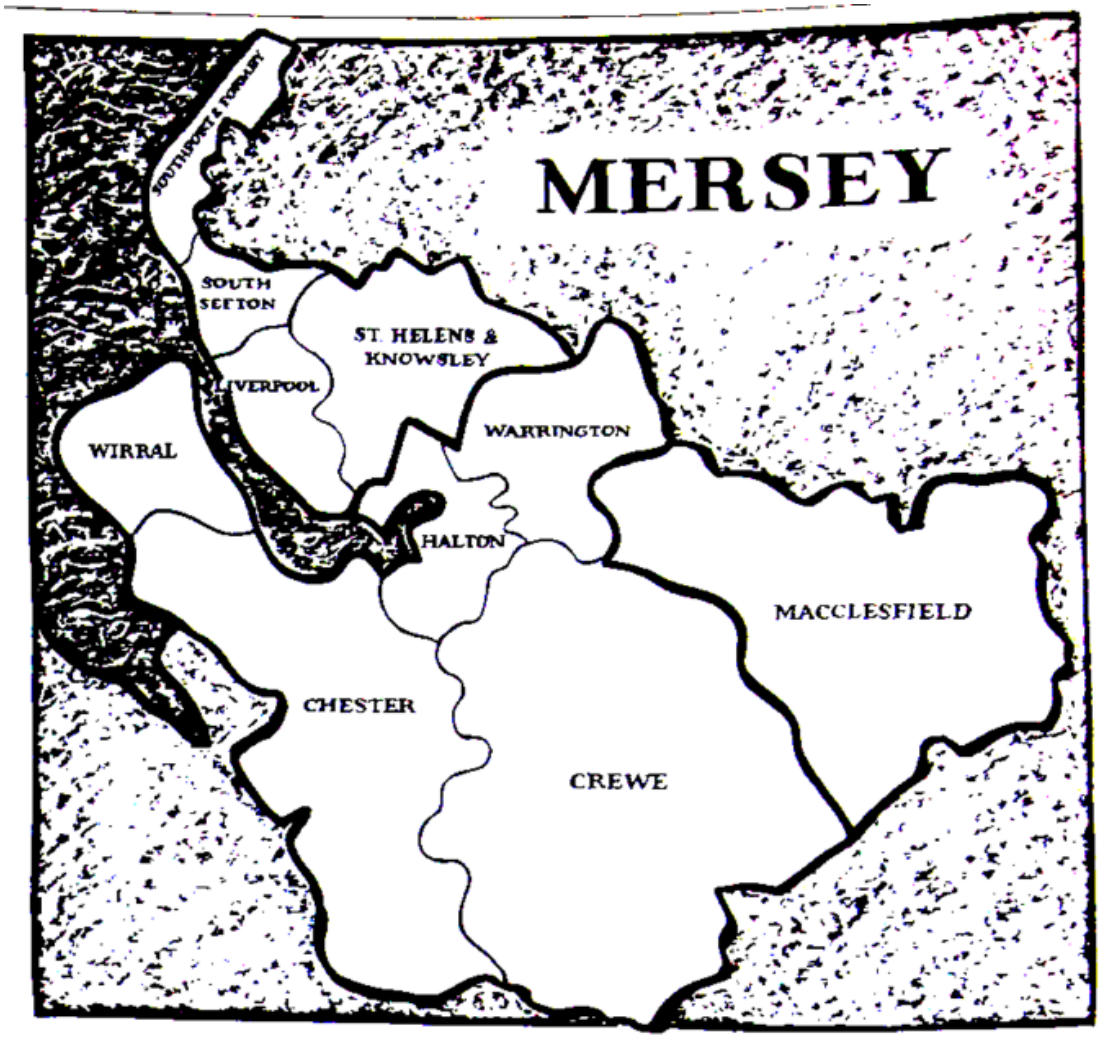

Figure 1: Mersey Regional Health Authority and its constituent District Health Authorities. *Health Services Journal*, 7 November 1991.

District Health Authority	Population
Chester	182,000
Crewe	240,000
Halton	136,000
Liverpool	528,000
Macclesfield	175,000
South Sefton	188,000
Southport and Formby	113,000
St Helens and Knowsley	372,000
Warrington	168,000
Wirral	363,000

Figure 2: Mersey Regional Health Authority, District Health Authority Population Projections, 1982. *Population and statistics*, 1978.

of the NHS in the region. Mersey RHA had two chairmen: Sir Eric Driver (1974-82) and Sir Donald Wilson (1982-94); five regional administrators and managers: John D. Shepherd (1974--78), J. W. Pearson (1978-81), Sir Duncan K. Nichol (1981-89), Geoffrey Scaife (1989-93) and Robert Tinston (1993-94); five regional medical officers: W. J. E. McKee (1974-77), J. Duncan Edgell (1977-88), E. M. E. Ramsay (1988), J. E. Peter Simpson (1989-93) and Professor John Ashton (1993-94); six regional treasurers and finance directors: J. W. Pearson (1974-78), Mike Collier (1978-85), W. E. Watton (1986-88), P. Fletcher (1989-90), Tony Bagnall (1990-93) and Jim Birrell (1993-94); six regional nursing officers: M. Storey (1974-77), M. Rose Worster (1978-85), J. R. Lawson (1985-89), Rosemary M. Knights (1989-93), J. Tyrer (1993-94) and Jean Faugier (1994); and two regional workers officers: Gordon Brooke (1975-83), Eric E. Stentiford (1985-90). These individuals represented the inner circle of senior leadership and decision-making figures within the authority.

Image 1: Sir Donald Wilson KBE

The influence of these figures to strategically shape health services across Mersey RHA varied widely, and across professional positions. Chairman Sir Donald Wilson was in many ways the heart of Mersey Region for twelve of its twenty years of experience. Wilson was 'feared and admired in equal measure', according to a 1991 *Health Services Journal* profile. Many of his admirers were those within the RHA who saw Mersey climb from last to first in performance tables, as well as those in the Department of Health and Social Security or Secretaries of State who saw a 'macho manager' achieve results. Those who feared him were unit or district general managers, NHS trust finance directors, union officials and staff who were on the receiving end of his 'explosive style' and under tremendous pressure to deliver the necessary results.[6] Sir Donald Wilson was one among many others. These people, personalities and professional cultures form a significant part of the history of the NHS in one place which have legacies on current services.

Mersey RHA was not, however, a static organisation throughout its lifespan and its form and function changed in parallel with changes in the NHS. The abolition of Area Health Authorities (1974-82) in 1982 increased the performance management functions of Mersey RHA.[7] The introduction of general management as a result of the 1983 Griffiths Report eroded consensus management which had been integral to the 1974 reorganisation.[8] From 1991 the introduction of the internal market gradually rendered redundant the purposes of RHAs altogether, leading them to be incorporated as regional offices of the NHS in 1996.[9] Moreover, the creation of Family Health Service Authorities (FHSAs) in 1990 and GP fundholding as part of the internal

[6] J. Dobson (1991) Target practice puts managers in Sir Donald's firing line. *Health Services Journal*, 7 November, 31.
[7] D. K. Nichol (1986) Action research and development in strategic planning. In G. Parston (ed.) *Managers as strategists: health service managers reflecting on practice*. London: King's Fund, 91-102.
[8] M. Gorsky (2013) "Searching for the people in charge": appraising the 1983 Griffiths NHS management inquiry. *Medical History*, 57:1, 87-107.
[9] E. MacKillop, S. Sheard, P. Begley & M. Lambert (eds.) (2018) *The NHS internal market: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy.

Figure 2: Mersey Regional Health Authority logo.

market meant that primary care was also – briefly – brought under the auspices of region for the first time.[10] These changes all had profound consequences for the roles and responsibilities of the RHA in relation to delivering health services across Merseyside.

The relationship between region, the Department of Health and Social Security (Department of Health from 1988), and central government changed over time. Labour Secretary of State for Social Services from 1968-70 Richard Crossman likened handling region in the NHS as 'a number of powerful, semi-autonomous [Regional Hospital] Boards whose relation to me was much more like the relations of a Persian satrap to a weak Persian Emperor'.[11] Crossman was, however, scathing of the capacity of regional chairs in their role as satraps, describing most of them – including David A. Solomon, then Chair of Liverpool RHB – as 'fairly feeble creatures trying to do a bit of public service but really dominated by their officials'.[12] Changes in government, secretaries of state and, after 1985, Chief Executives of the NHS Management Executive, all had a role to play in curtailing the autonomy of region and centralising power.[13]

Moves towards a 'single centre', despite the centre's division into the Department of Health and the NHS Management Executive, signalled the end of regional health authorities with local representation and accountability.[14] A series of scandals at Wessex,[15] Yorkshire,[16] and West Midlands RHAs[17] – with Sir Donald Wilson being seconded for a year by Secretary of State Virginia Bottomley at the latter – aggravated a reduced role for region within the new internal market. This culmination of events sealed the fate of region. Both Sir Donald Wilson's close personal political connections to Westminster as a leading Cheshire Conservative and Sir Duncan Nichol's appointment as Chief Executive of the NHS in 1989 meant that although all these relations were common to regions across the NHS, they were different for Mersey. For instance, it was the recommendation of Sir Donald Wilson – as Mersey's 'keen and supportive

[10] H. Glennerster, M. Matsaganis & P. Owens with S. Hancock (1994) *Implementing GP fundholding: wild card or winning hand?*. Buckingham: Open University Press; M. McVerry & L. Beavers (1992) Mersey. In. P. Day (ed.) *Managing change: implementing primary health care policy*. Bath: University of Bath Centre for the Analysis of Social Policy, 47-58.
[11] R. H. S. Crossman (1972) *A politician's view of health service planning*. Glasgow: University of Glasgow, 10.
[12] R. H. S. Crossman (1978) *The diaries of a Cabinet Minister, volume 3: Secretary of State for Social Services, 1968-1970*, London: Hamish Hamilton & Jonathan Cape, 466.
[13] S. L. Greer & H. Jarman (2007) *The Department of Health and the civil service: from Whitehall to department of delivery to where?*. London: Nuffield Trust, 8-12.
[14] B. Edwards & M. Fall (2005) T*he executive years of the NHS: the England account, 1985-2003*. Oxford: Radcliffe for the Nuffield Trust, 116-8.
[15] Public Accounts Committee (1993) *Wessex Regional Health Authority*. London: HMSO.
[16] National Audit Office (1996) *Inquiry commissioned by the NHS Chief Executive into matters concerning the former Yorkshire Regional Health Authority*. London: TSO.
[17] Public Accounts Committee (1993) *West Midlands Regional Health Authority*. London: HMSO.

chairman' – that Duncan Nichol obtained the appointment as Chief Executive of the NHS, according to then Secretary of State Ken Clarke.[18]

This witness seminar brought together individuals who were employed by or involved with the Mersey RHA, as well as those who were impacted by its policies and decisions, whether in politics, management, medicine, academia, health services or the civil service. The structured discussion covered the role of region in the NHS, its changing relationship with organisations under its jurisdiction, the impact of the internal market on its form and function, and the role of key individuals and appointments.

[18] K. Clarke (2016) *Kind of blue*. London: Pan, 196.

Contributors

Convenors

Professor Sally Sheard: Andrew Geddes and John Rankin Professor of Modern History, University of Liverpool.

Dr Michael Lambert: Research Associate, Department of Public Health and Policy, University of Liverpool.

Dr Philip Begley: Lecturer in the History of Medicine, Department of Public Health and Policy, University of Liverpool.

Chair

Mr Nicholas Timmins: Senior Fellow, King's Fund. Senior Fellow, Institute for Government. Visiting Professor, London School of Economics and Political Science.

Participants

Professor John Ashton CBE FFPH FRCPsych FRCPE FRCP FRSocMed: United Newcastle Hospitals House Physician, 1970-71, Senior House Physician, 1972, Registrar, 1972-74. Newcastle and Northumberland FPC GP Principal, 1974-75. Southampton University Lecturer in Primary Medical Care, 1975-76, 1978-79. Hampshire FPC GP Principal, 1975-76. Hampshire AHA Registrar in Community Medicine, 1976-79. London School of Hygiene and Tropical Medicine Senior Lecturer in Community Medicine, 1980-82. University of Liverpool Senior Lecturer in Public Health, 1983-93. Liverpool HA Honorary Specialist in Community Medicine, 1983-88. Mersey RHA Consultant Adviser in Health Promotion, 1988-93, Director of Public Health and Regional Medical Officer, 1993-94. North West RHA Director of Public Health and Regional Medical Officer, 1994-96. NHS NW Regional Office Director of Public Health, 1996-2003. NHS NW Director of Public Health, 2003-06. Cumbria PCT Director of Public Health, 2006-13. RCP Faculty of Public Health President, 2013-16.

Mr Pearse Butler: Liverpool HA Obstetrics and Gynaecology Unit General Manager, 1986-88. Chester HA District General Manager, 1988-90. Royal Liverpool Children's NHS Trust Chief Executive, 1990-94. Wirral HA and FHSA Chief Executive, 1994-97. Wrightington, Wigan and Leigh NHS Trust Chief Executive, 1997-1999. Royal Liverpool and Broadgreen University Hospitals NHS Trust Chief Executive, 1999-2002. Cumbria and Lancashire SHA Chief Executive, 2002-06. East of England SHA Interim Chief Executive, 2006-07. CSC Director on the NHS Account, 2007-14. Mersey Care NHS Trust Non-Executive Director, 2014. University Hospitals of Morecambe Bay NHS Foundation Trust Chair, 2014-18. Blackpool Teaching Hospitals NHS Foundation Trust Chair, 2018-.

Professor David Colin-Thomé OBE FRCGP FRCP FFPH FFGDP (Honorary) FQNI: Castlefields Health Centre, Runcorn GP, 1971-2007. Halton CHC Member, 1979-81. Shire District Councillor, Halton Borough Council, 1979-90. Halton HA Member, 1981-90. Cheshire FHSA Member, 1990-92. Mersey RHA Primary Care Adviser, 1992-94. North West RHA Director of Primary Care, 1994-96. Scottish Office Primary Care Directorate Senior Medical

Officer, 1997-98. Dorset Community NHS Trust and Dorset HA Primary Care Adviser, 1998-2001. NHS NW Regional Office Primary Care Adviser, 1998-2001. Director of Primary Care, London Regional Office, NHSE, 1998-2001. Primary Care Adviser, London Regional Office, NHSE, 1998-2001 2001-2. Honorary Fellow, Centre for Healthcare Management, University of Manchester, 1988-2002, Honorary Visiting Professor, 2003-2010. Medical Adviser, Central Manchester University Hospitals, 2005-20007. National Clinical Director for Primary Care, Department of Health, 2001-2007. National Director for Primary Care, Department of Health, Commissioning and System Management Directorate, 2007-10.

Mr Mike Collier CBE: Macclesfield Borough Council Accountant, 1960-68. Salop County Council Group Accountant, 1968-71. Birkenhead County Borough Council Chief Accountant, 1971-74. Stockport Metropolitan Borough Council Deputy Treasurer, 1974-78. Mersey RHA Regional Treasurer, 1978-85. Liverpool HA District General Manager, 1985-91. NHS Scotland Director of Finance, 1991-94. Funding Agency for Schools Chief Executive, 1994-99. North East England Regional Development Agency Chief Executive, 1999-2003. Non-Executive Director, North East Yorkshire and North Lincolnshire SHA, 2004-2006. Non-Executive Director, Yorkshire SHA, 2006-2009. NHS Institute for Innovation and Improvement Vice Chair, 2007-09. Leeds Teaching Hospitals NHS Trust Chair, 2009-13.

Professor Ian Cumming OBE: Manchester Royal Infirmary Healthcare Scientist (Haemophilia), 1981-86. Manchester Royal Infirmary General Manager, 1990-92. Mersey RHA Performance Manager (Acute), 1992-93, 1993-94. North West RHA Assistant Chief Executive, 1994-95. Lancaster Acute Hospitals NHS Trust Chief Executive, 1995-98. Morecambe Bay Hospitals NHS Trust Chief Executive, 1998-2006.. North Lancashire Teaching PCT Chief Executive, 2006-09. West Midlands SHA Chief Executive, 2009-12. Health Education England Chief Executive, 2012-.

Ms Kathy Doran: Civil Service Graduate Trainee, 1978-79. Department of Health and Social Security Civil Servant, 1979-83. Lewisham and Southwark DHA Project Manager, 1983-84. Department of Health and Social Security Civil Servant, 1984-88. South East Thames RHA Development Manager, 1988-89. Mersey RHA Corporate Development Manager 1989-91 and Business Planning Manager 1992-93. Wirral Community NHS Trust Director of Service Development, 1993-95. Director of Primary Care, Wirral Health Authority, 1995-2001. Department of Health Civil Servant, 2001-02. Birkenhead and Wallasey PCT Chief Executive, 2002-06. Wirral PCT Chief Executive, 2006-11. Cheshire, Warrington and Wirral PCT Cluster Chief Executive, 2011-13. Clatterbridge Cancer Centre NHS Foundation Trust Chair, 2019-.

Professor Brian Edwards CBE. Clatterbridge Hospital Junior Administrator, 1958-62. Cleaver Hospital Deputy Secretary, 1962-64. University of Leeds Nuffield Centre National Administrative Trainee, 1964-66. Leeds General Infirmary Administrator, 1966-67. Keighley Victoria Hospital Secretary, 1967-68. Mansfield HMC Administrator, 1969-70. University of Leeds Lecturer in Health Administration, 1970-72. Hull Area A HMC Deputy Secretary, 1972-74. Leeds AHA(T) District Administrator, 1974-76. Cheshire AHA Area Administrator, 1976-81. Trent RHA Regional Administrator, 1981-84, Regional General Manager. 1984-93. West Midlands RHA Chief Executive, 1993-96. NHS Management Executive Regional Director, 1994-96. University of Sheffield Professor of Health Care Development, 1996-2002. Chair of Nottinghamshire NHS Trust, 2001-2006.

Mr Geoff Greenwood. Winwick HMC Accountant, 1965-70. Winwick and Warrington HMCs Deputy Treasurer, 1970-72. Central Wirral HMC District Treasurer, 1972-74. South

Wirral DHA District Treasurer, 1974-77. South Sefton DHA District Treasurer, 1977-79. Sefton AHA Area Treasurer, 1979-82. Wirral HA Area Treasurer, 1982-85. Wirral HA General Manager, 1985-92. Warrington HA Chief Executive, 1992-94. North Cheshire HA Chief Executive, 1994-97. Clatterbridge Centre for Oncology NHS Trust Chief Executive, 1997-2003.

Mrs Rosemary Hawley MBE: Southwark CHC Member, 1976-84. Lewisham and North Southwark DHA Board Member, 1978-84. Mersey RHA Non-Executive Director, 1986-94. Liverpool FHSA Chair, 1989-96. North West RHA Non-Executive Director, 1994-96. North Mersey Community NHS Trust Chair, 1996-2002. Knowsley Primary Care Trust Chair, 2002-11.

Ms Sylvia Hikins: Liverpool Central and Southern CHC Council Member, 1977-81, Chair 1981-90; Mabel Fletcher Technical College , Lecturer 1979- 88, Senior Lecturer 1988-92; City of Liverpool College Director of Studies, 1992-98; Mersey Regional Ambulance Service NHS Trust, Non-Executive Director and Deputy Chair, 2004-10; NHS Urgent Care 24 Liverpool, Non-Executive Director, 2007-14; NHS Primary Care 24 Chair, 2014-18; National Council Member, Royal Pharmaceutical Society, 2004-10; National Accreditation Panel Member, Royal Pharmaceutical Society and General Pharmaceutical Council MPharm, 2005-18.

Dr Ruth Hussey CB OBE. Mersey RHA Community Medicine Trainee, 1983-89. Mersey RHA Honorary Consultant, 1989-91. Liverpool HA Director of Public Health, 1991-2002. Cheshire and Mersey Strategic Health Authority Director of Strategy, 2002-06. NHS North West Regional Director of Public Health, 2006-12. Chief Medical Officer for Wales, 2012-16.

Mr Hugh Lamont: *Bolton Evening* News reporter, 1968-72. *Daily Mail* reporter, 1972-73. *Liverpool Daily Post and Echo* reporter and editor, 1973-81. *Radio City* night editor, 1981-84. Mersey RHA Regional Communications Manager, 1984-94. North West RHA Public Relations Director, 1994-96. NHS NW Regional Office Communications Director, 1996-2003. Health Protection Agency NW Regional Communications Manager, 2003-13.

Mr Anthony McKeever: Department of Health and Social Security Civil Servant, 1976-88. Mersey RHA Executive Director, 1988-91. Macclesfield HA District General Manager, 1991-92. NHS Management Executive Waiting Times Task Force General Manager, 1992-93. Royal Shrewsbury Hospitals NHS Trust Chief Executive, 1993-99. Warwickshire HA Chief Executive, 1999-2000. MACS Managing Director, 2000-06, 2014-. Bexley Care NHS Trust Chief Executive, 2006-11. NHS Future Forum Member, 2011-12.

Sir Duncan Nichol CBE. King's Fund College National Administrative Trainee, 1963-65. St Thomas's Hospital Deputy Secretary, 1965-69. Manchester Royal Infirmary Hospital Secretary, 1969-73. South Manchester University HMC Deputy Group Secretary, 1973-74. South Manchester DHA District Administrator, 1974-77. Salford AHA(T) Area Administrator, 1977-81. Mersey RHA Regional Administrator, 1981-84, Regional General Manager, 1984-89. NHS Management Executive Chief Executive, 1989-94. Christie NHS Foundation Trust Non-Executive Director, 2008-12. Countess of Chester NHS Foundation Trust Chair, 2012-.

Mr Robert (Bob) Nicholls CBE. National administrative trainee in Liverpool Region 1961-64.Torbay Hospital Assistant Secretary, 1964-66. St Stephen's Hospital House Governor, 1966-68. St Thomas's Hospital Board of Governors Assistant Clerk, 1968-72. Southampton University HMC Deputy Secretary, 1972-74. Southampton and South West Hampshire DHA

District Administrator, 1974-77. Newcastle-upon-Tyne AHA(T) Area Administrator, 1977-81. South West RHA Regional Administrator, 1981-85. Southmead DHA District General Manager, 1985-88. Oxford RHA Regional General Manager, 1988-93. NHS Management Executive London Implementation Group Executive Director, 1993-96. British Council Health Sector Reform Adviser, 1996-2004. General Medical Council Lay Member, 1996-2006; and Chair of the Preliminary Proceedings Committee, 2000-03. National Clinical Assessment Authority, Chair, 2003-05. London Health Commissioner, Appointments Committee Member, 2005; and Chair, 2007-08. All-Party Pharmaceutical Group Member, 2009-14. General Pharmaceutical Council Chair, 2009-14.

Professor Mike Pearson FRCP: Aintree Hospital Consultant Physician, 1984-2018. Mersey RHA Regional Medical Advisory Committee Vice Chair, 1984-87 and Chair, 1987-91. RCP Assistant Director, 1997-98, Director, 1998-2006. University of Liverpool Professor of Medicine, 2003-06, Professor of Clinical Evaluation, 2006-11.

Mr Chris Vellenoweth: St Mary's Hospital Administrative Trainee, 1957-61. St Bartholomew's Hospital Deputy Hospital Secretary, Gravesend and Meadway HMC, 1961-64. United Sheffield Hospitals Senior Administrative Assistant, 1964-66. United Sheffield Hospitals Superintendent, 1966-69. West Cheshire HMC Deputy Group Secretary, 1969-74. Liverpool Eastern DHA District Administrator, 1974-77. Wirral AHA Area Administrator, 1977-85. Mersey RHA Head of Regional Services, 1985-90. Royal Liverpool University Hospital NHS Trust Board Secretary, 1990-92. NAHAT Special Projects Manager, 1992-98. House of Commons Health Committee Specialist Adviser, 1998-2005. Royal Liverpool Children's Hospital NHS Trust Non-Executive Director, 2000-08. Alder Hey NHS Foundation Trust Non-Executive, 2008-09.

In Attendance

Dr Paul Atkinson: Research Associate, Department of Public Health and Policy, University of Liverpool.

Mr Felix Goodbody: PhD Student, Department of History, University of Liverpool.

Mr Kieran Lamb: Stockport NHS Foundation Trust Knowledge and Library Services Manager.

Dr Colin Lorne: Research Fellow, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine.

Dr Sue Povall: Research Fellow, Department of Public Health and Policy, University of Liverpool.

Ms Eleanor Sheldon: Liverpool RHB Regional Engineers' Office Shorthand Typist, 1969-74. Mersey RHA Regional Works Officer's Secretary, 1974-84. Mersey RHA Regional Administrators' Secretary, 1984-89. Mersey RHA Chairman's Secretary, 1989-94. North West RHA Chairman's Secretary, 1994-96. NHS NW Regional Office Chairman's Secretary, 1996-1999.

Dr Patricia Starkey: Honorary Research Fellow, Department of History, University of Liverpool.

Professor Kieran Walshe: Professor of Health Policy and Management, Manchester Business School, University of Manchester.

Ms Milly Wright: Wirral SSD Child Protection Investigative Social Worker, 1979-84, Intake Team Leader, 1984-87, Assistant Area Manager, 1987-87, Principal Officer for Children's Services, 1989-97. Wirral University Hospitals NHS Foundation Trust Governor, 2008-11. St George's Medical Centre Patient Group Chair, 2011-17. Wirral CCG Patient Champion, 2012-13.

Image 2: Mersey Regional Health Authority, 1990. Reproduced with kind permission of Mary McVerry.

Areas for Discussion

1. The role of Mersey RHA in the NHS and strategic planning:
    a. What roles and functions did the RHA play in mediating and interpreting central government policy?
    b. What functions did the senior officials – chair, regional administrator, regional medical officer and regional treasurer – perform within the RHA?
    c. How did the RHA formulate and develop strategic thinking and planning?
    d. What was the role of clinical and medical expertise in the activities of the RHA, particularly the regional medical officer and the regional medical advisory committee?

2. Changing relationships with units, districts and the centre:
    a. How were the activities and performance of units and districts measured and managed by the RHA?
    b. What was the relationship between strategic regional planning and operational district activity?
    c. What were the consequences of the introduction of general management on the relation between region, districts and units?
    d. How did Mersey RHA engage with the Department of Health and central government decision-making?

3. Impact of the internal market reforms on the RHA:
    a. How did the internal market affect the role of the RHA?
    b. What was the impact on primary care of greater regional oversight and the development of GP fundholding?
    c. How was purchasing and providing developed across the region in relation to trusts and health authorities?
    d. What was the role of clinicians in the development of the internal market within the RHA?

4. Merger with North Western RHA and the end of Mersey RHA:
    a. To what extent was there a separate culture and way of thinking in Mersey RHA, what one Department of Health official termed when dealing with RHAs that ‘there were thirteen regions and Mersey’?
    b. How was the merger between North Western and Mersey RHAs managed?
    c. What roles and positions did former Mersey RHA staff occupy in the new RHA and the new NHS in terms of purchasers and providers?
    d. What was the impact of the move from RHAs within the NHS to regional offices of the Department of Health within the civil service?

Witness Seminar Transcript

Mersey Regional Health Authority, 1974-1994

Sally Sheard

Good afternoon. I'm Sally Sheard. I'm the overall lead for the Governance of Health project, but it is very much a team effort. Michael Lambert has taken the lead in this area, so thank you very much for doing all of the preparation for this, Michael. It has been a tremendous effort to pull everybody together, and to find lots of you to start with.

Along with Michael we have Phil Begley and Paul Atkinson in the team. This project has been running now for four years, and we have just had an extension to our grant from the Wellcome Trust, starting a project that looks at the history of NICE [National Institute for Health and Care Excellence].[1]

A witness seminar is an unusual event in that it enables us to capture views of individuals but then to challenge views by putting them directly against one another in a setting such as this. We have previously used witness seminars for other parts of the project. We have run very successful ones on the 1974 NHS reorganisation,[2] the 1991 internal market,[3] the development of NIHR [National Institute for Health Research],[4] and the evolution of health economics.[5]

Image 3: Chair Nick Timmins introducing the witness seminar

[1] The National Institute for Health and Care Excellence was formed in 1999 with responsibilities for producing guidelines on health technologies, clinical practice, health promotion and social care. See N. Timmins, M. Rawlins & J. Appleby (2016) *A terrible beauty: a short history of NICE: the National Institute for Health Care Excellence*. Nonthaburi: Ministry of Public Health.
[2] P. Begley, S. Sheard & E. Mackillop (eds.) (2017) *The 1974 NHS reorganisation: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy.
[3] E. MacKillop et al. (2018) *The NHS internal market*.
[4] P. Atkinson & S. Sheard (2018) *Origins of the National Institute for Health Research: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy.
[5] E. Mackillop, S. Sheard & M. Lambert (eds.) (2018) *The development of health economics and the role of the University of York*. Liverpool: University of Liverpool Department of Public Health and Policy.

Nick Timmins who is chairing today has previously chaired for us; we are very safe in his expert hands. I'm going to hand over now to Nick to properly introduce the event.

Nick Timmins

Very good of you all to be here, my pleasure to be chairing this thing, it should be fun. Mersey RHA and all that, of which of course it was famously said there are thirteen regional health authorities and then there is Mersey, and it did go through a period from being the worst performing RHA to the best performing RHA on the measures then available, so that's more entertaining. Now one thing I should say is that I know a lot of you here but I don't know everybody or quite what everybody's role is, and the fact we are on different tables is absolutely meaningless, you should all just chip in as and when we get to it.

There is a format program which you've got, which technically splits this first session into two, starting with the role of the RHA and NHS and strategic planning, and then looking at units, districts and the centre. But I suspect in practice those two just run into each other but we'll do those two up to the coffee break round about 14:45 and then we move to the *Working for Patients* reforms, the internal market. I think it's important we keep those two bits separate even though the first two bits may run together.

Now there is a risk here that this just sort of becomes the Don Wilson[6] show so to speak – an incredibly powerful personality, and we've all got our Don Wilson stories, including me, although I won't tell it at the moment – so we have to try and avoid that. I think one of the best ways of avoiding that is that we actually go back to the very beginning which is the creation of the RHA in 1974, which by coincidence was year I first started reporting on the NHS. And, of course it was the shift from the regional hospital boards to the RHAs with their much wider, bigger, planning functions and stuff coming across from local government and of course the RHBs are famously remembered from that great Crossman quote that dealing with them was a bit like dealing with a bunch of semi-autonomous powerful Persian Satraps up against a weak Persian Emperor in the shape of the Secretary of State for Health.[7]

The first question is: is there anybody here who was around in '74 or before who has any memory of what the shift between the old RHB and the RHA was?

Is that a long silence?

Chris Vellenoweth

I'll start that off if you like. I'm Chris Vellenoweth and in 1974 I was appointed as one of the two District Administrators of the Liverpool [Area] Health Authority, and of course I knew in

[6] Sir Robert Donald Wilson (1922-2001) was a dairy farmer, Board Member of the North West Electricity Board (1981-87), Chair of the North West Electricity Consultative Council (1981-85), Chair of the Cheshire Branch of the Country Land and Business Association (1980-82), Vice Chair of the Governors of Cheshire College of Agriculture (1980-84), High Sheriff of Cheshire (1985-86), Chair of Mersey RHA (1982-94) with a period as Chair of West Midlands RHA (1993-94).

[7] Richard Crossman (1907-74) was Labour MP for Coventry East (1945-74) and Secretary of State for Social Services (1968-70), who likened dealing with RHBs as akin to 'a number of powerful, semi-autonomous [Regional Hospital] Boards whose relation to me was much more like the relations of a Persian satrap to a weak Persian Emperor'. Crossman (1972) *A politician's view*, 10.

my previous role the old RHB. I think we all went through a fairly torrid time of reorganisation really and I think the Region initially struggled to make the transition from a *hospital* board to a *health* board, taking on the strategic elements of community care, the links to primary care and the links with the newly created number of authorities within the region.

Image 4: Chris Vellenoweth

My recollection is there was relatively little preparation – and we'll come onto this later I'm sure – between the regional health authority and the area health authorities[8], and it really was a fairly steep learning curve I would suggest, both for the regional health authority and indeed the area health authorities, particularly where some adjustment had been made to what might have been thought to be the natural communities for those areas.

Nick Timmins

It was all quite late wasn't it? Because I remember talking to Norman Warner[9], who was in the Department at the time – a civil servant – charged with implementing all this stuff they had been legislating for. He said 'So what are the functions of all these RHAs and AHAs?' and it turned out no-one had written it down, and he said 'So we just sat down there and invented it, put out a circular' you know, because it was all quite late. Do you think that had an initial impact on performance?

Chris Vellenoweth

In a sense, and I'll stick my neck out here, I don't think performance at that stage was being measured in any way at all.

[Agreement]

Nick Timmins

Anybody else from that time? Brian.

Brian Edwards

I was the Area Administrator for Cheshire, the biggest part of the Mersey region, not the poorest part, from 1976 to 1981, so I was pre-Wilson. I was with the others. We had five districts so

[8] Area Health Authorities were formed with the 1974 NHS reorganisation and oversaw community and hospital services. District management teams (DMTs) ran services operated below AHAs on a consensus basis. AHAs were abolished in 1982 and DMTs became District Health Authorities.

[9] Norman Warner (Baron Warner of Brockley) (1940-) was a civil servant in the Ministry of Health and Department of Health and Social Security (1959-85) and later Parliamentary Under-Secretary of State for Health (2003-05) and Minister of State (2005-07).

we were quite big, DGHs [District General Hospitals][10] being built all across Cheshire and we had the largest collection of large mental hospitals, I think in the country, there were 5,000 beds in Cheshire. My memories of the region at that time were almost entirely financially linked. I can't remember any performance review or any discussions about strategic planning, it was mainly about revenue and the revenue consequences of capital schemes. They were the principal conversations we had with the region. We had a closer relationship with the Cheshire County Council I think.

Nick Timmins

Right. So it was all finance. Balancing the books.

Brian Edwards

Predominantly.

Mike Pearson

But there were no figures at that point, so HES [Hospital Episode Statistics] and things like that didn't really come in until '86-87. Körner's, Edith Körner's, Reports[11] only began I think in about '81-82, the final report was a few years after that, so there were no data in that period. When I first was about to be appointed as consultant in Aintree they said 'We are to de-regionalise the unit we are appointing you to', so I went to find some data and I couldn't find any and a guy, actually a family friend, who used to work in the DH said 'Yes I used to run Mersey back in the '70s, from London, you don't need data, you need two sheets of A4'. It worked. The attitude then was that there was no data.

Nick Timmins

When you say it worked?

Mike Pearson

It worked in terms of getting our unit de-regionalised, remember we lost the money, we actually won the battle for a year or two and lost it later of course. Two sheets of A4 were more powerful than data.

[10] District general hospitals were the foundation of hospital services as a result of the 1962 Hospital Plan which modernised decaying capital stock, and the 1969 Bonham-Carter Report which advocated the establishment of a single centre in each district to provide a core of diagnosis and treatment services.

[11] Edith Körner (1921-2000) was Chair of South West RHA (1976-80) and Chair of the DHSS and NHS Steering Group on Health Services Information (1980-84) which produced the Körner Reports, implemented in 1987. For details see: A. Mason (2003) Edith Körner. In M. Rigby (ed.) *Vision and value in health information*. Abingdon: CRC Press, 1-10.

John Ashton

Just on that, just flagging up really, there was Bob Logan's[12] local hospital study[13] about that time, but before Bob became Professor of Medical Care at London School of Hygiene and Tropical Medicine. Bob had done that study which had provided information on bed numbers and so on and also on such matters as how inbred the Liverpool medical establishment was. There were no professors at Liverpool medical school who were not local graduates. So there was that.

Nick Timmins

Right. I mean there was national policy, but did anybody feel the influence of it, the impact of it, or was it very much just still in a sense – to go back to Crossman's thing – still a regional-devolved thing that by and large did what it thought it should do or was there a significant impact from national level?

Sylvia Hikins

Image 5: Sylvia Hikins

Can I say something on that? I'm Sylvia Hikins. I was Chair of the Community Health Council[14] Central and Southern [Liverpool] during all of the 1980s and one year of the 1990s. I have done various other jobs since including chairing a couple of NHS trusts, so I'm not a Trotskyist as some of you can see. But I thought it was very interesting actually in the papers that we've got here today when it suggested that the Mersey Regional Health Authority was a buffer. I looked up the definition of the noun 'buffer', which is 'a person or organisation that reduces a shock or that forms a barrier between incompatible or antagonistic people or things'.

[Laughter]

Now I don't have any Donald Wilson stories except what was reported in the press, and me against him if you were. I never really was conscious of ever meeting him, but I do know one thing, that when the vacancy for his chairpersonship came up, whenever it was, if Nye Bevan[15] had been alive then he wouldn't have been appointed; Donald Wilson would have, and that really tells you everything. Because of course if he was that buffer, he was receiving the very strong ideological messages about the health service and let's not kid ourselves, it's still there

[12] Robert Logan (1917-2016) was Lecturer (1950-54), Reader (1954-62) then Professor and Director of the Medical Care Research Unit at the University of Manchester (1962-67) and Professor of the Organisation of Medical Care at the London School of Hygiene and Tropical Medicine (1967-82).

[13] 'The Liverpool Study' was a partnership between Liverpool Regional Hospital Board Operational Activities Unit and United Liverpool Hospitals to deal with the consequences of the 1962 Hospital Plan on the region's bed distribution. Logan et al. (1972) *Dynamics of medical care*.

[14] Community Health Councils were established in 1974 to represent patients within the NHS. They were abolished in 2003.

[15] Aneurin Bevan (1897-1960) was Labour MP for Ebbw Vale (1929-60) and Minister of Health (1945-51) during the establishment of the NHS.

today and we know that. And he was having, within the remit within which he could work, and I do believe that the Mersey Regional Health Authority did some good things particularly in public health, and as was pointed out by Rosemary [Hawley] earlier, we were ahead of the game on things like stopping the spread of AIDS, and needle exchange and all that stuff,[16] it was a good thing, it wasn't all bad. But nevertheless it was partly his duty to keep that message strong – that political ideology – so I think we'd be kidding ourselves to say it was any different then than it was when there was a Labour Government in, and that it is now with an austerity program still intact. So that's my little oar in the boat at the moment.

Nick Timmins

Right. So…

David Colin-Thomé

I was a GP [General Practitioner].

Nick Timmins

Yes, you were a GP then weren't you? Indeed.

David Colin-Thomé

The region had very little to do with our world then, in fact I think it was only 1991 really with the internal market that primary care surfaced. We had our FPCs [Family Practitioner Committees][17] I think ,in those days, but they were more administrative. But I was a GP from 1971 in the area. This was nothing, it was only when the internal market came along that it all changed.

Bob Nicholls

I was a trainee in the Liverpool region in 1961-63, so skip forward a few years to '74 and I was an administrator in Southampton, and John Hoare[18], Wessex Regional Administrator and I wrote a paper called 'Too Many Tiers' and from what I'm just hearing, it sounds Mersey was similar to Hampshire and Wessex. So there were four levels: Units were where things actually got done – and separate GPs and FHSAs [Family Health Service Authorities][19] and most local authorities doing quite a lot of community care – so bringing together as '74 I think was

[16] On Liverpool and Mersey's contribution to the 'new public health' and 'harm reduction' see: J. Ashton & H. Seymour (1988) *The new public health: the Liverpool experience*. Buckingham: Open University Press; N. Vitellone (2016) *Social science of the syringe: a sociology of injecting drug use*. London: Routledge.

[17] Family Practitioner Committees were established as a result of the 1974 reorganisation and were responsible for administering and auditing general practice, pharmaceutical, ophthalmic, dentistry and other primary care services. They were abolished in 1990.

[18] John Hoare was Regional Administrator (1979-85) then Regional General Manager (1985-89) of Wessex RHA.

[19] Family Health Services Authorities were established in 1990, replacing FPCs, and incorporating the managerial and business changes associated with the 1983 Griffiths Report. They were abolished in 1996.

designed to do, didn't really happen and not only that, if you're looking for performance there's the Department, the regions, the areas, district management teams and units where the work actually took place. I've been asking Professor [Brian] Edwards who's the custodian of ancient documents to dig this paper out because I can't find 'Too Many Tiers' but we've got meetings with Keith Joseph[20] and Philip Rogers[21] at the time saying 'This is all very well, but if you really want things to happen from policy down to implementation there seems to be a lot of barriers in the way', some of which were statutory.

David Colin-Thomé

Brian [Edwards] mentioned about Cheshire County Council and of course before '74 they provided our health visitors, did our building….

Nick Timmins

Ran the ambulance service.

David Colin-Thomé

…Yes, so as a GP that certainly went in '74.

Brian Edwards

Just to add on a bit about Cheshire; Cheshire had five health districts, which was unusual in those days, and we had to go through the agonies of deciding whether to reduce them down from five to two or three. We decided in the end to leave it alone to keep the local sensitivity but I can't recall the region playing *any* part in that decision. I don't remember even talking to them about it. Then all this changed with Wilson. In those days they did not talk much about policy unless it related to revenue or capital.

Mike Collier

Brian's looking in my direction as if I have all that the answers and I have to confess this has all come as a bolt from the blue for me, going back 40 years is a hell of a long time, and a lot of things have happened in between times.

[Laughter]

But I came here as Regional Treasurer aged 35, against the best wishes of the assessors who they had in from London. I got a letter saying I'd not got the job but they were going to advertise again and would I keep my name in the frame, which I duly did and they changed the assessors and I got the job, and I got the job totally against the odds.

[20] Sir Keith Joseph (1918-94) was Conservative MP for Leeds North East (1956-87) and Secretary of State for Social Services (1970-74).
[21] Sir Philip Rogers (1914-90) was a Permanent Secretary in the DHSS (1970-75).

[Laughter]

Nick Timmins

This is when?

Mike Collier

1978. It reflected, I think, the reputation of Mersey region at that time, which was pretty awful. Just another side comment which is relevant possibly to later discussion – I came from local government and some months after starting the job in Mersey region, I went back to see my former boss and one of the things he said to me was 'Do you think you'll ever join the mainstream again' which I thought was quite interesting.

[Laughter]

Anyhow, I came in '78, so I wasn't around when the regional health [authorities] were created but one of the things that struck me, that hasn't come out in the papers at all, and I just think it had quite a profound influence on the health service, was when Dennis Healey came back from the IMF [International Monetary Fund] cash limits were introduced across the public sector, which meant clearer and firmer financial limits were imposed on the NHS for the first time.[22] I know Geoff [Greenwood] can say a lot more than I can about these things. But all I would say was that the task as I saw it from my perspective, was actually to develop the professional expertise of the finance discipline, not simply to count the numbers but actually – if you like – to develop the science of accounting and more importantly – or as importantly – the development of financial management as a creative thing rather than a passive thing.

John Ashton

Just a couple of prompts to peoples thinking actually – my experience of that time was the North East and Wessex as well. From the North East – and I discussed this with Duncan Nichol – my memory was that a lot of the administrators were ex-colonial that had been de-mobbed from the colonial service into the NHS and so that's a prompt for people to think about. Then the other one is that '74 is the biggest throwing cards up in the air and seeing where they landed before Lansley[23] did it much more dramatically six years ago,[24] with the abolition of the Medical Officer for Health and all of that. The fact Sylvia mentioned public health that we

[22] In 1976 Dennis Healy, the Chancellor of the Exchequer, borrowed £3.9bn from the International Monetary Fund who imposed cash limits on government spending, including the NHS. For details see: A. Maynard and A. Ludbrook (1980) Budget allocation in the National Health Service. *Journal of Social Policy*, 9:3, 289-312; C. Hood & R. Himaz (2017) *A century of fiscal squeeze in politics: 100 years of austerity, politics, and bureaucracy in Britain*. Oxford: Oxford University Press, 120-39.

[23] Andrew Lansley (Baron Lansley of Orwell) (1956-) was Conservative MP for South Cambridgeshire (1997-2015) and Secretary of State for Health (2010-12).

[24] This refers to the impact of the 2012 Health and Social Care Act which Lansley introduced. For details see: N. Timmins (2012) *Never again? The story of the Health and Social Care Act 2012: a study in coalition government and policymaking*. London: King's Fund and Institute for Government; J. Dixon (2012) Reform and the National Health Service. *Political Quarterly*, 83:2, 343-52.

developed later here, one of the bridges across at that time would have been Tom Hobday[25] because Tom had his feet under every table. It was his job I came to as senior lecturer in '82 – what's a decade or two between friends – and he'd been senior lecturer in the Public Health Department but he'd been a Conservative councillor on the City Council, Chair of the Health Committee, in charge of nuclear planning – defence planning – with the region, presumably had his feet under the table at the district as well, I don't know. He and Andrew Semple[26] as the last Medical Officer of Health and Brian Meredith Davies[27] who had been the Medical Officer of Health then became Director of Social Care as a public health doctor, the three of them had a lot of the health system tied up between them as drinking buddies at that time.

Image 6: John Ashton

Chris Vellenoweth

It's worth reflecting because you started very firmly in 1974 and we've come forward already a long way. But it's worth bearing in mind that Eric Driver[28] was chair from 1974 until '82 which is a long time and John Shepherd[29] of course was the Regional Administrator. I worked – if you like – to them both during that period and I think the strength of the Mersey region in that '74-'82 period, in my view, was its concentration on buildings and engineering. There was a lot of hospital development, obviously with the Hospital Plan backing it, but nevertheless there were some really strong initiatives taken. I think one of the strengths of the Mersey then, and more recently, has been its capital expertise in terms of the infrastructure. Some of that was due to Eric Driver's own background.

Nick Timmins

Which was?

Mike Collier

Civil engineer.

[25] Dr Thomas Hobday (1920-91) worked in Liverpool's Public Health Department (1958-60), for the World Health Organisation (1960-62) then the Ministry of Health (1962-64), becoming a Lecturer in Social Medicine and Clinical Epidemiology at the University of Liverpool (1964-82).

[26] Dr Andrew Semple (1912-2013) was Deputy Medical Officer of Health (1948-53) and Medical Officer of Health for Liverpool (1953-74) and Community Physician for Liverpool Area Health Authority (Teaching) (1974-77).

[27] Dr James Davies (1920-2013) was Deputy Medical Officer of Health for Liverpool (1953-69) and Director of Liverpool's Personal Health Department (1969-71) and Social Services Department (1971-81).

[28] Sir Eric Driver (1911-2010) was a civil engineer with Imperial Chemical Industries (1938-73) and Chair of Mersey RHA (1974-82).

[29] John Shepherd (1920-2013) was Secretary to Liverpool RHB (1967-74) and Regional Administrator for Mersey RHA (1974-77).

Chris Vellenoweth

He was a very austere man, but he was driving it in a different way and different areas from those of Don Wilson later.

Nick Timmins

I was just going to ask you to expand on that – Driver's character, Shepherd's character – what sort of people were they?

Chris Vellenoweth

John Shepherd was a well-respected group secretary who became the regional administrator. A very genial guy, a very pleasant fellow, and he was one of the assessors when I was appointed Deputy Group Secretary of West Cheshire HMC [Hospital Management Committee]. He and Eric Driver, I don't think it was good chemistry shall we say, and Eric Driver had been with Unilever I think it was, or one of the chemical companies, and was very much a company man, if I can put it in those terms. A very austere character, not very sociable, but competent – obviously – within his own area of expertise which I think led to this development of building and engineering

Nick Timmins

So if that was a strength, a couple of people have already said that by the end of the '70s, early '80s Mersey had a 'not good reputation'. Given that by the end of the '70s we'd begun to develop some measures of performance – but they are still petty crude – because the big development of that came in the '80s, why was the reputation not good and on what was that based?

Mike Pearson

Can I just challenge that? I am not sure it was bad in medical terms.

Nick Timmins

Right. Yes, that is an important distinction.

Mike Pearson

I think that as a trainee at that point there were plenty of applicants for posts, they were not difficult to fill. I trained throughout the Mersey region and I had to apply and had competition for every post so it wasn't a nod through or anything like that. I think you could criticise Liverpool medicine for being insular but if you trained in Liverpool you developed a habit and if you found someone from Manchester they had a different habit. So the same conditions were

treated differently because that was the way we had been trained but I don't think Liverpool medicine was bad. I think in organisational terms you may be absolutely right but I will just separate the two.

Nick Timmins

It's an important distinction. So let's move to '81-'82. Three things happened then. One, in '81 Duncan Nichol got appointed as Chief Executive of the RHA. Two, in '82 the AHAs got abolished. Three, and in '82 Don Wilson arrives. So this is clearly a sort of cusp of sorts. Duncan it's great to see you, what were you doing immediately before you became Chief Executive?

Duncan Nichol

Image 7: Duncan Nichol

I was in Salford, which was probably my favourite job. Salford was a single district teaching area so you didn't want to go anywhere. Oxford was another and Newcastle, there were only four in the country. It was always a great job but one could see things were beginning to go wrong as it were, and I was encouraged to think about the regional level so I waited until the last one was available, which was Mersey. Eric Driver was in the Chair on the [Authority] and I was the last person he wanted to appoint, he wanted to appoint the Head of Estates, Gordon Brooke[30], and John Pearson was there at the time so you had a lot of these austere people who weren't brilliant at building relationships with the wider community. So it was against their intentions that I got the job.

Nick Timmins

So if he didn't want it, how did you get it?

Duncan Nichol

That's a good question.

[Laughter]

I learnt later he didn't want me but at the time I imagine he was outvoted by others who thought we should not just stay with the director of estates; time for a change.

[30] Gordon Brooke was Regional Works Officer for Mersey RHA (1976-83).

Nick Timmins

Given the point we have been making – parking clinical quality – given that the region had not a terribly good reputation, and that jumping up always feels a risk, did it feel a risk?

Duncan Nichol

It felt like an opportunity.

Nick Timmins

Yes, right. So you must have had a year or so with Driver before Donald Wilson arrives in ’82.

Duncan Nichol

Yes it seemed like a short period, I don’t recall seeing a lot of him actually, and then we moved on to Don.

Nick Timmins
And the abolition of the AHAs at the same time. So that presumably is quite a significant reorganisation; stripping a tier out.

Duncan Nichol

I won’t talk about North West region but my time in Salford, and before that in Manchester, was with some of the colonial people we referred to. Andrew Scott[31] for example at United Manchester Hospitals so you have stuff going on there with the teaching hospitals and the regional hospital board as it was. You had Frank Pethybridge[32] who was a formidable character engaged in warfare with the teaching hospital in really quite difficult circumstances but a very very competent administrator. Salford managed over the five or six years I was there to really plough its own course. We did that largely because we made a relationship primarily with the local authority in Salford and that was really important, the city was very strong, and the city sent their top councillors to sit on our board, education, social services and the like so we had a strong power base in the City of Salford.

Bob Nicholls

There might be a correlation for Sally [Sheard] and the team that I moved out of a multi-tiered structure in Hampshire, which I think had four or five districts – I was in Southampton district – in order to move to a single teaching district area which was Newcastle, which I think was judged as a fairly weak Regional Hospital Board/Health Authority but had strong relations with

[31] Andrew Scott was Secretary to United Manchester Hospitals (1967-74).
[32] Frank Pethybridge (1924-89) was Deputy Secretary to Manchester RHB (1962-74) and Regional Administrator for North Western RHA (1974-82).

the university and very strong relations with the local authority again where I went to be in a single district teaching area. So there may be two correlations: one is the multi-tiers and the other is the connection to the local authority.

John Ashton

That for me – because I came from Newcastle to Wessex – it's interesting because it raises the issue about the relationship, the power relationship, between clinicians and other officers in the NHS locally, because the dominant figure in the North East was Henry Miller[33], as the Dean of Medicine and a very powerful character, and of course John Walton[34] as well was Dean of Medicine after Henry Miller, I mean you had this whole succession of very powerful people. People used to say, as far as Henry Miller was concerned there should be just one hospital for the whole of Northern England in Newcastle.

[Laughter]

If Henry had his way, everything would be centralised into Newcastle for the whole of the north of England. He had very great influence over what went on.

Sylvia Hikins

Can I just pick up on that John? Can I say that the community health councils, as you know were independent watchdogs. They didn't have teeth, they couldn't bite but had a tail that could wag and it was law that any changes to the service, the CHCs had to be involved in consultation so therefore we saw lots of documentation and could respond. The CHC I was involved with, we had a shop front on Whitechapel [in Liverpool] and I made it clear that whatever we got was made available for the public to see and it was a resource for all of the communities that we served. There is nothing like that now, we don't know what is going on now and of course when you have that you are going to get antagonisms. But can I pick on what you say: lots of the information that came to me, came from people working in the hospitals, not the administrators but consultants and you will laugh at this because a meeting place to hand me brown paper envelopes – I kid you not – was under the clock tower of Sefton General Hospital.

[Laughter]

'Meet me there at 2 o'clock'. I will not name the very, very senior people, some of them are not with us now God love them, but I was handed this stuff and what was I supposed to do with it? I couldn't name them, it would be quite wrong to do that but I had to do something about it. Let me give you an example, there was – some of you might remember it – the Royal Liverpool Hospital in the early 1980s, the Department of Health did a biological survey of the RLH and found it was safer to eat your food off the floor – this was actually in the report – than on a tray in your bed. Now that report sat with the authorities for six months and nothing was done about it and I got a phone call about it and I met a very senior person, who was a medic not an

[33] Dr Henry Miller (1913-76) was Reader (1961-64), then Professor of Neurology (1964-68), Dean of the Medical School (1966-68) and Vice Chancellor (1968-76) of the University of Newcastle.
[34] Dr John Walton (Baron Walton of Detchant) (1922-2016) was Professor of Neurology (1968-83) and Dean of the Medical School (1971-81) at the University of Newcastle.

administrator, in the usual place under the clock tower and was given this big brown paper package, took it home and read it, what do I do with it?

I wrote to the CEO and to the Area Health Authority and said I want to know in two weeks what you are going to do about this, some kind of an action plan because I think patients could be at risk or I am going to the media. I heard nothing, so on the 15th day after that I phoned up Granada Reports, I phoned up the [*Liverpool*] *Echo* and it was all over the media. And when I went to the meeting of the Liverpool Area Health Authority I was treated as if I had committed treason. I was hung out to dry because I couldn't name my sources but I still stuck with it and I was the *enfant terrible* that they could kick up the proverbial, but nevertheless it had to be done and there lots and lots of things like that. So really, inside those organisations, those people that are running the services who are face-to-face with the users, who knew the economic and social context – particularly in Liverpool in the '80s, we all know what was going on then with unemployment and poverty and so on – they were facing that day-to-day.

I've got six files of this, headlines and stuff, I just brought one today, with all the issues of waiting list lengths…you can see it all there, and it's back to this buffer again. In a sense of course, the CHC was a kind of buffer as well and it's a very interesting dilemma isn't it that you were raising, the role of those consultants and the sense of helplessness with some of them because they were stuck having to deliver policies that they knew weren't necessarily in the best interest of the users, although some were and I acknowledge that.

Nick Timmins

Anybody want to come back on that?

Brian Edwards

I don't recognise that story at all from the perspective of Cheshire. Partly because we were heavily decentralised down to the individual districts and our relationships there were very close. In Warrington I remember the doctors, the local authority people, used to meet regularly and we were very happy with that because it built that relationship up. So I don't recognise that as applying to part of the Mersey region. We had all our meetings in public if I remember including the private meetings – so-called – so maybe a Liverpool picture wasn't a Mersey picture.

David Colin-Thomé

From '79-'90 I was a local councillor in Halton and I was put on the Community Health Council there. But like a lot of these organisations, the leadership was all over the place, so Sylvia you had a dynamic reputation here, but I found it really a bit of a waste of time being on a CHC where we were because they didn't challenge anything, in fact they were almost like a lot of patient participation groups, you know, some become doctors' friends rather being critical and one of the reasons of the demise of CHCs may have been because of this huge variation. So maybe things were going well but I used to be frustrated that some of the challenges weren't there.

John Ashton

Liverpool CHC was the one the *Daily Mail* warned you about.

[Laughter]

Nick Timmins

I'd actually agree with that because I had some dealings with CHCs – they talked to the media – and you know, a number of them were excellent, but there were not very many of them that were excellent, most of them were a waste of space in my view.

Mike Pearson

I think it's also fair to say that the attitudes within the hospitals were very different as you moved around the region. The central Liverpool hospitals had a very different atmosphere to even going as far north as Walton, or out to Ormskirk.

Nick Timmins

Different in what way?

Mike Pearson

I think the Royal had been used to running the show, the 'Cohen effect'[35] was still there and I think there was also something that medics – senior medics – were feeling a bit put upon by these wretched administrators who were coming in. This was pre-Griffiths, but as you say post the invention of something that replaced what used to be the Medical Superintendent, which I think only went out in '74 or a bit later when some of them stopped.

Nick Timmins

I think it varied around the country

Mike Pearson

But I think Aintree was up to '77 or '78 before we stopped having a Medical Superintendent. So there were people with noses out-of-joint, but particularly people who had been used to having power and didn't have it anymore and I think that bred a distrust, I don't know, others may have different views on it.

[35] The 'Cohen effect' denotes the dispersal of medical specialities across the region rather than their concentration in a single teaching centre, named after Lord Henry Cohen of Birkenhead (1900-77) who was Professor of Medicine at the University of Liverpool (1934-65) and Vice-Chair of the Standing Medical Advisory Committee at the Ministry of Health (1948-63).

David Colin-Thomé

This is a hospital view. For us GPs we were untroubled by all this stuff.

[Laughter]

Nick Timmins

Duncan? Those sort of differences within the region. Do you recognise that story?

Duncan Nichol

In very broad terms it wasn't a single region, it was Mersey and it was Cheshire…and it still is. We've got an STP [Sustainability and Transformation Partnership] now that makes absolutely no sense whatsoever.

[Laughter]

Yes, and within Liverpool there were a set of issues which were, I think, predominantly about far too many beds, so what are we going to do about it? What can we take out? What can we do less of? It may have been a wrong diagnosis but it was perceived at the time as over-bedded. Cheshire caused us no problems, really, other than politically in Macclesfield.

[Laughter]

David Colin-Thomé

Also, the old inverse care law,[36] general practice in Cheshire was much better than you got in more working-class communities.

Rosemary Hawley

I think David's absolutely put his finger on it and going back to what you said earlier, you have to remember that the whole of the bit of the health service that most people used every day was outside all of this. I remember when I was appointed to the FHSA and Duncan was going and I said 'Does this come under you?' and you said 'not yet'.

[Laughter]

Because when you think of the way the GPs escaped in 1948. And ever since they were sort of separated. When you talk about the inverse care law – I have always lived, and I think that was my main credential for joining the health service, I've always lived in areas with very high poverty and very high sickness.

[36] The 'inverse care law' argues that 'the availability of good medical care tends to vary inversely with the need for it in the population'. J. Tudor-Hart (1971) The inverse care law. *Lancet*, 297:7696, 405-12.

David Colin-Thomé

I worked in Castlefields for the same reason.

Rosemary Hawley

Image 8: Rosemary Hawley

Exactly – here living in Kirby but coming from inner London – it seemed to me as soon as I began looking at this, that with a few exceptions – very famous exceptions like Princes Park[37] – the best services, Cheshire and so on, were where people were healthiest. There is still an element of this and also that in smaller places you have bigger group practices that in areas where there were lots of people living, high population, within a mile radius there could be ten different practices, not in more affluent areas, so all that was very very perverse and very difficult to turn around. What I think was tremendously striking about the region when I was there, was that although he was a bully, he would allow people to take terrific risks – Don Wilson – he was imaginative and saw things ahead and when I was asked to be the non-executive at Mersey who looked after and related to health promotion and all that side, he said to me about John [Ashton]: 'He's like a thoroughbred racehorse; very, very talented but needs restraining'.

[Laughter]

David Colin-Thomé

People have tried that for years!

Rosemary Hawley

But there was money for drugs, there was money for health promotions, there was money for AIDS long before anybody had ever heard of it, and that made it a most exciting and stimulating place to be.

John Ashton

If we're onto him [Donald Wilson], and I don't know whether you'll pull us back from this in a minute, it was always the 'Mersey first' thing. He always wanted to do something before anybody else got round to it.

[37] Princes Park Health Centre was established in Toxteth in 1977 by local GP and Labour Councillor for Granby Ward, Cyril Taylor, and unified a range of health and social services for patients at a time when single-handed practice flourished. For details see: M. Lyons (ed.) (2015) *Princes Park Health Centre: the destruction of community-based GP services*. Liverpool: Keep Our NHS Public Merseyside.

Rosemary Hawley

But he saw, he got the things that were important before others. But all the time, even when FHSAs did come, it was very hard to counter the dominance and the power of the teaching hospitals particularly, and hospitals in general. Although before that there were teeny little community services within that same ambit, the balance has always been terribly difficult.

John Ashton

But not as bad as London.

Rosemary Hawley

Well I come from London.

John Ashton

Well I've just been working in Kensington and Chelsea and what's going on there on the hospital side, they just don't try to address it. Because they just can't.

Mike Collier

Can I just add a contextual point, I don't want to be regarded as the statutory finance man, but it is worth remembering in the debate you just had about Liverpool and the rest of the region, that of course RAWP [Resource Allocation Working Party][38] was a profound influence. Not only was London feeding the rest of the country, Liverpool was feeding the rest of the region in terms of reallocating resources.

Nick Timmins

Absolutely. Just to go back a bit again as we started talking about Don Wilson; so '82 Don arrives, '82 the AHAs are abolished, we're beginning to get better performance data, Körner's arrived and then you get Fowler[39] and Clarke[40] arriving at Health. I would characterise their time, well much of the rest of the world thought the Tories were cutting the health service, I think genuinely Fowler and Clarke were trying cut anything except health*care* if you see what I mean, so there were these totally arbitrary manpower targets because no one could control

[38] The Resource Allocation Working Party created an equitable funding redistribution formula so that provision of secondary care matched need. For details see: J. Welshman (2006) Inequalities, regions and hospitals: the Resource Allocation Working Party. In M. Gorsky & S. Sheard (eds.) *Financing medicine*. London: Routledge, 221-40; Gorsky & Millward (2018) Resource allocation for equity.

[39] Sir Peter Norman Fowler (Baron Fowler of Sutton Coldfield) (1938-) was the Conservative MP for Nottingham South (1970-74) and Sutton Coldfield (1974-2001), and Secretary of State for Health and Social Services (1981-87).

[40] Kenneth Clarke (1940-) was the Conservative MP (1970-2019) then independent MP (2019) for Rushcliffe, and Minister of State for Health (1982-85) and Secretary of State for Health (1988-90).

their manpower, there was a range of scrutinies,[41] and Fowler and Clarke set up the regional reviews with the regional chairs and the regional chief executives, which were then replicated down in the regions to the districts, and this is all ahead of Griffiths. You get something that is now absolutely recognisable in terms of a way to manage the thing from the centre more. Is that fair Duncan?

Duncan Nichol

Yes that is fair. What I remember about those occasions is that it's easier to remember the style of how we did things rather than the substance of what we did. I think we were genuinely trying to engage in what we would now regard as performance management against some predetermined objectives that were heavily money – Mike [Collier] I think is right – and they were also heavily waiting lists. I mean, in the middle of the period we are talking about, one year in particular, we got growth of 3% from the centre which was just over £1.5m, and we got a waiting list initiative of just less than that which was £1.3 million. So, here's an amount for growth and here's an earmarked amount for waiting lists, and the region plays a high interventionist role in marshalling the bids from the districts for waiting list monies, sends them off to the Department and gets it back, and we achieved the cost improvement program Mike, in the year I'm thinking about of £9m, which was 2%, which we struggle to do now. So there were similar conversations going on. If anything they were dominated by talking about hospitals and they had no content with regard to safe, kind and effective – 'quality' – services. In my memory we didn't talk about that. If you look at the balance of the regional agenda, it wasn't an agenda with quality issues. It is easier to remember the style rather than the substance. It would be important, actually, to access the minutes of those review meetings, what the minutes of the decisions which were taken by the region at the time were so that you could actually remind yourself what decisions were actually taken as opposed to the style in which they were taken.

Sally Sheard

We will be doing that. We've just located a whole load of archives for the regional health authority and associate bodies,[42] so we could triangulate this history with written evidence.

Mike Pearson

I think in that period – I don't know whether we give credit to Duncan [Nichol] or to Sir Donald [Wilson] in those days – this initiative of taking on the first few metrics we had which were twelve month waiters and vaccination rates, Liverpool – or Mersey region – was the only region to actually achieve its targets and I think the most unusual thing was that it was the first time financial threats were used and actually implemented. I don't think any other region did this and so 'we've given you money for it, so where's the benefit? If you haven't given us the

[41] Public sector scrutinies were developed by Derek Rayner, Managing Director of Marks & Spencer, to introduce business incentives into all aspects of government and the civil service. For details see: National Audit Office, *The Rayner Scrutiny Programmes, 1979 to 1983*. London: HMSO.

[42] For details see: M. Lambert with P. Atkinson & P. Begley (2019) *Report of a scoping exercise on health service records relating to Merseyside at Liverpool Record Office*. Liverpool: University of Liverpool Department of Public Health and Policy.

benefit you don't get the money'. The money was withdrawn from one hospital and I think GPs also suffered similar outcomes – they didn't get their bonuses for getting the vaccination rates up.

Ruth Hussey

I think that was the new contract, though. It came after.

Mike Pearson

No, this is going back.

David Colin-Thomé

Yes. The GP bit was 1990 with the new contract.[43]

Mike Pearson

But '84-85 was a big initiative.

Duncan Nichol

I was fascinated to see that we managed to raise our measles immunisation rate in 1986-87 from 70% to 74%. It puts things in context.

Nick Timmins

Indeed. So we've got Don Wilson firmly on stage and we'll talk about Don doubtlessly more and more, but I wonder if it's possible to sort of tease out at all what was Mersey about this and what was national? Because the reviews were happening for all the different RHAs, there had been the appointment of what you might, if you were being disparaging – I'm not trying to be disparaging – but a bunch of Tory businessmen as Chairs of RHAs. So you've got Ackers[44] in the West Midlands, you've got the guy from the Samuel Smith Brewery in Yorkshire[45]. I didn't know them all but my memory of these people is that they were actually very powerful figures, they were very hands-on. I'm not sure all of them were but certainly those three were, so that certainly they stopped being just titular chairs of a health authority they were sort of executive chairs almost.

[43] The 1990 GP contract introduced a series of performance and quality indicators, as well as audit and external management. For details see: J. Lewis (1998) The medical profession and the state: GPs and the GP contract in the 1960s and 1990s. *Social Policy and Administration*, 32:2, 132-50.

[44] Sir James Ackers (1935-2008) was Chair of Ackers Jarrett Ltd (1974-91) and Chair of West Midlands RHA (1982-93).

[45] Sir Bryan Askew (1930-) was Personnel Director of Samuel Smith Old Brewery (1982-95) and Chair of Yorkshire RHA (1983-94).

Kathy Doran

They met monthly with the Secretary of State.

Nick Timmins

Exactly. So when we start saying this is what is happening in Mersey, performance is rising, is there anything particularly *Mersey* about this as opposed to the pressure that was…there must have been something because on the measures that were available as they became more sophisticated, Mersey did better and better relative to other regions.

Mac McKeever

I was in the Department [of Health and Social Security] convening the regional general managers' and regional chairs' meetings with Ministers at that point. The thing that strikes me, dissimilar from what you say is that they were partnerships: partnerships between the RGMs and the Chairs, so the distinguishing features were how strong was the partnership for each region? Although I may be a bit biased looking back on those times, I think there were one or two of the London regions which stood out, and Trent and Mersey were the two forward-looking, successful, progressive regions that you could see from the centre.

Duncan Nichol

Can I ask: what was it that we were doing well?

Mac McKeever

The thing that struck me was both the focus on results rather than process, and ambition, ambition *despite* some numbers. I think they were the things that characterised – for me – both Mersey and Trent, and occasionally bits of London.

Nick Timmins

Despite the numbers?

Mac McKeever

They may have had bad numbers but there was a determination to change the numbers, not just go through the process of doing waiting list initiatives, but to focus on an outcome-based result, in a range of settings, whether that be vaccinations, waiting lists, money, or whatever else, whereas at the time a lot of people were focused on the attempt.

Mike Collier

Could I ask: was that a one-way street or did in fact, if you like, the 'leading regions' actually have an influence on the centre in any way.

Mac McKeever

Yes, I was going to come to that later, if I may. Contrary to Sylvia's [Hikins] view I don't see the regions from my time as a buffer. I see them as more of a lightning rod, and some were more effective than others. If I look back over 30 or 40 years from my differing perspectives, the service as a whole from Ministerial policy through to implementation at grass roots moves more in step today than it did when I started out. The first signs of that for me, personally, were those observations from the regional meetings where a couple of regions influenced the centre very markedly by what they did, not just by what they said. So I saw an increase in that backward pressure on policy and everything else. At one point I think it was formalised into 'loose-tight' agendas where there was a tight agenda where you could count on some regions to do some things and the looser agenda was where we tried just as hard but where there wasn't such a contract, going back to the performance reviews.

Chris Vellenoweth

I think it's interesting that this dialogue is about centre and regions and management of waiting lists. I think we have to give just some recognition that the actual management of that was at local unit level and I think communications was an important part of this. Perhaps we do need to touch a little bit on the difference of the communications of members, chairs of authorities and so forth, and the line of communication of the management teams working to this. I think in that somewhere there's some issues about how regional chairs communicated with chairs of health authorities, recognising that there was that statutory relationship of authority to authority which did not of course exist so far as what I would call 'the officers' were concerned, and therefore the communication and commitment sign-on to these objectives was, I think, quite an important issue, as between chairs and authorities, professionals, at that level, and getting that into, and managed by, the units and that in itself was I think quite a difficult task.

Nick Timmins

And you are saying that was good in Mersey or bad in Mersey?

Chris Vellenoweth

I think…as with everyone, it was *mostly* good. I will duck it.

[Laughter]

Geoff Greenwood

Image 9: Geoff Greenwood

I was just going to say, the changes that went on you have to put into context, which has been raised in a way already. We didn't have performance management, we didn't have KPIs [Key Performance Indicators], to use the jargon, we didn't have dashboard reporting as we've got now, so none of that was in existence at that time, and the only way you could shift an organisation, or a big one like Mersey Region, and its component parts was actually to hit it with some sort of cultural impact. Something had to change and I think that's what probably moved Mersey region during that period, that there was…and I don't think I can put my finger on exactly what happened, but I think it's something that pervaded through that period, and the relationship between the region and the health authorities and units operationally did change significantly.

People became aware of performance and being accountable for what was being delivered, or not being delivered. The buffer has been mentioned a few times actually – I think the buffer worked at different levels. I mean I saw my role when I became a General Manager, Chief Executive, whatever titles we had…there was an element of trying to protect the sharp end from some of – and I'll use my words carefully – the worst excesses. So my job was to manage it so that it didn't have to impact necessarily on every single member of staff, as long as we delivered those objectives. So I just think there was a major cultural change and in the middle of it, boards as they ultimately became, also had a very different style of membership so there were people on boards that were used to setting objectives, to monitoring them, to appraising why they did or didn't happen in such a way, and I just think the culture eventually changed.

Bob Nicholls

I think we need to be careful about the introduction of general management.[46] We're talking about pre-general management. I think what Chris [Vellenoweth] said…I was going to use the semi-permeable membrane of regions, so not just a buffer, but something that protected where it happened from the ridiculous bits, but actually should secure enough influence up and deliver enough above, as people said before, to earn brownie points. It's interesting from the Department's [of Health and Social Security] perspective saying 'Which are the regions that were doing alright?' Fortunately, I hadn't got to region yet.

[Laughter]

But my two theories to add, before general management, one was size. Now the Trent example slightly challenges that, but I was thinking Wessex, Mersey, and Oxford – which I later went to – were all small enough, despite the rows which were clearly going on between Mersey and

[46] General management was introduced in 1985 following the publication of the Griffiths Report, Chaired by Sir Roy Griffiths, the Chief Executive of Sainsbury's Supermarket, in 1983. For details see: M. Gorsky (ed.) (2010) *The Griffiths NHS management inquiry: its origins, nature and impact*. London: Centre for History in Public Health, London School of Hygiene and Tropical Medicine; Gorsky (2013) Appraising the 1983 Griffiths NHS management inquiry.

Cheshire, I mean I got to Oxford, and Oxford sucked all the money in and my worst 'health indicators' were, of course, in Corby New Town and Slough, who were getting rather starved of resources. So those things were going on, but if you knew all the key characters, regional chairman or regional administrator as we're still talking about, or a powerful regional medical officer, you could get amongst them, and I go with the cultural influence because I don't think there was enough data at the beginning of reviews to actually do it very objectively so it was influence. The other thing then was characters and we're already touching on one huge character and even though I wasn't at region I knew about Mersey, probably from my colleague Duncan [Nichol]. So just at the end of this period I was going into South West [RHA], which I think was viewed from the centre as a bit wishy-washy, not really needing very much, not really delivering – and I didn't get the RGM job, because that was the impression – I think we were doing quite good things, but Oxford was doing better. It was size, it was characters like Rosemary Rue.[47] The exception to the Conservative businessmen, my Chairman Gordon Roberts[48] survived the cull and was very skilful at actually keeping Rosemary, who was the innovator, under control and actually doing enough of what Ministers thought was necessary to good points. So size and the characters that were in this game at that time, ahead of general managers. You could get 'earned autonomy' if you got the trust of the centre.

Nick Timmins

Any more votes for Size? Brian.

Brian Edwards

Yes, we were large but we were three distinct communities – Sheffield, Nottingham and Leicester – and it was the same philosophy we took in Cheshire: save the locality stuff and bridge it on top. For the researchers particularly there's one subject which you might want to use as a measure: how did the Mersey region cope with the large number of mental hospitals that it had? It had a *huge* number of mental handicap and mental hospitals and how did the Mersey region cope with that? I don't know the answer to that, but I know at this period of time you are talking about, that was an issue that was beginning to build.

Image 10: Brian Edwards

Mike Pearson

On top of that, the worst of medical care at that time was regarded as the mental health hospitals which still had closed wards and had some pretty awful goings on.

[Agreement]

[47] Dr Dame Elsie Rosemary Rue (1928-2004) was Assistant (1965-71) and Senior Assistant Administrative Medical Officer (1971-74) for Oxford RHB, then Regional Medical Officer for Oxford RHA (1974-88), combining the role as regional general manager (1984-88).
[48] Sir Gordon Roberts (1921-2003) was Chair of Oxford RHA (1978-90).

Duncan Nichol

I'm trying to decide whether this is a little bit unfair on all of us, perhaps one in particular at the time, but we had a lot of beds in the large institutions and the task was to reduce them to virtually zero in a given period of time. Not very different than getting the waiting lists down from there to there, and 'yes sir, no sir, three bags full sir', that's what we did. We said we'd do something, and we did something. On the other hand, I'm not sure – I am really not sure – we really thought about the consequences of doing that. We may have known what was going on in the seaside in North Wales in terms of where some of the patients were going, but as long as they went, we were ticking a box and that was a bad feeling actually. I don't think I felt it quite as badly as I did ten years after the event, or five years after the event. But I thought we let people down there by just saying we give a number to the Minister, come hell or high water we will deliver that never mind the consequences.

Sylvia Hikins

Can I ask a question? Of course you had to record and improve outputs and run the service as efficiently as you could to get value for money – no-one is denying that – but what I'd like to know from you all these years on is: how did you assess needs of the different communities within Merseyside? Very different, as Rosemary [Hawley] pointed out…the inverse care law, all that…that was the issue with all of this stuff, with the Hikins Report versus the Donald Wilson Report. It was all about those inequalities and people couldn't see how *you* were doing your best – you probably were behind closed doors and couldn't be open – to try and make the resources match the needs of those very different communities. Any little insights all these years on?

John Ashton

Can I just comment on some of this, because I think this whole issue about the relationship between the centre and the region, between the region and the localities, and the tensions and the management of that is really important. Looking back now, with the abolition of the regional health authority, and the regional tier is now non-existent really, the things that are called regions are basically civil service, inward-looking things, they are not outward looking. So the extent to which the region was charged with implementing national policy, there was also a sense, and Rosemary [Hawley] might want to say something about this, but there was very much an awareness of the need to represent the local population as well, it wasn't just about implementing national policy. In that sense it was a buffer. I was only involved with the regional health authority from '82, but later on we had these instances where the centre was wanting…well, to take the closure of the asylums and the learning disability places – that was a central thing based on erroneous academic analysis, because the research on the mental illness side that had followed from the advent of antidepressants and major tranquilizers, and the early impact they'd had on being able to treat people who had been institutionalised, was extrapolated on a straight line and the projection from a policy point of view was that you would be able to get everybody out and that was what was sent down the line from the Department of Health. So, it was a very naïve projection and it wasn't followed by the

concomitant build-up of community services anyway. I mean Albert Kushlick[49] in Wessex – you will remember Albert – had set up across Wessex, when I was down there, the network of community care homes for people with learning disabilities and it was a model of good practice. It was so that people could be deinstitutionalised…

Bob Nicholls

You needed that first. You needed that ahead.

John Ashton

But it wasn't followed across the country. It just didn't happen.

Nick Timmins

I remember when I was covering this, there was not a lot of money around – there never is – and the core problem was people discovered you didn't really save much money from the big institutions until you literally closed them. You might run the staffing down, but you've got buildings in there. It was really difficult to release resources.

John Ashton

One of the things Bob Logan used to teach at the London School of Hygiene was the only way in which you really save money with health care is by closing things properly. By trimming services back you don't save much, you have to actually close places to save money.

The other thing I was going to mention was, later on…I don't know when it was, quite a lot later on…all this central managerial stuff about centralising things, economies of scale and all of that which was driving such a lot, and they wanted to rationalise the blood transfusion service and close the Liverpool one and move it to Manchester. Sir Donald was very much looking after the Mersey end of that, he was very much against that, he locked horns with the regional chairman from East Anglia [RHA][50] who chaired that group, and with Sir Donald's *blessing* I spoke at a trade union rally at St George's Hall that was trying to keep the transfusion service in Liverpool and we saved it for a while, it later all got centralised anyway.[51] But that thing about actually acting on behalf of the local people and not just uncritically implementing central policy has to be on the table as well I think.

[49] Dr Albert Kushlick (1932-97) was Director of Research into the Subnormal (1963-71) and Mental Handicap (1971-74) at Wessex RHB.
[50] Sir Colin Walker (1934-99) was Chair of East Anglia RHA (1987-94).
[51] For details see the report into the impact of centralisation: J. Cash (1997) *Independent review of proposals for the transfer of bulk blood processing and testing from Liverpool to Manchester*. London: Department of Health.

Paul Atkinson

To ask a question for the research team: various people – especially Geoff – have commented on the way that there was such a lack of metrics, as we now like to call them, and therefore performance management if it existed relied on more cultural impacts. As a team we are very interested in the influence of three groups: the doctors, the health economists, the management consultants. Obviously, some of those groups are particularly interested in metrics. I wondered how this change from cultural influence over the organisations that you're supposed to be performance managing into much more use of numbers and metrics and even the use of the word metrics *happened* and how much it was influenced by people like management consultants or even possibly health economists occasionally. What were your experiences of that?

Mike Pearson

Körner was the first name that came to mind there, but the influence behind it was computing.

[Agreement]

Because this was the first time we could record things and when the PC [Personal Computer] arrived in the early '80s we could start recording the number of ECGs [Electrocardiogram] being done in a hospital – things like that – which were very nitty gritty, but you now had figures. Körner's first bit of data was actually reporting on things just like that – ECGs and exercise tests and breathing tests – but it wasn't until we got the HES data in '86/'87 that we could start saying: 'Right, your unit has seen 1500 patients this year, the other unit has seen twice as many'. It was 1990 when I was involved with some of the Mersey people producing figures showing that one surgical team received twice as many [patients] as another surgical team in *apparently* similar hospitals. So it was the ability to count which came with computing.

Nick Timmins

Yes. That's really important.

Kathy Doran

That's absolutely right, because working at the Department [of Health and Social Security] in the early '80s there was a huge room at Friar's House full of filing cabinets and every hospital's Hospital Episode Statistics routinely were sent, and, in a very civil service way, filed.

[Laughter]

And nobody did anything them until John Yates[52] from Birmingham started to mine them, and he started to pull them together in the very early days of computing and was doing a lot of

[52] Professor John Yates was an NHS administrator before working at the University of Birmingham HSMC as Director of the Inter-Authority Comparisons and Consultancy (1978-2003) and as adviser to the Department of Health on the waiting list initiative (1985-91).

analysis, very early analysis, which fed into the development of performance indicators and early metrics, but he was a lone voice.

Nick Timmins

The IT point is really important actually, and the development of that and the speed of the development of that, so we get Ian Mills[53] and his financial management initiative[54]: could not have been done a decade earlier, I mean literally could not have been done a decade earlier

Kieran Walshe

I was going to say almost exactly what Kathy just mentioned. When I became a [general management] trainee in 1985 – I'm slightly younger than most people here – on almost my second placement a BBC Micro arrived on my desk, with the John Yates, the eponymous John Yates performance indicators package on it. John had of course done his PhD on the inquiries into long-stay hospitals and institutions and shown – there's a *BMJ* [*British Medical Journal*] paper from the late '70s[55] – that if you used data on those institutions, things like ratio of untrained to trained staff, the numbers of doctors per bed, to predict which institutions were going to have scandals in the 1970s. He went on to do that with performance indicators which then the Department [of Health and Social Security] took over and expanded them from around 200 indicators to about 2000 indicators. Then he did that with the waiting list initiative of course, with the work on consultants[56] and *Serving Two Masters*[57], private practice, and in each area what he did was put data to work. He was a real pioneer of that movement to put data and metrics to work.

David Colin-Thomé

But Kieran that was only in hospitals. The biggest thing for general practice was Kenneth Robinson's[58] contract in 1966,[59] which gave incentives to practices who were doing stuff. But there was this huge variation, so even when we got computerised a lot of practices weren't using that for clinical data, they were using it for business processes. So that left general

[53] Sir George Ian Mills (1934-) was Director of Finance Management (1985-88) then Resource Management (1988-89) on the NHS Management Board.

[54] The Financial Management Initiative was the precursor to the Resource Management Initiative (RMI) and used computing to measure, cost and budget for different hospital and clinical activities in place of traditional functional management and spending. For details see: T. Packwood, J. Keen & M. Buxton (1991) *Hospitals in transition: the resource management experiment*. Buckingham: Open University Press.

[55] J. Yates & M. G. Davidge (1984) Can you measure performance?. *British Medical Journal*, 288:6434, 1935-36; see also J. Yates & L. Vickerstaff (1982) Inter hospital comparisons in mental handicap. *Mental Handicap*, 10:2, 45-47.

[56] J. Yates (1987) *Why are we waiting? An analysis of hospital waiting-lists*. Oxford: Oxford University Press.

[57] J. Yates (1995) *Serving two masters: consultants, the National Health Service and private medicine*. London: Channel 4 Television. The book accompanied a Channel 4 Dispatches Report aired on 18 January 1995.

[58] Sir Kenneth Robinson (1911-96) was Labour MP for St Pancras North (1949-70) and Minister of Health (1964-68)

[59] The 1966 GP Contract, also called the Family Doctor Charter, was the result of a Central Health Services Committee Subcommittee (1961-63) inquiry into the work of GPs chaired by Dame Katherine Annis Calder Gillie (1900-85), published as (1963) *The field of work of the family doctor: report of the subcommittee*. London: HMSO.

practice out of all this, apart from a few energetic practices really at this stage, and nobody in the system, including FPCs, took any notice of what we were doing really.

Nick Timmins

Right. We've got about half an hour more of this session. Can I do Bob and then Brian and then we'll move to Griffiths and general management and jump towards the end of this period.

Bob Nicholls

Just quickly about the data because I have been reading the diary of the Oxford Regional Health Authority[60] and I was reminded that in the early 1960s the Oxford record linkage study and Ox-Syms were under way as systems of data collection in general practice. [61] Donald Acheson[62] was in Oxford way back then with Michael Goldacre[63]. This was there, but I'm afraid not even the great Rosemary Rue let alone the rather weak Bob Nicholls seem to have fully realised their potential...

John Ashton

It was pre '74 Donald Acheson, before he came to be Dean at Southampton.

Bob Nicholls

That's right. So the stuff was there, it was all based on having computers, and yet the huge bit, the bigger bit, on health care and primary care had not been linked organisationally, even after '74. Well not even by Oxford region, I don't know what was going on in Mersey…

David Colin-Thomé

Oxford was one of the leading edges actually.

Bob Nicholls

So I think it is the right answer to say that it was the data lacking but it was still very much hospital information systems, good that there was a bit on mental illness. It's interesting how little joining up of the potential – the Oxford linkage study could have done it – was used in a

[60] G. Everton & A. Moss (1996) *Diary of a Regional Health Authority, 1947/1994: a year-by-year history of Oxford Regional Hospital Board and Oxford Regional Health Authority*. Oxford: Anglia and Oxford Regional Health Authority.

[61] The Oxford Record Linkage Study and Ox-Syms were established in 1962. For details see: D. Acheson (1967) *Medical record linkage*. Oxford: Oxford University Press.

[62] Dr Sir Ernest Donald Acheson (1926-2010) Fellow (1957-59), Tutor (1959-60), Lecturer (1960-65) then Reader (1965-68) in Medicine at the University of Oxford, and later Chief Medical Officer (1983-91).

[63] Dr Michael Goldacre (1944-) was Clinical Lecturer in Social and Community Medicine at the University of Oxford (1974-) and Director of the Health-Care Epidemiology Unit (1986-2015).

national way to get into performance management. I think the last point is that it did change with Griffiths.

Brian Edwards

There was some data available on primary care and poverty. I remember in Cheshire we had a joint review with the County Council on housing estates[64], and we'd assumed initially that the problems would be found in Warrington and Runcorn, and we looked at the housing estates in Warrington and Runcorn and began to ask the question: what could we do to up services? Then we discovered there were equally bad patches in Chester, in Crewe, and in other parts of the region, so there *were* people trying to mine the data and trying to ask the question 'what could we do?' Particularly with the local authority, with the housing estate dimension. I don't think we actually did very much.

David Colin-Thomé

And even that was a leadership thing wasn't it, rather than it being a systematic...

Brian Edwards

Yes. That was something we'd decided to do locally. Finally, just a small story on mental health – Winwick, which was the large mental health hospital in Warrington, had a very large very successful farm, and we were told to close it. I remember we did ring up Mersey region at the time, it must have been John Shepherd I think, and said 'We don't want to close it, our clinician's don't want to close it, can you save it?' The answer came back: 'No we can't'. A few weeks later a Minister sent a letter confirming it, because we'd asked the question. There were restraints, there were things you couldn't do, it started at the centre.

Ruth Hussey

Can I just pick up on the GP data point? I was a trainee in Community Medicine just as John [Ashton] arrived at the region, so that's '83 onwards, but later, as a consultant working at the University, we were sharing data with general practice. We did a piece of work[65] with Ian Stanley[66], the Professor there, so it's the late '80s early '90s, and it was novel to have *any* access to GP data whatsoever. But what happened was quite a rapid transition, I think supported by GP fundholding, certainly there was a big push for data and sharing, but the opposition to anybody having access to GP data was very strong at that time so it was a long time later before we saw that shift.

[64] B. D. Hall and G. A. Hamilton (ed.) (1977) *Cheshire household survey 1975*. Chester: Cheshire County Council Central Policy and Research Unit.

[65] Liverpool Medical Audit Advisory Group (1991) *One year's experience of a pilot project in Liverpool*. Liverpool: University of Liverpool Department of General Practice; (1991) *How was it for you? Thinking about satisfaction with services*. University of Liverpool Department of General Practice.

[66] Ian Stanley was the inaugural Professor (1985-96) in the Department of General Practice, later Primary Care, at the University of Liverpool.

Image 11: Ruth Hussey

Whilst I've got the floor: on the point about inequalities. I joined Liverpool as a Director of Public Health in '91 and I was told that whilst poverty was an issue for the city it was nothing to do with the health service, and yet, within five years, not least supported and fuelled by John's [Ashton] work on Healthy Cities[67], Liverpool Health Authority signed up to the City Health Plan[68] which was copied around the country and across Europe and it had poverty at its heart. So, the shift around that time was quite rapid, but it came from, I think quite a permissive region which created the conditions where you could actually take risks. Rosemary [Hawley] said it: if you delivered on the core things – such as changing services, on one hand – you had permission to really try something new and innovative on the other hand.

John Ashton

That was the thing about the culture side and Sir Donald, it comes back to him and Geoff Scaife[69] and all of that. One of the popular texts at the time was *In Pursuit of Excellence*[70] and that really spoke about successful companies that continued to be successful over time and that within them they had a group that was protected and able to do the left-field stuff and the off the wall stuff, which is where Howard Seymour[71] and I were doing the health promotion and Rosemary [Hawley] was protecting us, but on behalf of Chairman and the chief executive as well. You had that creative den within the organisation that was able to get on and take risks and do stuff, and that's something that is really important. A lesson from all of this, when you look around now, I have said since 2013, if we were back in 1984 and HIV was turning up, which local authority would now take the risk of doing syringe exchange? Where would that happen now with the way local authorities are functioning?

I just wanted to say something about the mental health stuff because it's a whole other topic, and maybe Sally [Sheard] and the team will get round to doing that separately sometime, but you have to remember that the model that grew out of the Victorian Asylums Act in the 1850s[72] and the asylums as comprehensive communities – I worked at St Nicholas in Gosforth in Northumberland where you had the farm, you had the workshops, you had the recreation centres, they were therapeutic communities of their times – they had run out of steam for various reasons but the *coup de grace* was paradoxically the discovery of the antidepressants and the major tranquilisers. There was a switch over from what had been a social model of mental illness to a medical model of mental illness, it was believed that medicine was going to have all the solutions so why would you bother having a farm? Why would you bother having

[67] J. Ashton (ed.) (1991) *Healthy cities*. Buckingham: Open University Press.
[68] J. E. Taylor (1996) *Liverpool City health plan*. Liverpool: Liverpool Healthy City 2000.
[69] Geoffrey Scaife (1949-2004) was a civil servant in the DHSS (1968-89) and regional general manager for Mersey RHA (1989-93).
[70] T. Peters & R. Waterman Jr (1982) *In search of excellence: lessons from America's best-run business companies*. New York, NY: Time Warner.
[71] Howard Seymour (1961-) was Regional Health Promotion Officer for Mersey RHA (1982-94).
[72] The 1845 Lunacy Act and County Asylums Acts changed regulations on patient admissions and institutional audit. For details see: K. Jones (1993) *Asylums and after: a revised history of the mental health services from the early 18th century to the 1990s*. London: Athlone Press, 78-92.

workshops? We can put them on tranquilisers and antidepressants, you don't need that stuff. So it just betrays the lack of rounded education of people making the decisions.

Rosemary Hawley

Can I just say something quickly about that? It's swinging from one thing to another. All the good things about those communities went away and it's exactly as Duncan [Nichol] said: institutions, asylums bad, domestic-style environments good. Without nurturing those and without putting in the support things we just knew we needed to get people out of, almost like concentration camps was the way it was presented to us.

David Colin-Thomé

But some were awful.

[Agreement]

Nick Timmins

I've got to close this section of the conversation down shortly because it's straying well away from Mersey region. Duncan.

Duncan Nichol

What I think is interesting is the amount of earmarked targeted money that flowed from the centre, and not exactly addressing your [Sylvia Hikins] point about me, but there was a very significant urban deprivation problem, again that was about half the size of the waiting list fund, so by the time we were finished we were involved in a bidding process where we collected ideas from the districts and sent them off and we got a return. How we prioritised those I've no idea. There was no sophistication around that process, so urban deprivation [money] went into Liverpool, it went into Rathbone rehabilitation for the elderly, it went into South Sefton etc. What I think that is characterised by is this sense you were at the end of the bidding process rather than in control of your own agenda necessarily. Chris's [Vellenoweth] point about how we dealt with that *vis-a-vis* the districts is, I don't think, a great story.

Mike Pearson

I think the other problem was in harnessing what to put forward. There was no co-ordinated way of doing it. You were dependent upon the odd academic in the University to come up with some ideas because they tend to be more visible, but you wouldn't necessarily go to the doctor working in Chester who's actually doing it and might have the answers, and so there was no way of garnering that information and producing a co-ordinated plan. And GPs, as you [David Colin-Thomé] say, never got into this at all.

Nick Timmins

Right. ’83-’85. Griffiths. General management. Which is a change again. You could make quite a strong case that general management was more important than any of the other NHS re-organisations. There was a line in the *BMJ*, which I kind of buy, that in some ways general management saved the NHS. Because we’ve been talking about all these pressures, but the money was incredibly tight and there was a real sense that services were under phenomenal pressure in the mid-‘80s. Well, throughout the ‘80s actually. General management arrives and consensus management goes. Up to now, in the period we’ve been talking about technically consensus management is the way the authorities have been run, in Mersey like everywhere else. So general managers arrive. Impact?

Bob Nicholls

My quick reaction from being outside was that Mersey didn’t have consensus management before general management…

[Laughter]

They had Don Wilson and Duncan [Nichol].

[Laughter]

Nice places like the South West, which I went into about the same time, were very consensual but perhaps not very effective.

Nick Timmins

Do you buy that?

Duncan Nichol

Can I say that we didn’t change our style at all…

[Laughter]

I’m glad I made an impression.

Nick Timmins

Which leads us to the moment we *will* talk about Don Wilson, which we’ve been very good about not doing so far. He was clearly an incredibly powerful personality. I only saw him sitting down in London, I think I only met him twice, but my impression was that he behaved like a fucking feudal baron and treated NHS money as his own. I mean the stories I used to hear from clinicians, we’re short of clinicians in this room, but he’d literally sort of do a deal with the

clinicians saying 'You do this for me and I will give you this money', and that's not a planning process that's a very personal direct relationship.

Let me tell you my Don Wilson story. Just after the *Independent* was founded, I came up here – I can't remember what for – and was going to spend two days in Liverpool talking to various people. I was going to be there overnight. So I dropped in on the RHA as a kind of courtesy call if you see what I mean. I was passing through and met Don Wilson for the first time. This huge man comes in – bang, huge personality – and he says: 'Nick who are you going to see?' I thought 'That's a bit controlling'. So I told him who I was going to see and it seemed alright, and then he said 'So where are you staying?' I said I was staying in this hotel and he said 'Oh we can put you up in somewhere much better than that and I can get you a car to drive you around to all these places'. I said 'Don, I'm from a newspaper called the *Independent*'.

[Laughter]

'We pay our own way and you can't use NHS money like that', and that's a true story. You know, the sacks of potatoes and the cheeses, we should have a bit of that. Who wants to have the first go?

Sylvia Hikins

Can I just say that in the *Liverpool Echo* in January 1988 – 'Is Mersey healthcare fit or fit to drop?'[73] – there's a picture of Don Wilson and he's described, perhaps a little unkindly…but anyway: 'Sir Donald Wilson is Britain's top NHS manager. As well as being Chairman of Mersey Regional Health Authority he's also Chairman of the 14-strong from Regional Health Authority Chairman Group, the 64 year old pig farmer from Pulford, near Chester…

[Laughter]

Is the man responsible for representing the NHS at bi-monthly policy meetings with John Moore,[74] the Secretary of State for Health'. So that's a typical thing, you're a pig farmer, but you're there…

Hugh Lamont

Can I sort of explain…the only explanation I've got for his description in the *Echo* as a pig farmer is that they mistook my Scottish accent.

[Laughter]

I probably said he was a *big* farmer.

[Laughter]

He never was a pig farmer. There's no logic behind that description.

[73] *Liverpool Echo*, 26 January 1988.
[74] John Moore (Baron Moore of Lower Marsh) (1936-2019) was Conservative MP for Croydon Central (1974-92) and Secretary of State for Health and Social Services (1987-88) and Social Services (1988-89).

Sylvia Hikins

I'm so pleased to know that after all these years.

Mac McKeever

So I declare my prejudice; he was awful and I loved him.

[Laughter]

Many layers to the man. At the heart, a lot of public service values which I respected immensely. But just to set other perspectives against your [Nick Timmins] examples, what I observed over a period of years was that he wasn't as spontaneous as he might have first appeared. Many of his spontaneous offers followed several sessions with Duncan [Nichol] or Geoff [Scaife] talking through themes and areas where we needed to develop. At one of your own history-taking sessions a former RNO [Regional Nursing Officer] for Mersey[75] pointed out that there was a generation of doctors that had been turned on by his direct spontaneity, which contrasted with the bureaucratic delays that characterised the health service at that point, because when the Chairman of the RHA knew you by name, came to you and asked you to get engaged, it was form of clinical engagement that they hadn't often seen. So there were those layers to him.

But the other side of it was that I also have a very vivid recollection of him as Chairmen of the Regional Chairman confronting Ministers in private, which would never get heard of again. At the time the centre of the NHS was learning about I&E [Income and Expenditure]. We didn't do income, we did cash accounting which had frustrated me and others as a civil servant because we couldn't keep score. Sir Donald stood up on behalf of the Regional Chairmen and explained that the Secretary for State needed to find £260m now to balance the I&E deficit in the NHS, and by the time that their friends told them they needed to put their hands in their pockets and do something, it was essential. Within three months, through the public finance process, that money had come back. So, there are many stories that go in different directions as well and different perspectives from having seen him operate in other dimensions. I recognise the stories that you tell and can see how it might come across that way.

Nick Timmins

What's your take on that Duncan because you were right in the middle of all that?

Duncan Nichol

It's a combination. He [Donald Wilson] did deals, there's no question about that, and with anyone he could do a deal with, he liked doing deals.

[75] Rosemary Knights was Regional Nursing Officer for Mersey RHA (1989-93) and Chief Executive of Warrington Hospitals NHS Trust (1993-97).

Nick Timmins

And a deal that you would not necessarily have known about?

Duncan Nichol

Quite possibly. If I didn't know about it then I wouldn't know it.

[Laughter]

As he saw bureaucracy, it did frustrate him. My best story about…call it spontaneity or whatever, but certainly 'I can't wait for this process we need to do something now' were his words almost when I first met him. We needed to move into a new office in [Liverpool] so he spent the weekend driving around to find a new office, and he came up with this one in Pall Mall which was a bargain, this was the deal of the century, because he knew the Church of Wales were running out of money and they needed to sell this off and he can't move quickly enough or 'we're going to lose it'. 'So what I suggest is I put a cheque in place now and get it back later'. Then I mentioned the term District Valuer…

[Laughter]

John Ashton

You know with the Brook Advisory[76]…that story. We wanted him [Donald Wilson] to invest in teenage pregnancy work and we took him to the Brook, which was quite rudimentary at the time, in Bold Street, upstairs, up a narrow staircase, and we said we want to put money in there. The next thing, *he'd been*, on the Tuesday night or something to see it for himself and he came in the next morning and said he'd been to have a look and there were girls all the way down the stairs on to the pavement with their boyfriends and it was quite obviously what was needed and he approved the spend.

Mike Collier

To just go back to the story of the office, there was a scheme brought in by the Department [of Health and Social Security] that allowed regions who were underspending, rather than the money be lost, they could lend it to one and other, and against his Chairman's best interest I think the Treasurer of Wessex agreed to loan us money and we used that money to complete that particular deal.

Just going back to Sir Donald, he's someone who's had quite a profound influence on my life, in the end all beneficial, but I had some knock-backs from him, and I had some good things from him, but I encountered him in different strata of my life. There are certain common themes which are encompassed in the word leadership. It's having focus, it's having drive, having an imagination and being able to see the bigger and longer picture and that's what he did. He had

[76] Brook Advisory was founded by Helen Brook (1907-97) to provide sexual health information and services for young people. The Liverpool centre opened in 1968.

his own individual style, but he wasn't alone. Duncan [Nichol], you played a major part, in my view, in what he achieved and what he did. I think you worked as a team and again I know from experience between chairman and chief executives it's a very crucial relationship and I think it worked extraordinarily well with you.

Duncan Nichol

What he was fiercely supportive of his people.

[Agreement]

I got myself into a bit of a tangle with the Chairman of the Liverpool Health Authority[77] and there was a showdown in his office, the three of us, and I found it pretty uncomfortable and he was having nothing of it. He was going to make sure that, whatever I had done or not done, he stood behind his person.

Nick Timmins

Did you, as the chief executive to his chair, ever feel the need to restrain him? If you did, was he restrainable?

[Laughter]

Mike Collier

Yes. Of course he did.

Duncan Nichol

I don't think it felt like that at all. I mean you were on a wave and most of the time that was OK because it seemed to hit the right spots, not always, but inside the Region and inside the Department, so what was to worry about this one? He took chances, usually in the interest of speed. He tended to listen to the voices that he wanted to hear from, so he maybe didn't get the full canvass all the time or alternative perspectives, but they were all like that. He may have been slightly extreme in that regard, but I think the extreme version of a lot of people's faults.

Ian Cumming

We may come onto more of this in the next session but I was interviewed by Sir Donald and Robert Tinston[78] for a job which kind of followed on from Mac's [McKeever] role, so this was

[77] James Fitzpatrick (1930-2006) was Chair of Liverpool HA (1986-91), the Royal Liverpool University Hospital NHS Trust (1991-95) and the Royal Liverpool University and Broadgreen Hospitals NHS Trust (1995-96).
[78] Professor Robert Tinston (1951-2010) was Chief Executive of the Royal Liverpool University Hospital (1989-91), Deputy (1991-93) then Chief Executive (1993-94) of Mersey RHA, and Chief Executive of North West RHA (1994-96) and the NHS NW Regional Office (1996-2001).

late ’91, early ’92. The interview lasted less than five minutes, he asked me one question which was: ‘Are you any good?’

[Laughter]

At the end of that question he turned to Robert and said ‘he’ll do’, got up and left and that was the entirety of the interview. I want to just pick up this issue about bully, risk-taker, innovator because I think he was all of those. Now personally I never once felt bullied by Sir Donald. I felt that he was a *very* assertive performance manager, but I personally didn’t feel bullied, I know other people did. One of the things about Sir Donald, and we’ll come to this later on I’m sure – we decided we were going to send 60 cardiac patients from the North West to HCI [Health Care International] Hospital as it was then, Clydebank in Glasgow[79], which would be about ‘93/‘94, and I was a bit nervous about this for a whole host of reasons. Sir Donald came into my office and he knew I was nervous and he said: ‘If this works, it’s yours, if it doesn’t I’m taking the blame’. That was sort of the protection that he put around some of his people, encouraging you to take risks, encouraging you to innovate, but also I found him quite supportive when it actually came down to it at the end of the day. I think there’s plenty of other stories that I’m sure we’ll come on to when we talk about the merger.

Pearse Butler

I think it’s interesting. I saw Sir Donald both under Duncan [Nichol] and then under Geoff [Scaife] and I think there was a difference. I can give you an example of where, to your favour Duncan, control is the wrong word but Sir Donald *made sure* what he did agreed with what you did. I can remember seeing Ben Meade[80] who was a cardiac surgeon running the Cardiothoracic Centre,[81] he said one day Sir Donald came round and promised him the biggest capital expenditure imaginable as they were going for trust status. Duncan rang him the next day and said: ‘you know that conversation you had, it didn’t happen’, and Ben understood that. Actually I thought he was *really* well directed under your time [Duncan Nichol], genuinely, I thought less so later. I think many of the apocryphal stories, in my judgement were later stories. That’s from someone who worked under both of those.

[Agreement]

Mike Pearson

I echo that entirely. I saw that and encountered it. Two comments on that. Firstly, because he was disliked almost universally by the medics he was also feared by them, because they knew if he said something he probably meant it. The discussions between Region and hospitals in particular I think had more bite because they thought there was some force behind it. But from

[79] The HCI Hospital opened in 1994 as a private venture, needing funding from the NHS and Scottish Development Agency to continue. The hospital was purchased by the Scottish NHS Executive in 2002 as the National Waiting Times Centre, before being renamed the Golden Jubilee National Hospital.

[80] Ben Meade was a consultant cardiac surgeon in Liverpool (1970-2001) based at Broadgreen Hospital and the first Medical Director of the Liverpool Cardiothoracic Centre NHS Trust (1991-2001).

[81] Liverpool Regional Adult Cardiothoracic Unit was established in 1981 with the merger of the Regional Cardiothoracic Unit at Sefton General Hospital and the Chest Centre at Broadgreen Hospital. The Unit became the Liverpool Cardiothoracic Centre NHS Trust in 1991, renamed the Liverpool Heart and Chest Hospital NHS Foundation Trust when it obtained Foundation Trust status in 2009.

a Regional Medical Advisory Committee point of view, I have to say, going to Sir Donald and having so saying 'Look you did say this last year, you seem to be changing your mind, do you really mean it?'. 'Did I say that? OK', and he would listen. I grew to respect him as a man of his word who if you pointed out that he might actually be wrong, quietly, he could accept and change. Never be a drinking companion of mine.

[Laughter]

I don't think I walked the same corridors that he walked, but I grew to respect him for that.

Kathy Doran

I don't think I've ever really come across gender discrimination in the NHS. The closest I came to it was with Sir Donald. It wasn't direct but I was working for him, alongside Mac [McKeever] at the time, in 1990, and I decided to have my third child so we did all the necessary to get to that point, and at the relevant time Geoff [Scaife] said 'You have to go and tell him yourself', so off I went to tell him and he said 'Is it a bull or a heffer?' and never spoke to me again. At all.

[Laughter]

Pearse Butler

My late wife had exactly the same experience when she worked in the Region and became pregnant with our second child.

Rosemary Hawley

If I can just follow that up. You'll remember when Virginia Bottomley[82] said there have got to be more senior women in everything in the health service,[83] he thought it was absolute rubbish. But because he'd been told to do it, he said 'Right if you want more women, you can have more women: you, you, you and you'.

[Laughter]

John Ashton

Well that was at the Christmas drinks do at Hamilton House, and he said to all of us 'When you come back in January, I want you to each come back with six names of women, I don't care what party they are so long as they are good women', because he'd had the word on the

[82] Virginia Bottomley (Baroness Bottomley of Nettlestone) (1948-) was a Conservative MP for South West Surrey (1984-2005) and Minister (1989-92) then Secretary of State (1992-95) for Health.
[83] Women in the NHS was launched in June 1991 by Virginia Bottomley when Minister of State for Health. For details see: P. Iganski & D. Mason (2002) *Ethnicity, equality of opportunity and the British National Health Service*. Aldershot: Ashgate, 30-53.

quiet from London that Mrs Thatcher wanted more women non-executives and he wanted to be in there first with Mersey.

Rosemary Hawley

Virginia Bottomley, who leaned on him lots in other ways and was always ringing him up, but she wanted this, and he thought that this was ridiculous but he could deliver it, and I was sent along to help with this. I think that was an example of something that came down from on high and he said 'Well if they want that I will deliver that'. On one side there was pleasing the government enough but also then there was having his own ideas and wanting to get ahead and one thing I remember, on the evening of Hillsborough[84], he rang me up at home and said 'What are we going to do about this?' and I said 'What do you mean what are *we* going to do about this?' Immediately that day he was moved by what had happened, it was affecting our area, so what were we going to do and there were all sorts of ideas by the next day. The quickness, and then the trusting – he spotted very good people – I mean that may have been a ridiculous interview but he knew what he was about, and then he would support people and trust people. That was good. It didn't mean he didn't have run-ins – partly over you lot.

John Ashton

There's a codicil to the Hillsborough thing which is that I discovered years later, after Bishop Jones[85] had done his panel[86] and everything got put on the net, there were letters that had gone in to the coroner from about seven or eight different sources including Downing Street and Whitehall and the Regional Chair of South Yorkshire and the office in Mersey, that used the same *phrases* to say how wonderful the emergency services had been. It felt as though that had been orchestrated from London somehow. So that is there.

Nick Timmins

Right. Chris who's been waiting very patiently for ages.

Chris Vellenoweth

I was Head of Regional Services for four years and worked quite closely for Donald Wilson, and indeed Duncan [Nichol], and Duncan may remember this one; just two quick anecdotes which are not apocryphal, they are true. We had a Department of Health review which was conducted by colleagues from the Department of Health and it was an executive-only meeting, and the Chair, the members, were not expected to be there. But Sir Donald, of course, wanted to be in on *everything* and he was desperate to be in on this meeting. Some of us will recall that

[84] The Hillsborough football disaster occurred on 15 April 1989 at the FA Cup semi-final between Liverpool and Nottingham Forest. 96 Liverpool fans died in the ensuing crush following overcrowding.
[85] James Jones (1948-) was the Bishop of Liverpool (1998-2013).
[86] The Hillsborough Independent Panel was appointed in 2009 and delivered its verdict in 2012. Hillsborough Independent Panel (2012) *Hillsborough: the report of the Hillsborough Independent Panel*. London: TSO.

Donald used to wear a tweed flat hat and one of our colleagues, John Wood[87], did a cartoon which really ought to have been kept in the archives, because Donald's comment was 'I'll just be a fly on the wall'. And John did this wonderful cartoon of a great big bluebottle with a flat hat overpowering and overtaking the room.
[Laughter]

Absolutely wonderful. The other one is slightly different. We had a problem in Macclesfield and Sir Donald got involved in this, and I was a bit of an intermediary on this with the District concerned and thought it would be a good idea, in Sir Donald's interests, if he actually had a conversation with the Chair. I suggested we went out there and he absolutely wiped the floor with me, he really did go for me in a big way, because he didn't go to see people, they came to see him. And he really went to town. Two days later he invited me to lunch at Oldfield, his house in Pulford with Lady Edna, and we had a very convivial enjoyable lunch and that was the end of that particular episode. At times I liked to believe that he did occasionally realise that he had perhaps overplayed or overstepped the ogre image as it were.

Bob Nicholls

Image 13: Bob Nicholls

I can't match all these inside stories from the Mersey region but I did observe them from the outside, quite a lot of them. I think it goes back to something that we're touching on which is the importance of, particularly post-general management, of the Regional Chairman/Regional General Manager relationship. This would have been Rosemary Rue and Gordon Roberts at Oxford in the days before I got there, but it may be something for the team to look at the correlation of people, of the stories about 'he was a powerful risk taker', well actually there were people *around* him, including Duncan [Nichol], who could manage that. I think Rosemary Rue was extremely powerful and got up the noses of most of the Ministers, because Oxford was Oxford and so on, but with Gordon Roberts it was the opposite way round. He who was the politician – small p – so maybe it was something that goes across, thinking of the size thing, but I think there's also a thing about combinations of people. You saw, with a good combinations in consensus management, I had in Southampton, terrific. Bad combinations of people can be absolutely disastrous.

Nick Timmins

In all these stories, personalities matter, and you just have to recognise that sometimes the chemistry works and sometimes it doesn't. Brian.

[87] John Wood was a health services administrator and junior manager in Mersey RHA who later became Operations Manager at University Hospital Aintree NHS Trust.

Brian Edwards

On the Tuesday morning after Hillsborough Donald [Wilson] rang my Chairman in Sheffield and said 'We must organise a meeting to learn together', and he did, it's a damn good job we did, because we were able to give that in evidence to the Hillsborough inquiry[88]. That was Don taking that initiative. Secondly, I can confirm the enormous presence at the Regional Chairman's meetings and meetings with Ministers. I've recently been through all the papers for those events and he dominates those papers. Thirdly, I actually was his Chief Executive for a few months when Donald went to sort out Birmingham[89], which he did for six months then Duncan [Nichol] flew me in to follow him. He did three things. First of all he calmed things down. Secondly, he was open with the press and the local radio. Thirdly, he sorted out the local authority and built a partnership with them. *Pure politics*. He was brilliant at calming things down, but when I asked him are we going to take the big decision, which was to take 1,000 staff out of Birmingham, he said 'Impossible, the politics are awful, you can't do it'. So we waited until he'd gone back to Mersey and then we did it. But we wouldn't have been able to do it unless he had built that political foundation, which he was superb at. Give him credit for that. He was a large part of rescuing Birmingham.

Sally Sheard

I only met this chap once and he made a big impression on me as a very junior lecturer, but the lady sitting at the back of the room is Eleanor Sheldon who was Sir Donald Wilson's PA [Personal Assistant]/Secretary for many years. I just wanted to acknowledge that Wilson had a very good team that stretched beyond the managers and non-executives to people in the office. Eleanor, I don't know if you want to say anything about working with him.

Eleanor Sheldon

When Sir Donald retired I bought him Tina Turner's album *Simply the Best*. I said 'You and Lady Wilson could dance to it down at 'Oldfields'', because he was 'simply the best'. There was a paper produced at one point entitled *Patients First*,[90] but in Mersey Region of course, for Sir Donald, patients were first. He loved Mersey and he worked hard to make Mersey the best. Sometimes there were difficult decisions to be made, but he was very loyal to his staff. For me it was an honour and a privilege to work for him and I don't think there has been or ever will be anyone who could hold a candle to him

Sally Sheard

Thank you.

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[88] The first inquiry into Hillsborough was by Lord Justice Taylor (1990) *The Hillsborough stadium disaster: final report*. London: HMSO.

[89] Sir Donald Wilson was brought in as interim Chairman of West Midlands RHA (1993-94) at the request of the Secretary of State following the dismissal of James Ackers. Brian Edwards served as Chief Executive (1993-94) then Regional Director (1994-96) of the West Midlands RHA. For details see: PAC (1993) *West Midlands RHA*; Edwards & Fall (2005) *The executive years*, 101-3.

[90] (1979) *Patients first: consultative paper on the structure and management of the National Health Service in England and Wales*. London: DHSS.

Nick Timmins

Well on that we will go to coffee.

[Interval]

Nick Timmins

Right, so we are about to hit 1988 – *Working for Patients* – implemented in 1991. Before we do can I just go back on two small points. One is that we talked about Griffiths and general management and Duncan [Nichol] said it didn't really change anything, and I kind of recognise from the point-of-view of the region and I kind of recognise that in some other regions as well, but the place it *really* did make a difference was in the hospitals because you got somebody in charge of the blue lamp so to speak. The relationship between regions and districts and chairs might not have changed a great deal, but with hospitals, general management was – I think – transformative, and not always for the good. I don't know if anyone would just care to reflect on that briefly?

Kathy Doran

The allied change was the responsibility for consultants' appointments moving to the units as well because the regions had done that. Until about '89/'90 I think, so it post-dated the general management, but when districts and units got control of consultant appointments that made the relationship very different on a local basis.

Nick Timmins

For good or ill?

Kathy Doran

I think it's for good personally and it didn't make sense that your consultants were appointed by a regional health authority, in my view.

Bob Nicholls

My point about the relationship between the Chair and General Managers being strong – there was another thing which Mike Collier touched on before, that as an administrator and then a manager it was always the cash that worried us – stay within your budget. I'm not sure of the date, but someone will know, but we were also made responsible for quality. A bit odd. One significant thing which was not often mentioned in public was; who was my boss? Was it my regional chair who appointed me, or was it the NHS Chief Executive because of my responsibility as the senior accounting officer? So Duncan [Nichol] could ring me up and he was my boss, and it was fine with Gordon Roberts because he understood, but with the next

man in Oxford, who I won't mention but you will found out, it was a different feel altogether. So dual accountability – the good was single-lined, but that also then suddenly, I think, began to separate – general managers were being pulled from the centre with the clinical community thinking that we're all stooges of whatever government was in power.

Pearse Butler

Can I just slightly disagree with that? I was there as a first wave UGM [Unit General Manager]. I think it produced a different kind of conversation with the clinical community but I was acutely aware that it wasn't the death of consensus management. Actually good general management brought people along with them, you did not drive change over the head of your doctors against their opposition – you would have got killed – you drove them down a path and you took them there over a period of time. I thought that change meant you had conversations with them about issues that you didn't have conversations before: case mix, numbers, quality.

Image 14: Pearse Butler

Bob Nicholls

Yes. I'm talking about the region's perspective.

Pearse Butler

So I think it was a good thing. I don't want it to be painted as sort of the death of consensus management. I never saw it in that way and still don't. But it did mean you were in a conversation that actually never took place before, didn't take place between clinicians before generally, and all of a sudden they were having these conversations about those kind of issues. Which in the end produces the stuff you see today around the CQC [Care Quality Commission]. You couldn't have done CQC if you hadn't had those changes that *started* those conversations.

Nick Timmins

That probably also goes back to the point that by this stage more data was becoming available so you could have the conversation.

Mike Pearson

I agree with that and I think that in the '80s – I was a young consultant at that point – that was when we started having medical meetings which would then be there to advise the management, and the management would generally take notice of those and they were broadly consensual. They were sometimes consensual in the sense that 'There's no money so you can't do it'. 'We want'. 'You can't have', was a bit of it. 'We've got to reduce beds'. 'Where are you going to make those cuts?' 'You choose'. Between a rock and a hard place. They were

uncomfortable some of those but it was a level where you started to be counting and detailing what was going on and that, I think to many of my senior colleagues, was quite a shock to suddenly find that someone was watching.

Nick Timmins

Fully acknowledging your point Pearse [Butler], but there was certainly in some places – the last remnants of the Medical Superintendents would have disappeared by this stage – and certainly amongst quite a lot of clinicians they felt disempowered by the arrival of general management. I kind of accept that good general managers did a good job of it, but in places there was quite a bit of warfare and given what you were saying earlier Mike [Pearson] about the power of the clinicians in the past in Liverpool, was that an issue?

Mike Pearson

Image 12: Mike Pearson

I think there were issues and it was probably most stark around specialisation. There were specialist units in Liverpool which were quite powerful, generally *not* in the Royal [Royal Liverpool Hospital]. The Royal wanted to be known as 'the bee's knees' but suddenly specialisms were becoming more important and of course that was a trend and we don't have general physicians any more in that sense. You would have a cardiologist or a renal physician, a geriatrician or whatever, but change in specialisation happened in parallel with this change in management. That both empowered and disempowered clinicians to start shouting for more and it became harder to cut some services because suddenly you had a specialist service which was 'the bee's knees' and it was going to make such a big difference and there was always, this bit of shroud waving, you could have to say 'I need more for my specialty'. The Royal was struggling to keep up at that point. Academically, the Royal had the University and it had many of the senior Chairs, who were very influential around the clubbable in Liverpool, but much of the work was going on in the DGH's and the rise of the Chesters and the Warringtons and the Whistons was paralleling in a way the decreasing importance of the Royal Liverpool.

Sally Sheard

I don't want to have too much of a digression but could you just reflect very briefly Mike: Do you think any of that is the Henry Cohen legacy?[91]

[91] See note 35.

Mike Pearson

The situation at the Royal? Very much. So, the senior physicians who were there when I was training were very much part of the appointees of Cohen and colleagues. They would remember him. Yes, there were still people at the Royal when I was training who thought general medicine was 'the bee's knees' and you didn't need specialists.

Ruth Hussey

I think it would be really helpful to unpack that transition to NHS Trusts. Mersey – Liverpool specifically – has a different arrangement of Trusts linked very much to, I think, what Mike [Pearson] was saying about small specialist units having a strong voice and link directly to the Region. If you look around the country I can't think of anywhere else that ended up with so many small specialist hospital Trusts. I would love to know, from the people in this room, how that came about, because I would argue that this has been something that has influenced the pattern of healthcare in Merseyside ever since. Even now, today, 25 years, 30 years later, the merger of Aintree and the Royal is on the cards *again* and I remember it being discussed after the '91 re-organisation.

Kathy Doran

Sir Donald [Wilson] was very instrumental in the development of the specialist trusts. I remember as part of my role in implementing *Working for Patients* being sent over to Clatterbridge, interestingly which I now chair but that's by-the-by, and there was a senior clinician whose name now escapes me and a grade four administrator, and that was it, that was their infrastructure in those days. To persuade them that they really ought to have a Trust for Clatterbridge for cancer services and I think the same went on with Walton Neurosciences and again, Ian Williams[92], he had to be persuaded by Sir Donald that he wanted to put forward a proposal for Walton to be a separate trust. Sir Donald had decided, and I think it was partly wanting to get a lot of trusts…

Pearse Butler

It was numbers. He wanted the Region with the most first-wave Trusts.

[Agreement]

Kathy Doran

Yes, I don't think it was about the specialisms at all.

[92] Dr Ian Williams was a consultant at Walton Hospital (1977-2003), Chair of the Regional Medical Advisory Committee (1981-87) and Medical Director of the Walton Centre for Neurology and Neurosurgery (1992-2003) when it became a second-wave NHS trust.

Pearse Butler

Can I say it's still having a massive financial impact on the NHS in Liverpool today. The Royal and Aintree are merging, and it will happen but the problem will be, if you keep specialist services out it will never be financially viable. All the big teaching centres make money out of specialist services because of marginal costs, the economics of it are obvious, and it's not going to be viable.

Chris Vellenoweth

All this goes back, all of this has its roots in Cohen's plans to create specialist units in general hospitals in order to lift the standing of those general hospitals, which is why cardiothoracic went to Broadgreen, burns went to Whiston, radiotherapy went to Clatterbridge and so on. It's that legacy that we're still dealing with – the argument about where vascular surgery should end up – and so on.

Hugh Lamont

Did the Pan-Liverpool Report[93] have some bearing on the way hospitals…?

Rosemary Hawley

Yes, I hoped we would talk about that, because over tea I was saying 'Now these mergers are happening, but when the Pan-Liverpool Review came it didn't lead to much change, but Mike Pearson was saying 'Yes it did'.

Mike Pearson

I sat on that little group. I think it had a number of effects. The biggest change it made was the reduction in casualty units as they were then from four to two. Aintree agreed that they would have just the one at Walton, and the Broadgreen one was shown to be non-viable by the A&E [Accident and Emergency] physicians, which gave the permission to get past the politicians who were fighting to keep it open. Because there was a huge thing in favour of Broadgreen, it was a very popular unit, hugely popular, but it was never going to be viable with a single consultant who could only be on for 40 out of 160 hours in a week. So the Regional Medical Committee did have that effect, and they had a bit of impact in things like eyes and ENT [Ear, Nose and Throat] – one was focussed at Royal and one was focused at Aintree for example – things of that sort, but it never had the opportunity to make a big shake up because the

[93] The Pan-Liverpool Review was established to review the medical services of Liverpool and South Sefton DHAs. The review was Chaired by Professor Frank Harris (see note 95), with Professor Sir Alasdair Breckenridge (see note 135), Sir Ian Gilmore (1946-), then Chair of Liverpool District Medical Advisory Committee and a consultant at the Royal Liverpool University Hospital, Mike Pearson, Peter Simpson (see note 98), Professor Rossall Sealy (1927-2006) who was Director of the Regional Centre for Radiotherapy and Oncology at Clatterbridge Hospital, and Ben Meade (see note 80). F. Harris (ed.) (1989) *Report of the review group into the future of medicine in the City of Liverpool*. Liverpool: Mersey RHA.

opportunity to join those trusts – they were two cultures that were so far apart that I don't think anyone could have…

Rosemary Hawley

Can I go back to something you said just now about the appointment of consultants? So, who is then responsible if something then goes wrong with that consultant? And this is because a long time afterwards, I understand that Sir Donald [Wilson] was deeply, deeply personally upset by what happened at Alder Hey[94] and thought it was partly his fault, and this is part of defending and looking after your own and the Mersey family and so on. I mean he didn't personally make that appointment, but when it went so wrong with such a big national tragedy and scandal, he felt to blame.

Pearse Butler

The Region did have hands all around the appointment.

Rosemary Hawley

I didn't know how close that was.

Pearse Butler

That was two or threefold. One is Frank Harris,[95] who we haven't spoken about. He was a hugely powerful in figure in Merseyside, and almost beyond paediatrics I'd argue.

[Agreement]

He was significant in that appointment. I remember it clearly: 'I can't get a paediatric pathologist. I've found a person. I'll construct a job to get the person', and probably didn't do enough due diligence. It was made for a study of infant death with a charity, and the Region had hands around it. To be fair a lot of that was Frank. Frank would cleverly play either the Professor, the Dean or a member of the Regional Health Authority when…

Mike Collier

He came to tell me what a wonderful appointment he had made.

[94] The scandal at Alder Hey concerned the removal and retention of children's organs by Professor Dick van Velzen without parental consent. The report of an inquiry was published in 2001 and informed the 2004 Human Tissue Act. For details see: M. Redfern (2001) *The Royal Liverpool Children's Inquiry report*. London: TSO.

[95] Professor Frank Harris CBE (1934-) was Professor of Child Health and the Director of the Institute of Child Health (1974-89) at the University of Liverpool where he was also Pro-Vice Chancellor (1981-84) and Dean of the Faculty of Medicine (1985-89). He was a member of Liverpool AHA (1977-82), Liverpool DHA (1982-84) and Mersey RHA (1983-89).

Pearse Butler

I can believe it Mike.

Nick Timmins

Duncan, when Ruth [Hussey] originally asked the question about 'Why so many Trusts' you were grinning ear to ear.

Duncan Nichol

The simple answer is: 'How does a small region get more Trusts than anybody else?' Well, you count everything that moves.

[Laughter]

Sylvia Hikins

If you look at things at the time, in effect you are facing an £11m funding cut threat unless hospitals opted out; so that was the driver wasn't it?

Nick Timmins

Let's just pause that for one second. Just let's say we get *Working for Patients*, Duncan Nichol moves up to the centre, and we have to get Trusts off the ground, and we have to get GP fundholders off the ground.

Mac McKeever

If I may, around this time, there was a deal of pragmatism, I absolutely remember that, but fondly I also remember that this was a time – an echo of points that you'd been developing in your time during your time at Mersey Duncan [Nichol] – the need to get clinicians and clinical leaders in place. I think of Aintree and Broadgreen and the characters Ian [Williams] and Ben [Meade] who were moving forces, Kathy [Doran] then came along with others and helped develop that and underpin it, but we did get clinical leaders: David [Colin-Thomé] in general practice, other people in fundholding around that time. A much-forgotten theme, of the Griffiths reforms about getting clinicians in leadership roles, was being played out in Mersey and it wasn't an accident. There may not have been as many as we would have liked but where they were there they got backed, they got supported, they got encouraged, they got pushed to the front and I couldn't tell who was leading the lobster quadrille when somebody like Ian would be talking to Sir Donald and being persuaded about what they needed to get.

[Laughter]

I should think that was a two-cornered fight really.

Duncan Nichol

The wider question which we touched on, I encountered it in London with Virginia Bottomley when Leslie Turnberg[96] came in to look at London and seventeen of this and six of that. I worked in all three teaching hospitals in Manchester. It took forty years to work anything sensible out there. The issue was not what do you attach the label 'Trust' to, it is what is the right clinical configuration? That doesn't mean to say you can't have an independence for a specialty as long as it arguably, virtually, is on the same campus at least and part of a joined-up academic health care science centre, arguably in Liverpool. This is easily reconcilable. The thing that stops it is that not all clinicians want to give up where they are at the moment.

[Agreement]

We had the most bitter, bitter fight in Chester with Arrowe Park [Hospital] about vascular surgery.

[Agreement]

The general wisdom, driven by the Royal Colleges is that you need a million people [to support a specialist unit], so Warrington and the Wirral and ourselves, that's a million people between us: who should have it? 'We'd rather stay where we are' 'To hell with the patient, rather than Chester have it'. So that's what it's really all about and then you are looking for the leadership, I believe from a Regional level, to resolve some of those issues because they are not going to be resolved locally very easily. I suppose that's my big beef with the STPs,[97] I mean what on earth is this all about? Change the law at some point, fine, we may go back to roughly where we were but on an integrated agenda rather than a narrow agenda. But it's about planning specialty care appropriately; the concentric rings of what should be in your DGH, the next ring out, the next ring out, then the stuff you will probably see in your region.

John Ashton

I think there's a number of themes running; I'm just trying to make sense of it really. One of them is the leadership thing and the nature of the leadership thing and the parallel courts that were in existence. Particularly the clinical court versus the general management court. At its most bizarre was that Christmas at Hamilton House when Peter Simpson[98] had his party and Geoff Scaife had his party and nobody was talking to each other across the divide. This thing about the medical court and the general administration court – and Frank Harris's own little court somewhere over there – and this leadership thing.

There's a number of points I want quickly to make. The specialty hospital things didn't start in recent times because Liverpool used to have lots of specialty hospitals. It had an ENT Hospital, it had [St Paul's] Eye Hospital, it had the Seaman's Dispensary, it had the [Hahnemann] Homeopathic Hospital, it had all sorts of these, in common with some of the big cities. I mean

[96] Professor Leslie Turnberg (Baron Turnberg of Cheadle) (1934-) was Senior Lecturer (1969-73), Professor (1973-97) and Dean (1986-89) of Medicine at the University of Manchester and President of the Royal College of Physicians (1992-97).

[97] Sustainability Transformation Partnerships were established in 2016 to improve arrangements between health and social care across NHS and local authority boundaries and services.

[98] Dr John Ernest Peter Simpson (1942-2018) was Regional Medical Officer for Mersey RHA (1988-93).

Paris had the most specialised hospitals I think – the history of that is something for Sally's team at some point – but that preceded Cohen. The Cohen thing itself, for those who haven't read it, it's worth reading Anthony Seldon, who some of you will be familiar with, Anthony is now Vice Chancellor at Buckingham University, but his [late wife] Joanna was the daughter of Pappworth[99] who wrote *Human Guinea Pigs*,[100] and he trained at Liverpool and he was completely side-lined by Cohen. It's worth reading Joanna Seldon's biography of her father[101] which she completed just before she died about his experience in Liverpool with Cohen. That's just an aside really but it's part of the story, I think.

The Deanships; people will remember that the role of the Medical Deans is very important in this story and we've hardly touched on it. There have been some, but not many, strong Medical Deans. I came back here in '82 and Shields[102] was the best one possibly and then Mike Orme.[103] The thing was that there was a seat there which no-one wanted to occupy a lot of the time and it was very difficult to get anybody decent to step forward to be the Dean. In recent times the Medical School has had problems, it's only in the last few years – less than five years – that its really began to get its act together again. The role of the Deans as a part of the leadership *system*, instead of people being off in their own courts is part of this story as well.

I just want to say two things about the Regional Medical Committee because when I first took on the role of Regional Medical Officer, one of my first experiences there, where I had referred somebody for an external review because of complaints, was I had a visitation from a very senior member of the medical establishment who said to me 'Johnny Ashton'… I've never been called Johnny in my life…

[Laughter]

He said, 'Johnny Ashton, look, if you are going to get on in this job you're going to have to learn a thing or two' and I was Regional Medical Officer. This was a thing about the Regional Medical Officer being the doctor's doctor, and being there to look after the doctors' interests as opposed to the corporate interest.

David Colin-Thomé

Hospital doctors.

[Laughter]

[99] Dr Maurice Pappworth (1910-94).
[100] M. Pappworth (1969) *Human guinea pigs: experimentation on man*. London: Routledge and Kegan Paul.
[101] J. Seldon (2017) *The whistle-blower: the life of Maurice Pappworth: one man's battle against the medical establishment*. Buckingham: University of Buckingham Press.
[102] Professor Sir Robert Shields (1930-2008) was a consultant at the Royal Liverpool University Hospital and Professor of Surgery at the University of Liverpool (1969-96). He was also a member of Liverpool AHA(T) (1974-78) and a member (1982-94) and Vice Chair (1985-6) of Mersey RHA.
[103] Professor Michael Orme (1940-) was a consultant at the Royal Liverpool University Hospital (1975-2001) and a Senior Lecturer (1975-81), Reader (1981-84) and Professor (1984-2001) in Clinical Pharmacology at the University of Liverpool, where he was also Dean of the Faculty of Medicine (1991-96).

John Ashton

Hospital doctors, yes. So at the first Regional Manpower Committee I went to I was totally gobsmacked and taken aback by the dynamics of that meeting because it was basically a question of which consultant had the biggest manhood – getting the most senior registrars, that's what it was all about – it was nothing whatsoever about planning services on a rational basis. It was all about macho power-broking for traineeships. It was an unbelievable experience.

Mike Pearson

It was a Liverpool-centric experience; the further you were away from the Liver Birds the less influence you had.

John Ashton

Then the other thing, of course Peter Simpson as the Regional Medical Officer – when I'd been doing the health promotion stuff from the University and then when Duncan Egdell[104] – that's a story in its own right – Duncan Egdell would have his meetings on a Tuesday morning and the rules were that there could be no agenda and no one could talk about health.

[Laughter]

He used to smoke his pipe watching the Isle of Mann boat going out down at the pier. When Egdell went, and I'd been getting on and developing the work on health promotions and so on – Ruth [Hussey] had already decided to cut adrift from the University and go and be DPH [Director of Public Health] for Liverpool, which is a great thing to do – but I applied for the job Simpson got because they wanted a doctor's doctor at that point. He was drafted in from the Department of Health. When that didn't work out and a Third World War was going on between the general management side of the house and the medical side of the house and eventually Peter went, I applied again a second time and they changed their thinking and saw that maybe public health was coming up on the rails and it had never been a regional function until that time and so they appointed me. When we merged with the North Western [region], my experience of being interviewed, and Ian [Cumming] might have been at that interview for some reason, he might have been carrying Sir Donald's [Wilson] bag for him I think…

[Laughter]

That was when it was either Stephen Horsley[105] or me to be it for the new North West Region. Well that interview must have taken a maximum of ten minutes because that was a takeover, that was not a merger. Sir Donald was quite clear that it was going to be me and so that was the way it worked. Then when they decided to abolish the Regional Medical Committees, I can't remember which year that would have been, I was sent into Salford to meet the consultants from that side and I had to break the bad news to them that the Regional Medical Committee wasn't going to continue anymore. We started to have this conversation and it went

[104] Dr John Duncan Egdell (1938-2017) was Regional Medical Officer for Mersey RHA (1977-86) and held an Honorary Lectureship in Community Health at the University of Liverpool (1980-86).
[105] Dr Stephen Horsley (1947-) was Regional Medical Officer for North Western RHA (1986-94).

on for about ten or fifteen minutes before I realised that their understanding of multidisciplinary was doctors and nurses, none of the other clinical professions whatsoever, and that was their understanding: that we're going to have to do stuff with the nurses and not just the doctors anymore. That was just about acceptable, but I had to clarify the situation actually that it was going to be multidisciplinary and multidisciplinary wasn't just doctors and nurses.

Nick Timmins

That last bit jumps forward a hell of a long way.

Mike Pearson

Can I take it back? One of the things that happened in the late '80s, again it was an initiative which I think came via Sir Donald, was sending medics on management courses. This was the first region to do it. I was the first *victim*, but it was the best course I ever, ever went on in my career.

[Agreement]

I went to Ashridge. I had wonderful experiences there. It was about 'Can you bring medics on to actually understand what management is about' and I think that was quite formative about what happened later in the '90s.

Bob Nicholls

I just want to hear from our GP. This is very interesting and I'm smiling at John's [Ashton] story… I think I'm in Bristol at this point and its exactly the same issue of power and powerful groups leading at particular times – even more in Oxford – but as David [Colin-Thomé] keeps reminding us – I thought we were going to get a bit of that at last – I mean '74 didn't really bring primary care or general practice in at all. The thing that did it was GP fundholding.

Just to finish the stories about Trusts and specialist hospitals; this man [Duncan Nichol] rings me up and says 'Nicholls, your new chair has got a revolver in his briefcase, and it's for you unless you get the number of Trusts up'.

[Laughter]

Me? Meek and mild diplomatic Duncan? I got the message. The only one I could get in year one was the Nuffield Orthopaedic Centre who hated the JR [John Radcliffe Infirmary, Oxford] and didn't want to be taken over. According to the regional plan they had to merge; they had to come onto the same site. So that was interesting. Luckily I had GPs who were pretty good and I had an ex-SAS officer who I put in charge of GP fundholding and we were top of the league of GP fundholding! Bottom of the League for Trusts, but I just about hung on to my job.

[Laughter]

It would be really nice to see, was it GP fundholding, when finally did healthcare, community, primary, mental; when did it actually begin to come together and did the internal market help?

Sylvia Hikins

Can I say that what is coming across to someone who is outside of all this is an incredible scenario, not of consensus management, but of coercive control, that was mainly male based and probably based on a certain background of education as well, and I'm surprised it actually worked out as well as it did to be honest.

[Laughter]

Nick Timmins

So we reach the stage where Mersey has become top of the performance tables rather than bottom of the performance tables. There's the move to get *Working for Patients* done and Mersey ends up with the highest number of Trusts in the first wave and the highest number of fundholders. So why?

Sylvia Hikins

What were the casualties in all this? We're only hearing about the success. We're only hearing about the good times. What about the casualties?

Mac McKeever

Image 15: Mac McKeever

I think we should hear from David [Colin-Thomé] about fundholding because that will paint an interesting picture. Just on the things that we drove and the things that happened, I think there was a tight agenda of things that we all operated on and that can be caricatured in the way that you describe. There was also a lot of happenstance and opportunity that came with things that developed. The emphasis on developing clinicians and clinical leaders driving change had other spin-offs. One of the things I remember from about the same time in Mersey was the way in which Mersey got to the front of developing the NHS's systems for clinical indemnity. We were the first to establish arrangements – insurance arrangements – within the NHS to replace the old Crown Indemnity.[106] Indeed one of the Vice Chairs of the RHA went on to become the Chairman

[106] Before 1990 medical negligence claims were funded through medical defence subscriptions as part of regional contracts. After 1990, clinical indemnity was the responsibility of NHS organisations, later amalgamating as the Clinical Negligence Scheme for Trusts. GP indemnity only began in April 2019 with a new contract. For details see: National Audit Office (2001) *Handling clinical negligence claims in England*. London: TSO; BMA (2019) *General practice state-backed indemnity scheme and its impact on overall pay*. London: BMA.

of the legislative authority.[107] As well as this tight agenda which was driven fiercely in the way that we describe, there were lots of things happening sporadically because somebody around the region had a passion for it and an opportunity to drive it and had earned credit for achieving something on one front that happened alongside it. Fundholding, to me, felt like that more spontaneous eruption within the region rather than something that was orchestrated. Yes, we were there counting and doing all the rest of it but from David's end I bet it was a completely different perspective and story.

David Colin-Thomé

Well the message we got from Mersey Region, which wasn't the same round the country, was this was something we had to do, so there was a regional emphasis on this. That also spun off to the local health authorities because they got the message too, and again, in lots of regions you'd get about 10% or something of fundholders. In North West Region, as it was then, you'd a juxtaposition of about 80% of fundholders in one health authority and 10% in the next and that was to do with leadership. So the person who in that atmosphere had the most impact on me – and no one has mentioned this – was the FHSA Chief Officer which was Clive Parr[108] in Cheshire. I had tensions because my party was against all this nonsense and yet to me it seemed exciting.

John Ashton

The letter to Neil Kinnock.[109]

David Colin-Thomé

I know. That came later. So he [Clive Parr] persuaded me saying 'David', because he knew me, because I'd always been quite keen on pushing on general practice, 'This is what you've been waiting for', and so I became one. I suppose the thing was interesting because, for me, I didn't give a bugger about purchasing. I wanted a budget and that was the only way I could get a budget. And despite that not being the norm, Sir Donald [Wilson] was keen because I had got a high profile and was going around to conferences and knew Ministers and all that stuff. So he loved his leading lights, whatever you were doing, as long as we were good. One of these little stories; I was at a Mersey function and he said 'Colin', you know he could never get my name right...

[Laughter]

He took me out and said 'Look, you know, I've been warned against you, because I believe you're a Labour supporter', and he said 'I don't give a fuck what you are, you do a good job,

[107] The NHS Litigation Authority was formed in 1995 to administer indemnity insurance and manage legal claims made against services provided by the NHS. It was renamed NHS Resolution in 2017. Sir Bruce Martin (1938-2018) was Vice Chair of Mersey RHA (1986-88) and the first Chair of the NHS Litigation Authority (1995-99).
[108] Clive Parr was the Administrator of Cheshire FPC (1975-89) and General Manager of Hereford and Worcester FHSA (1989-96)
[109] Neil Kinnock (Baron Kinnock of Bedwellty) (1942-) was Labour MP for Bedwellty (1970-83) and Islywn (1983-95) and Leader of the Labour Party (1983-92).

come in and have a drink', and it was that sort of atmosphere of support in a bizarre way. I didn't think he was a nice man but he was an energiser and some of us needed that permission and support at a senior level to do it and that's what happened. The regional team led by Mary McVerry[110] and Pauline[111] and Glenys[112] and Val Vernon[113] went out and chatted everybody up and we got lots of support.

Mac McKeever

May I just ask though, who led the dance on fundholding? The fundholders or the region?

David Colin-Thomé

Well once we were allowed to be fundholders as it were, I think it was left to us, and one of the reasons – if I can be a bit pretentious – is that because we were doing stuff, of course, Ministers learnt from us as well. We had lots of access to Ministers in those times because this policy was politically difficult and we got a lot more influencing in shaping things, so I've always said to GPs 'Go for first wave' then you've got more change of influencing than being told what to do. So we got access and Donald loved all that stuff.

Kathy Doran

You were definitely an early adopter David. I think there were lots of parts of the region who weren't as keen. The regional team did spend a lot of time going out and persuading and cajoling. If I remember my old patch even before you were there Pearse [Butler], I remember stories of them having very hostile receptions from the GPs originally, and one or two got interested. Then the team worked with them, but I think it was a mix and match. I think it took quite a lot of stimulation from the regional level

Nick Timmins

Can I just interject there as well? This is all being talked about in terms of the influence of the region on all this, there were the Local Medical Committees.

David Colin-Thomé

Yes, but they were against all this stuff.

[110] Mary McVerry was Director of Primary Care at Mersey RHA (1989-93).
[111] Pauline Cook was a Primary Care Manager for Mersey RHA (1989-91).
[112] Glenys Marriott was Deputy Unit General Manager for Sefton DHA Community Services (1987-89), Fundholding Lead North (Merseyside) for Mersey RHA (1989-90), and Chief Executive of Wirral FHSA (1990-92) and Cheshire FHSA (1992-94)
[113] Valerie Vernon was Fundholding Lead South (Cheshire) for Mersey RHA (1989-92).

Nick Timmins

I was about to make that very point. They were against all this. There was war. Fundholders were called quislings by some of the doctors.

David Colin-Thomé

Image 16: David Colin-Thomé

One of my proud achievements is I've never been a member of the BMA [British Medical Association] so…the LMCs [Local Medical Committee] were generally against it and we got to the bizarre situation where the national council was against fundholding when the majority of them were fundholders. So we did it despite that because we were that sort, the first wave. By the time seven years went down the line and it was abolished there were over 50% of us around the country and a lot of that was spread by enthusiasts enthusing other people - something we are trying to mimic with this Primary Care Network stuff.[114] That's the history of where we were, but the budget was to me was important, and it did more for primary care, if you look at all the assessments from Howard Glennerster and things,[115] rather than all this purchasing nonsense.

Ruth Hussey

That was a real issue though in Liverpool because there were so many single-handed doctors.

[Agreement]

Yes, the profession wasn't necessarily embracing the concept but because so few took up fundholding in Liverpool the resource distribution then went in completely the opposite direction to the direction you'd have wanted it to according to need. I think I'm right in saying 48% of GPs were single-handed at that time.

Rosemary Hawley

Yes, incredibly. I mean I was Chair of Liverpool FHSA and you see into this mix is a new kind of a health authority which hadn't previously existed. To be fair to Sir Donald [Wilson] he treated us as the Chairs of the DHAs and we all met together. But we were lent on to get people to do this, and in many ways we could see the benefit of doing this. For a long time I thought that GPs should have more responsibility and also more say about the dominance of the hospitals.

[114] Primary Care Networks (PCNs) are a strand of the NHS Long Term Plan which aims to integrate primary care services and GP practices with community and acute secondary hospital providers.
[115] Glennerster et al. (1994) *Implementing GP fundholding*.

David Colin-Thomé

And also management of resource.

Rosemary Hawley

Exactly. We used to say it was like a GP going into a supermarket and filling up the trolley with everything, in terms of referrals and prescriptions, and then someone else pays the bill at the checkout.

David Colin-Thomé

Government took notice of that because remember they introduced community fundholding because there was a population size, so they did find ways to give GPs more say. One of the successes of fundholding I always used to say was anti-fundholding because it got GPs off their backsides. So I was quite close to the anti-fundholders who often used to invite me to their conferences.

Nick Timmins

Yes, there were all these purchasing consortia formed who were not fundholders but were…

David Colin-Thomé

But purchasing was a distraction because the best way to purchase is not to refer because you're doing better in primary care and also to sometimes challenge some of the interventions that secondary care people were doing and things like… you know, we had been fighting to get rid of outpatients for the last twenty-odd, well, hundred years, so it was that way around and we got this rolling program.

John Ashton

I think that there's another theme here which is about people who, in these siloed parallel courts, were moving between different bits of it. David [Colin-Thomé] did that and Rosemary [Hawley] did that. David occupied a space between the Parties as well, which is quite a trick to pull off. He and I used to have regular meetings at Castlefields when we'd chew the cud over, going back to the early '80s, over public health and primary care and population-based approaches and things like that. We used to go and have a sandwich in his lunchtime. When all the row broke out over fundholding early on we wrote this letter together to Neil Kinnock, which I call my 'Letter to Brezhnev'[116] – I've still got a copy of it somewhere – which was basically saying: this isn't all bad, there's something about this the Labour Party needs to get

[116] *Letter to Brezhnev* (1985) is a British romantic comedy about working-class life in Liverpool and the vagaries of life under the Thatcher Government directed by Chris Bernard.

its head round. Neil arranged for us to have tea with Bryan Gould[117], who was at that time a rising star before the great fiasco. So there was this crossover of policy and you moved through that gap in the middle and were able to carry on very successfully for many years.

Rosemary was bridging some of this stuff – she's a major figure in this story – but I'm just reminded of some of the initiatives. Talk about Sir Donald's macho-ness or whatever, but he had a soft part to him as well, and the initiative that he had on children who were care givers, Young Carers[118], which was a major initiative that he had with children who were looking after very disabled family members and Sir Donald was very moved by this. Part of this I think was because he didn't have his own children. He had a soft spot for these kind of issues.

The other one I have in mind is the Sexual Assault Referral Centres[119] where he said to Rosemary 'I want you to go and set some of these up', and you got, what, four semi-detached houses around the region where women who had been raped could be taken to a domestic premise and be interviewed in conducive circumstances and then have a shower and everything when they had finished doing what they had to do. These were things that Sir Donald took up, but where Rosemary moved between the macho neck of the woods and the humanistic neck of the woods.

Rosemary Hawley

Let me pick up on something. What Ruth [Hussey] said about single-handed practice is absolutely a key thing and it goes back to what I was trying to say before about the inverse care law and the nature of general practice. Dave had this wonderful practice that was going against the grain in every way, a large practice in a new town, which was rare wasn't it? Because the pattern was completely different. But I do think when all this came in… to think that the health service took so long to bring in all that… it was still spending public money, still delivering health care but was acting as completely separate and independent. Absolutely extraordinary when you think about it.

David Colin-Thomé

It's an interesting paradox isn't it? Because I know at the time, and it probably still does, the Labour Party was keen on having us GPs as salaried employees of the state and that isn't always a great recipe for success, because it takes away some of our influence. So there was a mixture of these semi-private providers being given a chance to be part of the mainstream health service and *at the same time* being more accountable. It seemed the perfect way to get what we wanted without having some simplistic answers about how you paid and things.

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[117] Bryan Gould (1939-) was Labour MP for Southampton Test (1974-79) and Dagenham (1983-94) who held shadow cabinet posts before resigning and leaving the Labour Party having unsuccessfully challenged John Smith for the Leadership of the Labour Party.

[118] Young Carers on Merseyside was a venture between the National Carers Association, Personal Service Society, Barnardo's and Mersey RHA which informed national policy changes. For details see: S. Bilsborrow (1992) *Young carers on Merseyside*. London: Carers National Association; J. A. Reed (1994) *Young carers projects on Merseyside*. Liverpool: Mersey RHA.

[119] Sexual Assault Referral Centres (SARCs) began in 1982, with Merseyside's first centre opening in 1986 as a partnership between Mersey RHA and the Rape and Sexual Abuse (RASA). For details see: J. Lovett, L. Regan & L. Kelly (2004) *Sexual assault referral centres: developing good practice and maximising potentials*. London: Home Office Research, Development and Statistics Directorate.

Kathy Doran

Image 17: Kathy Doran

Organisationally, also, it enabled the bringing together of the hospital side and the GP side. If you go back, I can remember when we were putting the legislation together in the early '80s surrounding *Patients First*, in the Department [of Health], we looked at whether we could have brought the then FPCs and the DHAs together and there was a terrific rumpus from the GMSC [General Medical Services Council][120] and the Society of Administrators of Family Practitioner Services, on the back of which FPC's were created as separate organisations, and there was still a very great resistance from that part of the world. They were then translated into FHSAs and it was only by, I think, fundholding bringing the two together it enabled us to then bring the DHAs and the FHSAs together and they became single organisations, but that took ten, fifteen years to come through and fundholding was part of the bringing all of that together.

David Colin-Thomé

The other thing is that a lot of the leading lights in general practice after that often had been fundholders, because they were given much more of a leadership role. So forget the fundholding in one sense because it was vehicle. All of us who have been involved in policy around primary and community services see this as trying to find vehicles for these independent contractors. We failed with community pharmacy, but it's those ways of keeping your independence but being part of the system.

Paul Atkinson

Part of the fundholding jigsaw we've not mentioned is the national lobby group for fundholding. How influential was that in the Mersey region? The National Association of Fundholding Practices.[121]

David Colin-Thomé

I was a member. I don't think it was because we were doing it anyway.

[120] The General Medical Services Committee of the BMA represented the voice of General Practitioners and was Chaired during 1990-97 by Liverpool GP Ian Bogle (1938-2014).

[121] The National Association of Fundholding Practices (NAFPs) was founded in 1991 and published *Fundholding* magazine. With the demise of fundholding under New Labour after 1997, NAFP merged with the Association of Independent Multifunds (AIM) in 1998 to become the National Association of Primary Care (NAPC).

Nick Timmins

Can I ask one more question about the first wave, high number of trusts, and the big follow-on thereafter? I mean, certainly in some places the application for a hospital to become an NHS Trust was done by the general manager in the teeth of opposition from the consultants. Did that happen at all in Mersey? It certainly happened in some places.

Pearse Butler

I was at Alder Hey [Children's Hospital] and we had a vote amongst the kirk, and it was absolutely clear if they voted no then it wouldn't have happened. I can remember the evening the vote took place. It was *absolutely explicit*, in fact I think Sir Donald [Wilson] promised it to the doctors: 'If you don't want it…' But he then said to me afterwards 'I never meant a vote, Pearse'.

[Laughter]

We had a vote and they voted yes, so we went forwards. Certainly where I was, and I was a first-wave NHS Trust Chief Executive, it was *absolutely critically dependent* upon clinical support. It was explicit, it wasn't implicit at all.

Bob Nicholls

In Oxford, it was interesting – small region, new people – actually they seemed to like what region did mainly. They weren't interested in all of this and the critical thing Kathy [Doran] mentioned earlier about who was appointing, you would have thought that could have been an issue but no – region appointing consultants was alright – except give a few more to Kettering rather than all in Oxford. We wouldn't have moved without clinical support. The Nuffield [Orthopaedic Centre] wanted to keep away from the JR [John Radcliffe Infirmary], and they had an orthopaedic surgeon and a professor who thought this was exciting. It was only really later…in fact they were one of the last…the lowest take-up of Trusts.

David Colin-Thomé

But Oxford was high for fundholding?

Bob Nicholls

Yes, very high for fundholding.

Mike Pearson

I think a couple of things happened around the '91 reform and the split. The first was that consultants ceased to be appointed to a district but they were appointed to a trust.

[Agreement]

At the same time we also almost completely abolished domiciliary visits and we lost, in that split, the joint meetings that used to happen where GPs came for postgraduate meetings in hospitals. So consultants and GPs split at that point quite considerably and most of the consultants now working in hospitals now have no knowledge of primary care.

David Colin-Thomé

But in the early days of fundholding there was quite a lot of relationships between hospital doctors and fundholders, especially if I can put it this way, the numbers of consultants who wanted to reshape hospitals because there was a common agenda there.

Mike Pearson

Many of those initiatives, like I'd go and do a vascular clinic in primary care, the organisation wasn't there to support them, and people would go out to do a clinic and only three would turn up and it wasn't worth it.

David Colin-Thomé

Yes, but the assessment early on from fundholding was that that was one of the issues that proved to be pretty pointless actually.

Mike Pearson

I think the change in attitude around how you provide services was governed largely by a lack of understanding from hospitals on what was going on in primary care. So the single-handed GPs were a thorn, but they weren't your responsibility anymore and you could ignore them.

David Colin-Thomé

But it had a clinical impact because, number one, we found out that hospitals didn't know which GPs were referring patients, for instance. They didn't keep records. The other thing, it made a big difference to practice organisation because most practices didn't know about each other's referral patterns, so what turned us on was a clinical modernisation rather than some sort of political thing that woke us up to reshape.

Rosemary Hawley

There were lots of knock-ons…

David Colin-Thomé

Well that was the purpose why a lot of us went into it in the first place: having a budget.

Nick Timmins

Can I raise something else, which is not specifically at this time but somewhere round about this period. Duncan [Nichol] goes off to be Chief Executive of the NHS as a whole, but there's actually quite a lot of interchange with people coming in from the Department into the Region. So there's a sort of semi-permeable barrier going on there, did that have an impact on the Region? A, was that typical and B, was there an impact?

Duncan Nichol

There's a slightly wider context there. So when I went there, the NHS Management Executive was populated by eight Deputy Secretaries and I said to Chris France[122] 'I don't want any of them because they don't know anything about the health service'. We coined a phrase at that point which was 'the single centre' and that meant that I would work with the regional general managers as if we were a single centre organisation. The civil servants were not happy about that, Chris France said 'How many more of my people do you expect me to magic away?'

[Laughter]

I said 'Well I don't really mind, we're doing OK, but can we try it this way'. Virginia [Bottomley] said, 'But can we trust them?' I said 'We can't operate unless we change the rules in this way and operate as a single centre'. Now that threw into sharp focus this issue of who were the regional managers accountable to? Did that mean that they were accountable to me? Now I think we could have worked an arrangement with the regional chairs and myself and the RGMs if we hadn't had, and I hate to say it, if we hadn't had some powerful people like Jim Ackers and Don Wilson who couldn't handle the ambiguity and couldn't handle what they saw as the thin end of the wedge and all the rest of that. So I said to Ministers at the time: 'We have to bite the bullet and we have to step down the regions'. A number of Ministers said that would be a big mistake, whilst I probably thought that was the right thing to do, so we had a debate. What I hadn't banked on was the Department of Health being opportunistic shortly down the line a couple of years afterwards when they turned the regional l managers into civil servants. Had I foreseen that I would have put up with Donald Wilson and Jim Ackers.

[Laughter]

Nick Timmins

To follow that point through, as the RHAs began to get wound down, the Chairs survived through all of this. Certainly Virginia [Bottomley], I know, really relied on the Chairs. She'll tell you all the time, 'They were my eyes and ears'. There was this kind of parallel power

[122] Sir Christopher France (1934-2014) was Permanent Secretary at DHSS (1987-92).

structure of the single centre management bit and the Ministerial line down through the Chairs that was different.

Duncan Nichol

Absolutely. There were formal accountability meetings with myself and regional general managers. Another fly-on-the-wall story is that Sir Donald [Wilson] wouldn't have a meeting with me and the regional general managers without being a fly-on-the-wall. These were the *accountability* meetings. They were very clear that we didn't work it to the authority, we worked it down the management line. Even if it wasn't being assumed that I was taking some line control over the managers, it was impossible, and we needed a single centre. We had to have less confusion about who was pulling strings elsewhere. So what politicians did, Kenneth Clarke was certainly amongst them, was to make sure that Chairmen still felt that they had a place in the sun. But no more than that.

Bob Nicholls

At the previous witness seminar[123], Sally [Sheard] will remember, Ken Clarke said without general managers and the single centre, delivering the '90 reforms would not have happened.

Ian Cumming

Just to pick up on Duncan's [Nichols] point, it's really quite interesting and resonates as I became an SHA [Strategic Health Authority][124] Chief Executive in 2009 and we had the exactly the same debate about whether we reported to the Chairs of the boards in the regions, or did we report to David Nicholson.[125] Now we knew in reality that we reported to David Nicholson because that was the very clear line management as far as we were concerned, but we had this board at a local level that we almost pretended that we had a reporting relationship to, with far less powerful chairs and non-exec[utive]s than we ever had twenty years earlier than this era we're talking about now.

Duncan Nichol

One last thing. The two-way traffic; my best example is John James.[126] John James was destined for the heights of the civil service and I was playing that 'Either you or us won't be as competent if he doesn't have a twin ticket'. So folks from the service should come to the centre, and folks from the centre should certainly go to the field. So John said 'How can we do that?' and I said 'Well I will arrange for you to go through Northwick Park [Hospital, North London]', and he said 'Can you do that?' I said 'We'll find out'. So he went to Northwick Park and he

[123] MacKillop et al. (2018) *The NHS internal market*.

[124] Strategic Health Authorities were created in 2002 to provide support to both commissioning and providing arrangements on a regional basis. The original 28 SHAs were reduced to 12 in 2006 before being abolished in 2013.

[125] Sir David Nicholson (1955-) was NHS Chief Executive (2006-14).

[126] John James (1944-) was a Principal (1971-78), Assistant Secretary (1978-86) then Under Secretary (1986-90) in DHSS and Director of Health Authority Finance to the NHS Management Board (1986-89).

never came back to the centre. It was really about saying we should be having people who are excellent thinkers, policymakers, but they need to understand the subject matter as well. It's about the twin ticket, and I still think that's something hugely important.

Kathy Doran

It is interesting though the number that came to Mersey because largely those twin tickets were around London, the big number of them. There's a little trickle and the fact that Geoff Scaife came and then he brought other people in who he had known in the civil service or known of in the civil service, I think that made a difference in Mersey that maybe other regions, not in the Metropolitan area, perhaps didn't have so much of.

John Ashton

That was the civil service bit of it, but the other bit of it was the desire to bring people in from the private sector. I mean there was a flurry of those, some of whom didn't last very long at all.

Nick Timmins

Yes. But that was not unique to Mersey.

Pearse Butler

That was years earlier, maybe ten years earlier.

David Colin-Thomé

In New Zealand it lasted longer I think, the private sector involvement, but that went as well even though it persisted longer

Mac McKeever

The other thing that strikes me is that the flow wasn't *only* into the region from the Department, there was a flow out into the real NHS from the region as well in Mersey, which was again not accidental but orchestrated. I think that had a sort of microwave effect; its effect went on long after you'd done it. Ian [Cumming] is another person who travelled through the RHA and then on to the outside world. Kathy [Doran] and others the same.

David Colin-Thomé

I had a part time job at North West Region as it was then, even though I was still mainly out there, so there was this effort of trying to make it more comprehensive.

Nick Timmins

Do you think what you describe was atypical for Mersey?

Mac McKeever

I think it was intended and something that was shared within Mersey. As Kathy [Doran] said, I don't think it was typical in other regions.

Nick Timmins

So we've hit all this and Geoff Scaife has arrived replacing Duncan [Nichol]. Did that change the way things worked?

Mac McKeever

I was there at the time bridging that. I think the points made earlier about the relationship between Sir Donald [Wilson] and the general manager naturally shifted at that point.

[Agreement]

Geoff had many things in common with the way he went about things with Duncan because he'd learnt in that tradition, but I think they were noticeably different and subsequently when Rob Tinston came, again there was a shift there, so I can certainly see a shift.

Nick Timmins

Would you like to describe how they were different?

Mac McKeever

I think they were a continuation of things that had started with Duncan. The links with the departments and down into the districts and so on that was a theme that was developed. Duncan had developed things around the Regional team, the leadership team and links out into clinical leaders, they were things that Geoff tried to build on. He was playing catch-up in some respects, we spoke earlier when Brian [Edwards] asked the question about mental health hospitals, I think the real answer there is, as Duncan pointed out, was that we were slow to the party and it was shifted initially on numbers but then the initiative was followed through by Geoff and Hilary [Hodge][127] before Geoff became the general manager. One of the things there were the policies around using social security money to support voluntary agencies to provide really homely settings for people moving out of the institutions and I carry with me a memory of Annie and two of her friends in that institution that Brian described, being rehomed on the

[127] Dr Hilary Hodge was District Dental Officer for both South Sefton and Formby and Southport DHAs and Area Dental Office for Sefton AHA (1979-85), UGM of Community Services for South Sefton DHA (1985-91) and Director of Priority Services at Mersey RHA (1991-94) and North West RHA (1994-96).

Winwick site. She had been institutionalised aged fourteen for promiscuity, so by the end of those processes that Geoff carried through, you could see the emphasis on the individual and on care and on getting it right even though it had started off as a numeric process. I think it was largely a continuation of trends that had been set, but obviously personalities and emphasises changed.

Duncan Nichol

One other last thing, which is the original struggle with issues. On the one hand with public health leadership and, as they saw it, on the other hand a vacuum in clinical leadership at the regional level. Peter's [Simpson] appointment was less about the doctor's doctor, it was over Donald's [Wilson] dead body and I knew we could arrange it because I got Walter Holland[128] to come up as the external assessor to make sure we had Peter. It doesn't matter who the names are or who the individuals are but what it was saying is we've got a massive agenda in Liverpool which is about rationalising clinical services, nobody is going to vote for Christmas here, and they didn't in Manchester. I think London went remarkably smoothly actually. But they didn't in Manchester, and they weren't going to in Liverpool. We were wondering what the best thing to do was. We wanted to be able to talk to the Regional Medical Committee. I know it's simplistic, but we thought if we could get a clinician to handle that part of the agenda and the rationalisation of services, acute services – we're talking about secondary care services in Liverpool here – it was a massive agenda at the time. I'm not going to say that would free John [Ashton] and Ruth [Hussey] up to do the things that they were great at, but I think that there was something in that as well. So we were looking for two people and we only had one post.

Bob Nicholls

Footnote from Bob Nicholls – London. I was told by Duncan when he asked me to go and help implement the Tomlinson Report[129] that I would have a choice of staff – if I had a few civil servants who had written or read the report that would be handy – and I had a choice of nurse and medical officer. When I arrived at Russell Square in my new office, which I insisted shouldn't be in the Department [of Health], who did I meet for the first time? Peter Simpson. I think whatever had happened in Mersey…we review regional specialties. Who was the person who could talk to the doctors – and they were all against the rationalisation of regional services, much as the same as everywhere else – but we had a doctor who could talk to them. It was a very interesting theme which I hadn't really thought about.

[128] Professor Walter Holland CBE (1929-2018) was Professor and Director of the Department of Clinical Epidemiology and Social Medicine (1969-91) at St Thomas's Hospital Medical School.

[129] Sir Bernard Tomlinson (1920-2017) chaired an inquiry into the impact of the internal market on London's teaching hospitals. His 1992 report recommended the establishment of a London Implementation Group (LIG) (1993-97) to manage the reforms. For details see: B. Tomlinson (1992) *Report of the inquiry into London's health service, medical education and research*. London: Department of Health; M. Gorsky and V. Preston (eds.) (2013) *The Tomlinson Report and after: reshaping London's health services, 1992-1997*. London: Centre for History in Public Health, LSHTM.

Duncan Nichol

Last example and then that really is me. As the Accounting Officer, the Public Accounts Committee had lots of stuff about waiting lists, young and disabled services, whatever. Donald Acheson would say: 'The person I've got to brief you on this is…' Well what a waste of time that was. I wasn't prepared to go into the room with that person because they weren't going to help me on the day. So I would ask the lead Professor in Rheumatology at Leeds teaching hospital to come and sit alongside me. I would ask Brian [Edwards] to come sit alongside me at waiting lists, and this is unconventional. This is not about public health, it's about how do you defend your position if you've got the wrong people advising you.

Mike Pearson

I would agree with that assessment of Peter Simpson and the way he was used. One of the commonest questions I had from colleagues around the region was 'We've had a really good chat with Peter, but does he actually have any power?' So at least there was a dialogue to region so when a policy came from Sir Donald [Wilson], they might not like it, but at least they knew they had *some* influence on it.

Hugh Lamont

Speaking as a semi-outsider at the time, it looked to me like the Pan-Liverpool Report wouldn't have happened without A. Peter Simpson and B. Alan Doran.[130] They drove it through and it had to be done.

Sylvia Hikins

I'd like to ask a question actually. The Regional Health Authority was funded by public money. All of you appointed were receiving your salaries from public money. So what were the structures of corporate governance and transparency? Was there a board? Were there appointed or elected non-executives? Was there a structure there? There's lots of fascinating anecdotes and almost a vision of a benign dictatorship – I'm sure it wasn't – but what was the corporate governance holding it all together?

Pearse Butler

Can I say something because I understand why… there is a danger here in all of these discussions that we talk about Sir Donald [Wilson] as if this *was* some kind of benign dictatorship. Actually there a series of public organisations, public boards and public accountability. He was a big character – no question about it – but there were other big characters around the system at the time in medicine, in general management, other chairs. I

[130] Alan Doran CB was a civil servant at DHSS who acted as Secretary to the Dyson inquiry (1978), became Chief Executive of Liverpool HA (1991-94), Director of Purchaser Performance Management for North West RHA (1994-96) and the NHS NW RO (1996-97), Chief Executive of North Cheshire HA (1997-2000) and St Helens and Knowsley HA (2000-02) before returning to the Department of Health (2002-07), subsequently serving as Chief Executive of the Human Fertilisation and Embryology Authority (2007-12).

was acutely aware whatever job I did, my accountability was to my board and my chair. There is a danger this stuff around anecdote implies that there wasn't the kind of accountability that, trust me as a chief executive, I felt *very* acutely Sylvia. You know I really did. Now sometimes I'd come out and think how in God's name do I reconcile what I've just heard from the region with my board, and my job was to drive back to wherever I was at the time and work that out. But I had a board, and I had a clear accountability.

Kathy Doran

I can remember one very famous occasion when that board reined back what you were trying to do and it took us another six months to implement it.

Pearse Butler

Exactly. You know, it was real. The danger of the, its Sir Donald Wilson, we implied that didn't exist. Absolutely existed, where I worked.

Ruth Hussey

Can I just come back to the point about the change in the health services in Liverpool? Liverpool Health Authority fronted the debate around that and I think it's fair to say that at one point there was a petition of thousands of people and placard protests saying that Liverpool Health Authority were murderers because of plans to reorganise services. I think it's important to locate the responsibility for those decisions *in* the Health Authority. I don't recall, because I was on the board at the time, I don't recall Region being a big voice *in public* saying we have to do this. This was very much Liverpool Health Authority's responsibility and Alan Doran was responsible for steering the board through very difficult decisions. So, on one hand we'd have conversations with the local councillors which were about changing services, a substantial number of sites closed in a period of about five years, though some were replaced with centralised, modern facilities, I could name them all – obviously the most controversial was Broadgreen A&E[131] – at the same time you could have positive conversations with the Council about the City Health Plan. Literally, at the same time in the same year we were having those parallel conversations. Clinically, there were two people in particular, doctors in the city, who were willing to support *publicly* the changes at Broadgreen. They were both at the Royal.

Duncan Nichol

I think that's right and the brunt of it was there. We did have a public face on one occasion as a region, and the non-executives were involved as well. The Chief Constable rang me up and said 'The place you are thinking of holding your meeting is too small, you need somewhere

[131] Broadgreen Accident and Emergency Department closed in 1995 prior to the Trust merging with the Royal Liverpool University Hospital NHS Trust. The move was deeply controversial. For details see: R. Akehurst, E. Robertson & R. Slack (1992) *A review of accident and emergency and related services in Liverpool*. York: University of York Centre for Health Economics; J. Greenwell (2000) *NHS hospital restructuring*. Unpublished PhD thesis, University of Bristol, 159-88.

much bigger'. So we finished up at a much bigger place, Senate House [University of Liverpool], and he said 'By the way you'll need the police dogs as well'.

[Laughter]

John Ashton

This must have been one of Sylvia's.

[Laughter]

Duncan Nichol

The only problem was that they bit the wrong person. They bit one of our non-executives.

[Laughter]

David Colin-Thomé

Just two quick things. It was Geoff [Scaife] and their team's leadership that helped primary care and fundholding, because Duncan had already gone and was supporting nationally, and Peter [Simpson] – even though I got on with him, if I could understand what he said, because he spoke in an interesting way – was heavily secondary care focused and put me as the token GP to sit and watch on his committees, but that was it, he had no real understanding of primary care issues. It was the *non*-clinical leadership that helped to support us.

John Ashton

Perhaps another difference between what had gone before was that what had gone before Geoff Scaife and Peter Simpson spoke English.

David Colin-Thomé

I was alright with Geoff, because I went to actually work with Geoff at the Scottish Office for a couple of years too, when he was working there because he was trying to develop primary care. That's a separate story.

Nick Timmins

Can you develop on that bleak remark slightly?

John Ashton

Well they both spoke this very strange language and it was very difficult to follow. We attributed it to them having spent too long in the Department of Health but it was very difficult to follow what they were saying.

Kathy Doran

I worked with Peter in the Department of Health before he came to Mersey and it was no different. We didn't understand him either.

[Laughter]

He had his own particular style.

Mike Pearson

He needed to have a twenty-minute conversation to get to the point.

Hugh Lamont

There was one interesting development in primary care at that time David [Colin-Thomé] – I nearly called you Colin, apologies – we put salaried GPs into deprived areas in central Liverpool where no-one wanted to work.

Image 18: Hugh Lamont

David Colin-Thomé

Yes, you did. Apart from the fundholding thing there was much more awareness of primary care issues. What I'm really arguing for is that fundholding was a vehicle – again – for that and the thinking and it grew from there.

John Ashton

Another thing where Sir Donald [Wilson], opportunistically, ever the entrepreneur, but ever the opportunist for the service, and linking mental health and primary care, was the last bit of the closure of the mental hospitals. We were told that if the money was spent within twelve months or something, half of it was from the sale of sites, the residue of the Rainhill site for example. If it was spent within twelve months half of it could go into reinvesting capital, and he took the decision to invest that in big health centres and they built about six of them. There was one of them in Salford that was built at that time, but it was from recycling the money because otherwise it was going to go back to the Treasury.

Hugh Lamont

There was one in Toxteth

Rosemary Hawley

The one in Toxteth was a completely different thing. We devised at the FHSA a deprived area strategy to try and do a bounce to the poor, and I explained it to Sir Donald and he said 'I didn't really understand what you are on about but if you need a new health centre you can have one'.

[Laughter]

Geoff Greenwood

The general point from this session and just before the coffee, the message coming out to me, is that despite whatever top-down national reorganisation there might be, whatever the labels you put on it – and yes you've got some big players – none of these things would have worked if it hadn't had been for these individuals. They may have been explosive or they may have been quietly doing their jobs in all sorts of different ways, but one of the things that happened in Mersey is that there were a number of people at a lot of different levels, not just from the region, but a lot of different people whether its district, health authorities, whatever we'd call ourselves who were encouraged to operate in this way. I think it's a really important message that none of this would have happened unless lots of people, across all professions, actually made that effort to make it work, and you were encouraged to do these things, you weren't constrained. I never felt I was threatened from the Regional Headquarters at any point in time despite the odd annual review that went a bit pear-shaped.

Nick Timmins

Just for the record, a lot of heads were nodding at that.

Bob Nicholls

Is it different now? I don't know but it seemed, and someone said it in the first session, that if you delivered on a core you had space…

Kathy Doran

Absolutely. And money.

Nick Timmins

So we're kind of moving towards the next bit which is the merger. A merger as the result of a decision taken to shrink the number of RHAs from fourteen to eight. We go into the start of a

period of somewhat turmoil in RHA history. But Duncan [Nichol], fourteen to eight. Rational decision?

Duncan Nichol

Brian Mawhinney[132] and I made that decision in an Indian restaurant in Manchester, on the back of a napkin, and he wanted a region that was kidney shaped and went across the middle of the country from Oxford to Cambridge. What's all that about? I can't remember much about it. He doesn't inspire confidence in any of this, but there is accountability absolutely in these informal conversations. I mean something like that happened…

Nick Timmins

I suppose the RHAs were big organisations, or quite a few of them were at this stage, and you've got Trusts and you've got fundholding and they began to look like rather a large overhead, didn't they?

Duncan Nichol

Yes, I think so.

Nick Timmins

And the story of the arrival of the internal market was that it was costing an arm and a leg with all this contracting and all these men in grey suits going around contracting, so there was pressure on the management budget, just politically. This was the arrival of Alan Milburn[133] as opposition Health spokesman, the men in grey suits stuff, counting the numbers of administrators and making big headlines. There's pressure to cut the perceived management overhead, so we go from fourteen to eight I suppose.

Image 19: Nick Timmins

Hugh Lamont

This was surely before Alan Milburn?

Kathy Doran

Milburn was stimulating it with his parliamentary speeches when in opposition.

[132] Brian Mawhinney (Baron Mawhinney of Peterborough) (1940-2019) was a Conservative MP for Peterborough (1979-97) and North West Cambridgeshire (1997-2005) and Minister of State for Health (1992-94).
[133] Alan Milburn (1958)- was Labour MP for Darlington (1992-2010) and Secretary of State for Health (1999-2003).

Nick Timmins

Yes, he was an opposition Health Minister, he was making his name.

Hugh Lamont

But he wasn't in power driving it

Nick Timmins

No, but he was driving the headlines. My point is he was the opposition Health spokesperson. I remember writing up the stories, he just kept pouring this stuff out.

Ian Cumming

Image 20: Ian Cumming

So if we take this from a Mersey perspective; Keith Wright[134] and I were asked to be the forerunners for the Mersey-North Western aspect of the merger. The first thing to say is that despite every one of us in Mersey being absolutely convinced that Sir Donald [Wilson] was going to be our new Chairman for the merged region, he wasn't. On a couple of occasions we had conversations with him about him feeling he was perhaps too old and perhaps that they wanted to bring somebody new in and use this as the opportunity, and he was also very clear – and I would be interested in Duncan's [Nichol] view on this – that his pitch was that if he took on the merged region it wasn't going to be a merger it would be a takeover because he would be taking his team with him and it would be his style, his approach and his attitude and he didn't know whether he had convinced the politicians of that nationally. So the day, literally the day it was announced that Sir Donald had been anointed as the new Chair for the region, he sent for Keith Wright and myself and said 'Right, off you go, advance party, head off down to Gateway House in Manchester. You're to park in the Chairman's parking space'.

[Laughter]

'Because I am now the Chairman and I want you to go and find out what really goes on in Gateway House, you have my complete authority to go anywhere, talk to anybody and find out what's happening'. He said 'And make it clear that they will be doing things differently, they're bureaucratic, they're slow, they're risk averse and all that changes from now'. It was one of the most uncomfortable days I think I've had in my working life.

[134] Keith Wright worked in local authority finance before serving as a management consultant for Coopers & Lybrand (1986-92) then Director of Provider Performance for Mersey RHA (1992-94), North West RHA (1994-96) and the NHS NW RO (1996-98) before becoming Director of Finance (1998-2002) for NHS NW RO and the North of England Regional Directorate of Health and Social Care (2002-03).

[Laughter]

We weren't welcome, I think it's fair to say. Then beyond that as things started picking up momentum, he very quickly wanted to gain a real understanding of what the real issues and challenges were in the North West and he said 'Right, we will start in the far flung'. So the first places that we went to were South Lakes, Barrow and Kendal, because he said 'I bet they hardly ever see anything of the RHA up here so we will start there, everybody knows what's going on in Manchester', and he actually had a point in terms of the issues. But he very much wanted to take the Mersey approach, as he saw it, to waiting list management, to performance management, to priorities, to delivery, into the North West, and not have a merger of cultures but have a definite takeover.

John Ashton

Nobody's mentioned 'Don's Tours'. He had a baseball cap with 'Don's Tours' on it, when he went to them on his peripheral visits

Mike Collier

Can I just give a wider perspective? When I went to Scotland one of the first jobs I got involved with was creating the purchaser-provider split in Scotland, and of course interestingly they've since abandoned it. I was an enthusiast very much from the perspective that it gave the opportunity for some kind of strategic management from a commissioning point of view. When I returned to the health service as a non-executive many years later, I was depressed to find that commissioning seemed to spend much of its time contracting and getting bogged down. Did it work in Mersey? Has commissioning worked in Mersey to achieve strategic ends?

Image 22: Mike Collier

Nick Timmins

That's a very good question.

Pearse Butler

Can I just pick up something about the merger? By this stage I was in one of the Trusts, and as someone in a Trust it just felt great because they just felt further away.

[Laughter]

Genuinely. The scale was such that they could not possibly operate at the level of grip that they operated on in a smaller scale. It's blindingly obvious, but it was almost apparent from day one. As a Trust chief executive that felt great. In a macro sense whether it was the right way to run systems is a very different discussion. You did feel it was different though is the point.

Hugh Lamont

It wouldn't have felt like that in Manchester.

Pearse Butler

You're right. It might not.

Hugh Lamont

It was much closer, because of the tools that John [Ashton] mentioned, and also they discovered things that Ian [Cumming] was involved in, thousands of people thinking they were on waiting lists who were just completely forgotten.

John Ashton

All those cataract people were on the waiting list for four or five years and got sent to Glasgow didn't they… no, Salford.

Ian Cumming

Well we sent a large number of cardiac patents to Glasgow, and we put hundreds and hundreds of cataract patients through a private sector initiative. We basically rented a private hospital in Salford.

Bob Nicholls

Can I ask a question? Luckily I'd been seconded to the Department [of Health] to sort out London, so I was out of it, but the notion of joining Oxford to Cambridge for anything – mind you it will be alright when we get the expressway – but then, this banana shaped…well it actually had worse acronyms than that…but how long did the authorities last?

Nick Timmins

Two years, then they became regional offices.

Bob Nicholls

It strikes me that it was the beginning of the end.

Nick Timmins

Regional offices, now these were not – and this almost goes back to accountability – were *not* authorities. They were civil servants. They *became* civil servants, but chairs remained.

Hugh Lamont

But chairs had a totally different role. When Sir Alasdair [Breckenridge][135] succeeded Sir Donald [Wilson] his total involvement was with appointments. Nothing else.

Nick Timmins

Yes.

John Ashton

I think if I've got the years right, this coincided with the nuclear testing in the South Pacific when our then President of the Faculty of Public Health, June Crown, wrote to all the public health consultants in the country and asked us to write to our Members of Parliament protesting against the French nuclear testing in the South Pacific. I dutifully wrote to all 63 Members of Parliament in the North West, and John Major[136] was in the South Pacific at the time and the phones went into meltdown as all these Members of Parliament started phoning, asking why their Regional Medical Officer was writing to MPs about nuclear testing in the South Pacific.

[Laughter]

Sir Donald [Wilson] came into my room, as he would, put his feet on my desk, and said 'John, you and I, we are not going to make it in the civil service are we?'

[Laughter]

He said 'We're both mavericks'. But then he minded my back of course, as he always did, and made sure I was alright.

Nick Timmins

Can we just touch very briefly on regional offices? Duncan [Nichol], seeing as we are *currently* building seven regional offices, what lessons are there from the regional offices for the regional offices?

[135] Sir Alasdair Breckenridge (1937-2019) was Chair of Clinical Pharmacology at the University of Liverpool (1974-2002), and a member (1990-94), Vice Chair (1993-94) and Acting Chair (1993-94) of Mersey RHA, as well as Chair of its Research Committee (1987-91), before serving as Vice Chair and Director of Research and Development to North Western RHA (1994-96), and Chair of NHS NW Regional Office (1996-99).
[136] Sir John Major (1943-) was Conservative MP for Huntingdon (1979-2001) and Prime Minister (1990-97).

Duncan Nichol

I had gone by that time.

Nick Timmins

Yes, you had.

Duncan Nichol

If I could offer anything then I would.

Ian Cumming

There is a difference though in what we're building now and what we had then. The regional offices in those days were part of the civil service. The regional offices that are being built now are part of NHSI/E[137] so therefore they are not civil servants, they are NHS managers and I think that is different.

Kathy Doran

They don't have a board.

Kieran Walshe

Image 21: Kieran Walshe

The other important difference is that there are no non-executives or statutory existence. They are essentially branch offices of a national organisation. It's interesting in retrospect to trace the decline of the regional tier. Everybody always used to say 'We'd survive a nuclear war and there would still be Regional Health Authorities', but no it declined. I think from the point you [Duncan Nichol] put the finger on earlier when RGMs became part of what you describe as the single centre, in retrospect that was the start of the decline of the power of these big regional statutory authorities.

[137] NHS Improvement and NHS England were formed as part of the 2012 Health and Social Care Act and merged in 2019 with Simon Stevens (1966-) combining both Chief Executive roles.

John Ashton

You know that they were originally the Civil Defence Regions? I have the map from the Second World War. The original configuration was Civil Defence Regions.[138]

Pearse Butler

I disagree. I actually think the demise of the region occurred when we got rid of the authority. I think there *was* something about having an authority, and the governance and accountability that meant that they had a degree of independence. They had a lot of discussions and pressure from the centre, but once that ceased to be an authority, a legal body at a regional level – forget the scale of that – I think we lost something and I don't think we'll get it back with the new arrangements.

Nick Timmins

That may well be true, but it is also interesting that it looks a little bit like we are rebuilding a regional tier. A different sort of regional tier but…

Duncan Nichol

They were called regional offices but they had no legitimacy. They weren't representative of the region that they were called, they were civil servants.

John Ashton

They were creatures of government, which is the issue. There's a gap now which is not about looking after the interests of the regional population.

Pearse Butler

An authority does see itself as having that role. It might not perform it brilliantly all of the time, but that accountability is missing in the system.

Rosemary Hawley

You see, you would have your meetings in public. I can remember when we merged with the North West, I was on the new RHA, and I remember being swamped by people protesting. It was something to do about some merger in Manchester, and in the whole meeting there were people outside shouting and with banners and all the rest of it, and of course that's all covered in the press, so there's a focus there that people can express.

[138] For details see: C. Webster (1988) *The Health Services since the War, volume I: problems of health care. The National Health Service before 1957*. London: HMSO, 262-82.

Sylvia Hikins

It was the same with the District Health Authority with the proposals to close Myrtle Street [Royal Liverpool Children's Hospital]. The public – now there is such apathy – but then they actually had police with dogs to try and control them.

Pearse Butler

We were locked in, Mike Collier and I, remember, once in Liverpool University weren't we?

Mike Collier

Yes. Absolutely.

Ian Cumming

Don't forget that we lost them and got them back again, because Pearse's point, we had SHAs right the way through until 2012, *with boards*, who felt that they were responsible for the health of the local population. We had our own SHA Directors of Public Health in those days. This isn't a '95/'96 phenomenon because they came back afterwards.

Pearse Butler

Yes, I agree, but I think that's the real loss, that authority,

Chris Vellenoweth

We had a continuum, didn't we, if you like, of representative authority on the boards, right back to HMCs and right through. So there was a continuum – as I said earlier – of communication from authority to authority and members had their contacts with the community. My regret is that we had imposed the nomination of local authority members at one time, which caused a lot of disputes, but we've lost the whole of that representative and accountability to the public now. We have gone, have we not, from representation to management *in toto*. I don't think there are the levers in place now which, unless there's a crisis, enables the public representative view to be made to those who are running things.

Kathy Doran

Well there are now Overview and Scrutiny Committees, and Trusts and CCGs[139] have to go on a regular basis and defend what they're doing. I think it's different. I've certainly had very

[139] Clinical Commissioning Groups were established in 2012, replacing Primary Care Trusts as the local commissioning body, with an emphasis on clinical rather than public health leadership through GP involvement and locally-informed decision-making and population needs. For details see: J. Storey, R. Holti, J. Hartley & M.

uncomfortable Overview and Scrutiny Committees where they have demonstrated against a proposal. Vascular services was a good example; going to Warrington to tell them we were going to put the service in Chester was not my most wonderful hour.

John Ashton

But it's very arcane. Those of us who've actually spent our lives in the NHS and ran it have difficulty understanding the arrangements. Anybody outside hasn't got a clue.

Mike Pearson

I think there's also something about size, that when you were dealing with a population of 3 to 4 million you could plan a regional service for cardiology, or cardiac surgery, or things like that, which was a reasonable sized service for that population, and small enough that someone at region could understand who you were serving. Once you put it into North West, you now had two or three centres and it became very divided and no-one could actually encompass, in their mind, what they were trying to produce. Now we have individual CCGs with their own particular little axes to grind, so it's very difficult to plan a serious regional specialist service.

Duncan Nichol

If you look at what's happening now in the STP for Merseyside and Cheshire, you've got Liverpool City Region,[140] which could be a natural base. You've got two councils in Cheshire, which might come together with Warrington to form a second natural base for strategic planning purposes. Or will the legislation – if it ever comes – *de facto* try and put back something that looks like a Regional Health Authority. I think that time has passed now, I think we're moving into, perhaps, a different view of local democracy.

Kathy Doran

It is interesting. Mike [Collier] referred to Scotland. Scotland runs a totally different system. If you look at Greater Glasgow now it's got one board for all its hospitals, all its GPs.

Mike Collier

Can I just broaden the point that Duncan's [Nichol] making? My last paid job, my last full time job should I say, was as Chief Executive of a Regional Development Agency,[141] and of course

Martin (2019) Devolving healthcare services redesign to local clinical leaders: does it work in practice?. *Journal of Health Organisation and Management*. 33:2, 188-203.

[140] Liverpool City Region Combined Authority was established in 2014 and provided strategic direction and pooled resources for the six constituent local authorities – Liverpool, Sefton, Wirral, St Helens, Knowsley and Halton – in several domains, which does not include either health or social care.

[141] Regional Development Agencies were created in 1998 covering 8 geographic regions, 9 from 2000, to provide leadership and resources for economic regeneration. They were abolished in 2012, with most of the functions transferred to smaller Local Enterprise Partnerships (LEPs).

they were scrapped. My instincts are similar to Duncan's, that something will come back. Given that health is much more than just simply planning hospital services and in the long-term should be increasingly less about the curative services, more about prevention and using all the tools that are available, I just wonder whether there is something on the horizon which actually doesn't narrow the health focus into some kind of organisational structure but actually can be part of something much wider and broader that would be on a much more devolved basis.

Nick Timmins

I'm sure something that you might describe as some sort of a region will come back, and it may be in a very different form, but it just seems to be the lesson from history from '48 until 2010, there has always been something you could describe as a regional link. Because you can't run it all from Whitehall – we tried to do that for six years and it doesn't bloody well work – so something has got to come back.

Duncan Nichol

But then if you look at what's happening in the STP – and I only know about ours – it's not going to organise the world. If the geography here was Mersey and Cheshire, 80% of decisions would be resolved in nine health and care communities co-terminus with Local Authority boundaries. That's a level at which you can get something going between primary care, local authorities and community services – which are separate in our part of the world – and the hospital sector. There is something that happens above that, we usually talk about it as a major health promotion campaign or tertiary services, but we are now moving to place-based neighbourhoods and it's got nothing to do with the old region really.

Nick Timmins

It always seemed to me that if you want to sort out community services, GP services, care in the community, you need something really quite *local* because you need to know the people, you need to get it done, so it's got to be quite small and we can argue about what big or quite small really means. Then above that you need something to sort out major secondary care reorganisations, your tertiary services and all that, and for that you need something *big*.

John Ashton

The NHS has always had conversations that start with structures, and you have to start with the functions. It may be emerging that the population size that seems to make sense for the kinds of things we're dealing with, an ageing population and so on, is this 30 to 40,000 size population where you can integrate health and social care, but the strategic level is what we are beginning to see in Greater Manchester and what we might see here; for Merseyside one-and-a-half million or something.

Sylvia Hikins

Can I say that over Christmas I was taken as an emergency into Arrowe Park Hospital – the staff were superb, absolutely superb – but I saw there all the things from a patient's point of view, not real joined up community services. Why is it, 30 years later, we are still talking about 'bed blockers', the same terminology being used, and separation of budgets? Put yourself in the moccasins of the users; you want a transition back to your own home, where you might be on your own. I saw an old woman – well, she was probably my age actually – who'd had bladder surgery and she'd been kept in overnight, general anaesthetic, but she had to go back to her own home, to live on her own, and she had to inject herself at home against a deep vein thrombosis and a nurse came round with an orange and said would you like to practice on the orange before you are sent home, and she was so frightened. I followed that old lady up, four weeks later I phoned her, and she said she sat there, no-one visited her and she was afraid of sticking the needle in her leg. Now that is the reality for so many people. So the hospitals have got to join up with the local authorities, joint budgets, and get it sorted, and like Duncan [Nichol] said it's got to be on a far more local level and actually I think that approach would *save money*. It would stop people being suddenly readmitted back to A&E and blocking expensive hospital beds and so on, and it was being said in the '80s and it's still here now.

Mike Pearson

That's one of the problems of separating hospital and community services.

Rosemary Hawley

It's also a problem of separation of the NHS and local authorities. Different functions, different funding, and that's a much *much* more difficult issue.

David Colin-Thomé

Another issue is that it's been fragmented within the local level.

Nick Timmins

It's been an issue ever since 1948, so we're not doing terribly well. We've got about ten minutes to go. Can we try and move back? I'm not saying that the conversation isn't terribly important in comparing yesterday with today and what has or has not changed. Can we just go back to the merger of the two authorities? Various points have been made, like suddenly it was further away, a lot of energy must have gone into – given that it was more-or-less a takeover – the North West as a result of that. What else happened as a result of the merger?

John Ashton

I think it's been touched on, but one of the things was that Sir Donald [Wilson] had had this stand-off with the universities here years before about writing out a big cheque every year and

not knowing quite what was going to come back from it, from the Medical School and everything. When the merger happened they discovered that nobody had ever had that conversation with Manchester's university systems, so that was another thing. Also it became clear that this issue of geography was very important on the North Western side, something that we'd known for a long time, that the further you are away from a cancer centre, the more delayed treatment is, but that led to an early decision to put a cancer centre into Preston[142] because there was a concern for equity of access which nobody had thought about before in Manchester. It's still rumbling on in South Lakes about putting chemotherapy into Westmorland General. At the moment, as we speak, it's been going on for years that discussion, but this thing about equitable access to specialist services is something which was addressed.

Ian Cumming

John is absolutely right and this came about, I know people joke about this, but these Wilson's Tours or whatever you want to call them, the minibus that would be hired to take a team of six or eight people out to part of, predominantly the North West because we all knew Mersey, to look at services, to look at the needs of the population, get a public health perspective but also to look at performance and whether the hospital was delivering what was being needed. These actually became incredibly informative in terms of shaping policy and shaping decisions, like 'We need a cancer provision somewhere north of Manchester because it's not reasonable to expect people to travel that far'. The other area that was changed very much was the whole approach to performance management. There is a whole story about the clocks and Sir Donald [Wilson] for waiting times; the concept of awarding a clock to every hospital when they had nobody waiting over twelve months for treatment. Everybody thought that this was about an award and this was about recognising the team in the hospital who'd achieved it. That wasn't what it was really about at all. What it was about, underneath it was that Sir Donald was of the opinion that some places were lying about their waiting time data and the conversation was: 'If we go to a hospital present them with a clock, Hugh [Lamont] does his stuff, we get them on the front page of the local newspapers, let's see how many letters come back in from patients saying 'I've been waiting longer than 12 months'.

Image 23: Waiting Time Clock, 1995. Reproduced with kind permission of Ian Cumming.

[Laughter]

Then we will know if they are telling the truth or not. That was the sort of performance management approach that was introduced to a number of key targets because he [Donald Wilson] just wasn't convinced that we had really got under the skin of what was going on in the North West.

[142] The Rosemere Cancer Foundation was established in 1996 at Preston Acute Hospitals NHS Trust, which was created in 1994 from service units in Preston DHA: Royal Preston Hospital and the Sharoe Green Hospital.

Mac McKeever

May I ask whether the results shifted? Certainly looking back to old Mersey in my day you couldn't say we were over regulated. These days there's lot of regulators who all have a say and there's regional offices and the rest of it. Did the results shift when the merger happened and has the regulation that's come at around the same time as the merger affected our ability to be nimble and transformational, as I'd like to think Mersey was at one point?

Mike Pearson

We've seen an awful lot of initiatives and particularly performance initiatives over the last twenty years, but the number of patients being admitted as emergencies continues to rise by 1% per year *in spite* of all these initiatives. I think one of the points that we've lost is what is it that means people want to go to hospital to be admitted rather than relying on their community? We're not giving them the alternative of staying at home.

Rosemary Hawley

It's the social care thing again.

Mike Pearson

Social care, yes, but also providing the right nurse or GP.

Nick Timmins

It's also to do with the blowing up of GP co-operatives and all that. The moment patients think they won't get a GP, they turn up at A&E, and you can start providing the GP services again and they will still turn up at A&E because they don't believe they will get a GP. I mean [Andrew] Lansley has a lot to answer for that.

David Colin-Thomé

One thing is that we are more fragmented in the community, so that GPs and community services and social care have no real incentive, unless there is personal leadership, to work together. That's what I think, for modern policy, where this primary care network stuff is meant to go, because otherwise you might have a good practice and a rubbish social care or vice versa and there was not that… so some of Sylvia's case study could have been sorted out by that sort of organisation rather than depending on the hospital who would not have as much knowledge of local arrangements.

Nick Timmins

Can I go back to that very good question: what happened to performance in the North West after the merger? Was there any detectable effect?

Ian Cumming

What we measured improved but I'm not certain we measured the right things.

Hugh Lamont

I'm probably the only person in this room that thinks this, but I think there was a major problem when the 1991 reforms happened and we lost service planning. We used to have service planning departments that tracked patient movements and if you knew where the patients were going to be treated you could put services where they were needed – community services, you could boost GP services, you knew what was needed in hospitals – and all that went with the 1991 reforms. The market was supposed to take care of all this and planning was something we did in Soviet Russia.

Kathy Doran

Well that comes back to Mike's [Collier] question about commissioning and the extent of the success of commissioning. I think it was successful in parts and not in others. I don't think there's a simple answer. Ruth [Hussey], you've probably got a view on that as well.

Ruth Hussey

I've worked in different parts of the UK and I think we've been diverted by the purchaser-provider world. If you look in the places where they don't have that split they have *exactly* the same health challenges, *exactly* the same issues. I think there is something much more fundamental, which is another conversation altogether about the way health systems have developed and the way professionals work within those systems and the power relationship with patients who use the services. There's something much more fundamental than whether it is a market model. Commissioning was an experiment that didn't succeed in changing *the core design of services* in order to meet today's health challenges.

Kathy Doran

It's also something else we have touched on a lot this afternoon; the levels of planning. Some levels of planning have to be very local around the sorts of primary care and social care services you are talking about, but for others. I look at my existing Trust, we serve the whole of Cheshire and Merseyside. How do we plan cancer services across that in a way that is integrated with local views, with local hospitals? There is no easy answer to that. That's why we are all in jobs really. We come back to these issues and we make attempts to fix them. There isn't a single right way.

Mike Pearson

Regional planning, I think, did have a useful discussion base to try and set up a wider policy and I would agree with you Hugh [Lamont], we have lost that.

Hugh Lamont

The problem with the '91 reforms was that money would follow the patients and just the opposite happened: patients follow money and they were treated where the contract's been placed.

Nick Timmins

That's true, but to be fair but that has since changed. I said we'd finish at 5. Sally, Mike [Lambert] is there anything you wanted raised that I've not raised?

Michael Lambert

Definitely, from my point-of-view, it's on the screen.

[Laughter]

Nick Timmins

The cheese. I did mention cheese.

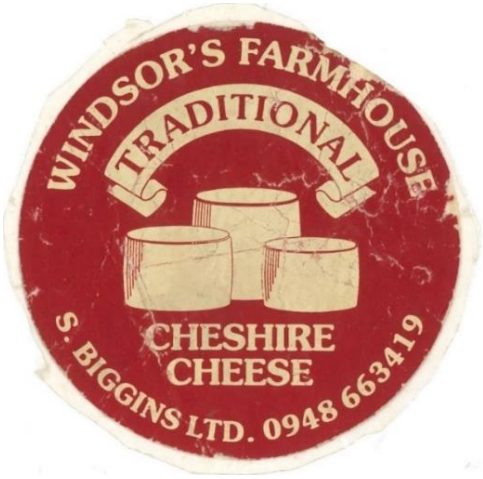

Image 24: Sir Donald Wilson's cheese label, 1992. Reproduced with kind permission of David Cain

Michael Lambert

How this has not come up so far, I do not know, because this is something that every interview, without exception, has been top of the list. I realise that I'm lowering the tone and pushing it in a different direction, but it's so symbolic of Mersey and what it did that I'd be interested just in a general reflection about how important a small piece of dairy was?

John Ashton

How many cheeses are in this room?

[Laughter]

Geoff Greenwood

I was here before Sir Donald [Wilson], and I was still there when Sir Donald left, and I didn't get a cheese

[Laughter and Sympathy]

Pearse Butler

They were only given to people at regional office.

Hugh Lamont

Tony McKeever can put that right, he's authorised to give them.

Mac McKeever

I need to respond to the anecdote. One of the things I did after Sir Donald retired was pursued him for five years to get cheese giving rights and I am an approved and certified cheese giver by Sir Donald courtesy of Lady Edna, who eventually persuaded him. One of the things I offered to do for Michael [Lambert] was to see if I could get a batch and have them sent to everybody who came today and participated, and I will gladly commit to trying to do that.

[Laughter]

Pearse Butler

Thank you Mac, I feel so much better after all these years.

Nick Timmins

We've got to finish, we have literally two minutes. Is there anything here that's not been said that anyone here is absolutely *burning* to say and can say within two minutes?

Chris Vellenoweth

I want to say that we have concentrated rightly in this seminar on the Regional Health Authority and the contribution of the Chair and others within that authority, but I think really, echoing a point that Geoff [Greenwood] made earlier, we do have to recognise – and perhaps it is elsewhere in the study – that at local level, at the area, district and indeed unit, there were initiatives being taken by forward-thinking managers and clinicians which balanced quite well with some of those regional initiatives. As a clinical colleague of mine said at one point: 'Let's feed the beast and get on with what we need to do'. I think we do need to recognise there is a balance here to be struck.

John Ashton

I think that given what's gone on over this period that we're talking about and the kind of *psychotic* sort of reorganisations and the compulsive OCD behaviour of government, it's quite remarkable that people have made as much sense of it as they have and have been able to do creative things despite all of this background noise. That's a lesson really.

Sally Sheard

Can I just finish by saying a big thanks to Nick [Timmins] for steering us?

Nick Timmins

Thank you.

[Applause]

[Ends]

Appendix 1

Witness Statement by Rob Barnett

I qualified as a GP in 1987 and was elected onto Liverpool LMC [Local Medical Committee] in 1988, becoming LMC secretary in 1990. Consequently, I was only around in the latter part of the period.

My first comment is that I always believed that Donald Wilson was a pig farmer. It was a revelation to read that he was a 'big' farmer! Needless to say, my opinion of him won't change.

As a GP, I had precious little interaction with the Mersey RHA. In the early days, GP connection with the NHS was via the Family Practitioner Committee, which morphed into the Family Health Service Authority, in 1990. From my perspective the former administered GP services, whilst the latter was more active in the planning and delivery of GP services. They were then replaced by Health Authorities in 1995.

Pre 1990, I was a GP representative on the District Medical Advisory Committee. In those days, hospitals were directly managed units. My limited recollection was that through this Committee many services were planned and co-ordinated. It had little relevance to general practice, however through that committee waiting list information on all services provided in Liverpool hospitals was collated. This was extremely useful but was something that disappeared once competition was brought into the service. No one provided this information in a user-friendly format for GPs (or their patients), and it was only with the introduction of the e-referral system in the last 10 years, that GPs were able to find this information in a meaningful format.

The FHSA brought with it a Chairman (Rosemary Hawley) and a general manager (Christine Wall)[1]. These roles were new as far as general practice was concerned. My first meeting with Rosemary was memorable in that I was told that Liverpool had too many very small or single-handed GP practices (there were approximately 109 practices, with over 45% being single handed) and that over the following 5 years they would all disappear. That clearly was the plan, as handed down by the RHA. My response was that such a change would take a generation to achieve. Needless to say, my prediction was almost correct in that 30 years later we have approximately 80 practices in Liverpool with only a few remaining single handed.

It was clear to me that Rosemary Hawley was very close to the RHA Chairman. Anything that she was asked to achieve she embraced with enthusiasm, even if it made little sense to GPs. I always felt that my role was to temper her enthusiasm and inject realism. If she was tasked with seeing GPs provide 'health promotion' clinics, she would strive to see that they were delivered even if the clinicians delivering them believed them to be pointless. The fact that they might be being paid extra was irrelevant to the GPs; it seemed like a tick-box exercise which would result in the FHSA being looked upon favourably by the RHA.

Of course, it wasn't always like that. There were problems with general practice provision in the 1990s, and the FHSA did have the ability to create new practices in deprived, under-

[1] Christine Wall was General Manager (1991-93) and Chief Executive (1993-97) of Liverpool FHSA, then Director of Primary Care and Deputy Chief Executive of Liverpool HA (1996-2003).

doctored areas. Resources were found for initiatives that resulted in the development of, for example, Vauxhall Primary Health Care.[2] This was a new GP practice that opened in 1993 in an area with inadequate GP services; it was an area of deprivation with high morbidity and mortality. However, I feel that when it suited those on the FHSA, rules were bent to achieve an outcome, without considering the potential consequences further down the line. It would only be many years after managers had left that problems would be uncovered, often with GPs being left without a safety net.

It is my opinion that this was something that drove the RHA during Donald Wilson's tenure. A classic example was the building of the Liverpool Women's Hospital.[3] I was a student and junior doctor at Mill Road, Catherine Street and Oxford Street, and also was an SHO [Senior House Officer] in gynaecology at the then 'new' Royal Liverpool Hospital. There is no doubt that there were many issues: clinicians working across too many sites, and two hospitals in desperate need of repair (I recall something in the order of £2m being spent keeping hospitals going in the year prior to closing). Sir Donald was intent on a new build on a brownfield site disconnected from the new main hospital; common sense was to provide the services on the site of the old Royal Infirmary, adjacent to the Royal Liverpool. History clearly tells us that the wrong decision was made. As an aside, but a real consequence of the decision, was the fact that women with complex gynaecological or obstetric problems were caught between two sites as the new hospital did not have an ITU [Intensive Treatment Unit], nor the clinicians in other specialties to deal with complex conditions.[4] On a personal note, when my partner was pregnant and unwell in 1999, clinicians could not decide which hospital should provide care. As a result, she was ferried between hospitals, with our son eventually being delivered in the Royal Liverpool.

GP fundholding was introduced in 1991. The FHSA very strongly promoted GP fundholding even though there was absolutely no evidence that it would benefit society. It certainly did benefit those GPs that embraced it in the first two waves, and it did give an illusion of improved services for some patients. The LMC did not support its introduction, even though it is clear that some members benefitted financially. It resulted in a two-tier health care/delivery system which was completely unaffordable. In essence, GPs could purchase services from hospitals at the time that competition was being introduced into the NHS. On the ground, to make it work,

[2] For details see: K. O. Chung & H. McKendrick (2008) Participation, equity and inter-sectoral collaboration in general practice: the case of Vauxhall Primary Health Care. *London Journal of Primary Care*, 1:2, 103-5.

[3] Liverpool Women's Hospital opened in February 1995. It consolidated three existing sites – Liverpool Maternity Hospital (Oxford Street), Liverpool Women's Hospital (Catharine Street) and Mill Road Hospital – and associated community services which had previously been Unit 3 (Obstetrics and Gynaecology) of Liverpool DHA since 1982. Their unification formed the basis for becoming a second wave NHS trust in 1992 as Liverpool Obstetrics and Gynaecology Services NHS Trust, renamed Liverpool Women's Hospital NHS Trust in 1994. The redevelopment of the site was part of 'Project Rosemary' spearheaded by the Bishop of Liverpool, David Sheppard and backed by Mersey RHA. For details see: A. Bradstock (2019) *Batting for the poor: the authorised biography of David Sheppard*. London: SPCK, 189; M. Royden (1995) *Caring for women and babies in Liverpool*. Liverpool: Liverpool Women's Hospital NHS Trust, 58-62; M. Royden (1993) *Mill Road: the people's hospital*. Liverpool: Liverpool Gynaecology and Obstetrics Services NHS Trust, 47-8. On the original plan to transfer obstetric and gynaecology services to the old Liverpool Royal Infirmary site see: Community Productions Merseyside (1988) *Five into one won't go*. Liverpool: Community Productions Merseyside.

[4] The issue of transferring women and babies for other forms of treatment to different sites has been an ongoing issue. The closure of the maternity unit at Aintree University Hospital NHS Trust in 2003 and a recent review commissioned by Liverpool CCG in 2016 both consider the problem. For details see: Verita (2010) *An independent review of governance at Liverpool Women's NHS Foundation Trust*. London: Verita; NHS Northern England Clinical Senate (2017) *Review of services provided by Liverpool Women's NHS Foundation Trust*. Liverpool: NHS Northern England Clinical Senate.

a Liverpool GP would deal directly with a Warrington Hospital with a view to having patients seen in a particular specialty within 4 weeks, for example. The fact that the general waiting time in Warrington was 18 weeks was irrelevant. This meant that some Liverpool patients were being prioritised above Warrington residents for identical care. Simultaneously, some Warrington GPs dealt directly with a Liverpool hospital to have their patients seen equally quickly. The problem was that for Liverpool patients of non-fundholders, the waiting time would be 18 weeks, and similarly the waiting time for Warrington non-fundholders referring to Warrington hospitals, the waiting time was 18 weeks. Hence the two-tier system. The other issue was the overall cost. It was estimated, at the time, that if every GP practice had become fundholders on the same terms as first and second wave fundholders, the overall cost of the NHS would have been double what it actually was.

Pressure was placed on practices to embrace fundholding. I was in a practice that did not embrace it. I believed that there was something fundamentally wrong with the principle of fundholding which was rewarding individual practices (and thus individual GPs) in the way it was doing, in a state funded system. The pressure being placed upon us was, however, enormous, to the extent that a group of like-minded practices decided to explore the development of a multi-fund total purchasing pilot. The problem was that practices were expected to sign a 'fundholding' contract by the 31 March 1995. I know that managers were being performance managed to deliver a success in having more practices signed up to fundholding. Needless to say, we did not sign, and on 2 April we started having proper discussions as to how the agreement should be written.

In a similar vein, Merseyside saw the creation of more hospital Trusts per square mile than anywhere else outside London. This was driven under Donald Wilson's tenure. We still live with that legacy, although the local system is slowly trying to dismantle it. I clearly recall the situation when colleagues who worked across say Royal Liverpool and Broadgreen, or Royal Liverpool and Aintree hospitals were told that they had to be in one hospital or another, and that the other hospital was now a competitor hospital. This caused much angst within the clinical community. Another bizarre effect was the creation of Trusts within single sites, resulting in the Broadgreen site having both 'Broadgreen Hospital' and the Liverpool Cardiothoracic Hospital' (now Liverpool Heart and Chest Hospital) within one building. Something similar occurred with Walton Hospital and Walton Neurology Hospital. With regards to the Broadgreen site, to divide the one hospital into two, I recall large doors being installed on the main A-K corridor with signs 'Welcome to Liverpool Cardiothoracic Hospital'. Of course, hospital systems, within the same site, developed independently, and clinicians still experience the ludicrous situation that tests/investigations in one part of the site cannot be viewed in the other. Five years ago, this was pointed out as being a ludicrous situation, and it still has not been resolved.

Appendix 2

Witness Statement by David Cain

It was 1989 when I first joined the Mersey Regional Health Authority following an interview by the Regional General Manager Geoff Scaife. This was at the recommendation of Rosemary Knights, who was Regional Nursing Officer at Mersey RHA, but who I knew when we were colleagues in Manchester. I was appointed as Regional Waiting List Manager with additional duties as an Assistant Chief Executive. My role, based in the office next to the Regional Chairman – Sir Donald Wilson – was to oversee and ensure delivery of our 18-month waiting list target. There was no doubt that failure was *not* an option. The Regional Chairman, RGM and Executive colleagues such as Anthony McKeever and David Fillingham[1] were all clear we had to do everything possible to pull this off.

At the outset the Regional Chairman made it clear to me that he expected me to know the waiting list inside out. He had at his disposal statisticians, analysts and an accountability framework that would highlight the required tasks, the waiting list hot spots and special initiatives; but the stick and carrot belonged to me. Indeed in the first week Mac McKeever entrusted me with a plastic magic wand to act as a prop and conjure some 'Mersey magic' to those who needed special treatment.

From a personal perspective Sir Donald said he had faith in me and that he had heard I was good, but that would be tested. He said if I delivered that a good career lied ahead, otherwise I would be back on the motorway! He expected twice weekly reports as a minimum and frequently rang my home on a Sunday morning to get information that he would use when he rang the respective Chairman to pester them if their Health Authority was falling behind. I had to take real care (of course we had no remote access to information in those days) not to give the wrong information, but he expected that I had it at my fingertips. To illustrate this he played a game with me. At any point in the week he would select any of our ten Districts, a specialty – for example orthopaedics, ophthalmology and plastic surgery were regular favourites – and ask me specifically, without reference to notes, how many 18-month waiters remained, what risks there were, and which clinicians held the most on their list. He asked six questions in a row and said I would never get six right. It happened once but I regularly got five out of six. I still possess a really good memory for detail stemming, I think, from the pressure I was under to learn facts.

We were regular visitors to our hospitals and I was tasked with eyeballing the Chief Executives to convince myself, then Sir Donald, that we would deliver. I was occasionally allowed to provide some incentive funding to obtain additional lists in both the NHS and private sector to reduce patients on waiting lists. On one occasion we brought in some temporary operating theatres from the military which had been used in the Falklands War. Sir Donald made it a number one priority and if you hit the target we had a little ceremony which in later years, once Mersey and North West merged, included being presented with a clock. The atmosphere on occasions was tense but the clarity of purpose was unquestionable. We delivered the 18-month objective for our Region. Another 'Mersey First'.

[1] David Fillingham (1960-) was Regional HR Manager and Assistant Chief Executive at Mersey RHA (1989-91), then Chief Executive of Wirral FHSA (1993-93) and St Helens and Knowsley HA (1993-97).

In 1991, in no small measure as a result of these experiences, I was selected, aged thirty-three, to be the first Chief Executive of the Walton Centre for Neurology and Neurosurgery, a second wave NHS Trust. In 1993 we were given as evidence by the RHA to Parliament as one of the most successful second wave Trusts given our clinical expansion and strategic achievements.[2] I had settled in the post when I was invited in the see the Regional Chairman and Geoff Scaife who wanted me back at the RHA to be the Regional Director of Primary Care for Merseyside following the merger with North West RHA in 1994. This was a huge privilege particularly working alongside one of the best teams I have ever worked with including David Colin–Thomé (GP), Ken Mackay[3] (GP), Peter Rowe[4] (Pharmacy Advisor), and Pauline Cook (GP Fundholding) along with wider team in Public Health and Priority Services.

The same attitude prevailed: push the boundaries, back the innovators, cut the deal, measure the results and patient care impact. The RHA lead from the front and the accountability framework was crystal clear. We would journey on our review meeting packed into a mini-bus with Sir Donald in the front passenger seat. We were literally on tour. When we reached our hospital or Health Authority destination we would pile out and face up the officials who turned out to ensure that delivery plans, capital programmes and finances were being well managed. Throughout, failure was still never an option.

[2] Hansard, House of Commons, 31 March 1993, vol. 222, cc. 471-78.

[3] Ken Mackay worked as a GP (1969-2002) from his Kenmore Practice in Wilmslow, Cheshire. He was a third wave fundholder and member of the Mersey RHA (1993-94) and North West RHA Primary Care Teams (1994-96).

[4] Peter Rowe was a pharmacist who worked as part of the Primary Care Team at Mersey RHA (1989-94) before becoming Regional Director of Primary Care for North West RHA (1995-96) and NHS NW Regional Office (1996-98).

Appendix 3

Witness Statement by Hilary Hodge

The starting point is an anecdote that helps to illustrate the ability and importance that an individual, in this case Duncan Nichol, can make by taking risks in those who he appoints. When I was appointed as the Sefton Area Dental Officer I agreed a start date and then gave my notice to Salford Health Authority. I received a call to go to a meeting about my resignation as I had given insufficient notice. Not having been in any hierarchies as a dentist I was blissfully unaware of this requirement, so went along to tell whoever it was that I was going on that date whatever he said and duly followed through. It was not until very much later in my career that I realised that the person concerned was Duncan Nichol.

Despite having virtually no management experience when the job of Unit General Manager [UGM] for Priority Services in Sefton came up, as there was a push to appoint clinicians, I was persuaded, much against my better judgement, to apply. The external assessor was Duncan Nichol and much to my amazement I was appointed, despite a longstanding experienced local administrator having been one of the other candidates. What made it even more surprising was that I had been politically active, having stood as the Labour candidate in Wallasey in the 1979 general election, against Lynda Chalker,[1] and was a Merseyside County Councillor from 1980 to 1983, and a member of the Police Authority at the time of the Toxteth riots.[2]

My husband, Colin Barnett, was the Regional Secretary of the TUC [Trade Union Congress] and of NUPE [National Union of Public Employees] and was feared by many managers in the North West.[3] After my appointment he wrote to Duncan giving an assurance that he would not compromise my position as a manager. I think that this speaks volumes for Duncan, who also supported David Colin-Thomé and John Ashton, both of whom in other places might not have been so well accepted.

It is important to consider not only what the Region did but also what it allowed to happen. As an example, as Area/District Dental Officer I obtained large sums of money from the Manpower Service Commission to employ unemployed people to design, implement and evaluate dental health programmes and then to run wider health activities. This was a policy which was not enthusiastically supported by the dental profession, as the people I recruited were 'untrained'…so how could they possibly teach about dental health. However, the Region just let me get on with it. The project even had a visit from Lady Trumpington, a government minister, who sat on our health bus and handed round sweets.[4]

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[1] Lynda Chalker (Baroness Chalker of Wallasey) (1942-) was Conservative MP for Wallasey (1974-92).

[2] The Toxteth riots were part of a series against the policing of black communities across Britain in the summer of 1981 For details see: D. Frost & R. Phillips (eds.) (2011) *Liverpool '81: Remembering the riots*. Liverpool: Liverpool University Press.

[3] Colin Barnett (1929-2010) was North-West Area (1959-61), Assistant Divisional (1961-71) and Divisional (1974-84) Officer of the National Union of Public Employees, Regional Secretary of the North-West Regional Council of the Trades Union Congress (1976-85), a Member of the Manpower Service Commission Area Board for Greater Manchester and Lancashire (1978-83) then Merseyside (1983-86). For details see: R. Marriott (2007) *Limping and waddling to the revolution: a memoir of Colin Barnett*. Kirkby Stephen: Hayloft.

[4] Jean Barker (Baroness Trumpington) (1922-2018) was Parliamentary Under-Secretary of State for Health and Social Security (1985-87).

Another example was that as the UGM I employed a social scientist – Bie Nio Ong, or Pauline, as she is usually known[5] – who carried out the South Sefton Health and Lifestyles Survey, the results of which were later included in her book *The Practice of Health Services Research*.[6] At the time this was a very radical thing to do, but it is an example of how the RHA allowed innovation to flourish.

The RHA decided to delegate the responsibility for the closure of the long stay institutions to the unit level,[7] which meant that one of my roles was to organise the closure of Greaves Hall Mental Handicap Hospital at Southport and, together with the UGMs of Liverpool and St Helens, Rainhill Mental Illness Hospital – no mean feat to undertake. Historically anything outside hospitals was thought of less importance and the care sectors covering community-based services, mental health and learning disability were of very low status. Consequently, none of the 'big boys' were interested in leading in these areas and there was substantially less knowledge and awareness of the issues within the health service leadership.

Closing hospitals and re-providing community-based alternatives is a very complex undertaking and involves not only multidisciplinary working but liaising across organisational boundaries. Each organisation has its own philosophy, decision making systems, professional boundaries, financial practices and managerial accountabilities and somehow these have to be brought together. There were also firmly held beliefs amongst various parties involved as to the benefits or otherwise of undertaking this route of hospital closures, with some of the strongest opposition coming from those working within them and particularly from the psychiatrists. Conversely the local authority staff and others working within the voluntary sector tended to be anti-hospital-provision but had a wide variety of views as to how best resettlement should be achieved. Resolving these differences and making progress was not the easiest of tasks.

Another issue which was of major importance was that of resources and the need for a process for bridging the changes. Unfortunately, both the Health Authority and the RHA saw the closures as a way of releasing money that could be transferred to the acute sector and those of us trying to create sustainable community provision fought many long battles to try to protect these resources. Without a fantastic Finance Officer, who was not particularly high up in the hierarchy, but would always find ways of doing things rather than telling you it wasn't possible, we could not have achieved what we did. One could argue that the RHA showed great foresight in delegating these responsibilities to the lowest organisational level which turned out to be justified. Compared with other regions the Mersey approach did seem to work more effectively than the top down approach and the closures were achieved more quickly.

I arrived at Region after the merger of Liverpool and Sefton's community units as a result of not being appointed to lead the combined unit. I was none too pleased as a favoured person from Region had got the job! This was a well-known route for moving people around. One of the first things I did at Region was to go to a conference at which young carers, who were now

[5] Professor Bie Nio Ong was Research and Development Manager at South Sefton DHA (1987-89), then Professor in Health Research at Keele University, serving as a Non-Executive for Mid Cheshire Hospitals Trust (1994-97) and South Cheshire HA (1997-2002) before becoming Chair of Central Cheshire PCG (2002-06) and Central and Eastern Cheshire PCT (2002-10).

[6] B. N. Ong (1993) *The practice of health services research*. London: Chapman & Hall. See also: B. N. Ong (1996) *Rapid appraisal and health policy*. London: Chapman & Hall.

[7] Mersey Regional Health Authority (1985) *Strategy for mental illness and mental handicap*. Liverpool: Mersey Regional Health Authority.

young adults, told their stories about their experiences during their childhoods. The presentations were very moving and distressing. I discussed what had happened with Mary McVerry, who then told Sir Donald's wife,[8] who obviously lobbied her husband. I was then given the go ahead to set up a young carers scheme in St. Helens,[9] one of the first in the country. This was my first introduction to decision making at the RHA.

When I arrived at Region, although there were some individuals who had some vague responsibilities for non-hospital issues, there was no team with designated objectives. Over time I created a multidisciplinary team which started to provide regional oversight and support for community, mental health and learning disability issues and for the hospital closure programme.

My team was made up of people with a range of health and social care backgrounds, wide experience in the field and all of whom shared strong beliefs in providing often disadvantaged groups within the community with good quality support and care. This belief was necessary because there was a lot of opposition to the closures. All of us had to persuade clinicians, staff and most importantly, particularly with mental handicap hospitals, the parents and relatives who feared for the future of their relatives. We also had to liaise with all the outside agencies some of which were sceptical if not antagonistic to what we were trying to achieve. There were some voluntary sector and not for profit agencies who were already providing care for these groups outside a hospital environment and with which we worked. However, the quality of what they were doing was sometimes doubtful and they had tended to care for the less disabled cohort.

Matthew Clarke,[10] who was a Liverpool social worker, had an idea about setting up a charitable organisation to develop residential community care for people with mental health problems and learning disabilities, but needed some initial funding to get it off the ground.[11] I managed to persuade Sir Donald and Geoff Scaife that this was something which we should support. It was with much anxiety, hoping that he would succeed, that I watched Matthew develop his ideas and create the organisation Alternative Futures. This was a success, has expanded over the years and is still in existence today. Again, Geoff and Sir Donald were willing to support non-conventional approaches.

I developed a strategy in relation to Sir Donald that if he ever asked me something that I was unsure about I would just acknowledge that and offer to find out the answer. The problems came when people told him what they thought he wanted to hear, the consequences of which was that sometimes doubtful decisions were taken as a result of him having been given incorrect information. My observation was that Geoff Scaife was very skilled at managing these incidents and getting Sir Donald back on the right track. Although Sir Donald was to some extent wary of me because of the political background, he said on one occasion 'well I don't understand what you do but you seem to get results so just keep on doing it'.

One dispute which I had with him arose from the fact the capital released from the institutional closures had been used to buy properties to support people living in the community. He

[8] Lady Edna Elizabeth Wilson (1924-2016).
[9] See note 116 of the Witness Seminar transcript.
[10] Matthew Clarke (1947-) trained as a social worker at Liverpool Polytechnic before working in Liverpool and Knowsley in child psychiatry, moving into the Forensic Psychiatry Unit then becoming Principal Social Worker at Rainhill Mental Hospital (1978-90) and the founding director of Alternative Futures Group in 1992.
[11] The Alternative Futures Group was established in 1992.

suddenly came up with the idea that these should be sold and the residents could then pay rent. I argued that as there was a complex arrangement with the benefit system which would preclude this, and anyway those resources were for that client group, his idea should not be followed. It was quite a tense moment but he then dropped the issue, again I'm sure persuaded by Geoff Scaife.

Sir Donald created other difficulties for the team. The Department of Health had made some revenue available for hospices, however Sir Donald told the St Helens hospice that they could use the money for building works. The problem this gave us was how to account to the Department for how the money was used.

Overall I think the leadership of Mersey Region was successful because of the combination of Sir Donald, with his political links and determination to get things done, together with Duncan Nichol and Geoff Scaife, who were both very insightful and experienced leaders who were able to manage Sir Donald. I think the negative aspects included the bullying culture and the macho environment. There was also, particularly amongst the hospital Chief Executives, what I called the 'thrusting young man syndrome' of all these men trying to outdo each other. I thoroughly enjoyed my time both as a UGM and at the regional level and consider myself to be very privileged to have been able to have such a fulfilling career.

Appendix 4

Witness Statement by Glenys Marriott

I moved from Cumbria County Council to work for Sefton Council in 1985 as Chief Education Social Worker, based in Bootle Town Hall. I soon realised that support services to children from both health and social services were poorly integrated, and we had many children on our caseloads in need of mental health support. I wrote several letters raising my concerns to South Sefton Health Authority which were ignored until community services were transformed with the introduction of general management. I wrote to Dr Hilary Hodge who was newly appointed as Unit General Manager of community and priority services; she responded to my complaints and, on visiting her at Fazakerley Hospital, I found we shared a passion for developing community services, and she was eager to listen to how they should be shaped. I subsequently applied for the post of Training Manager in her unit, and started work the same day as Dr Pauline Ong, the unit's new social science researcher.

Moving into the NHS proved very exciting and I was soon involved in a wide range of new developments including the closure of Rainhill Mental Hospital, the expansion of community mental health services and the rapidly changing world of drug and HIV services. I changed roles to become Deputy UGM leading on drugs and HIV services, Human Resources and the transfer of staff from Rainhill. The main sea-port servicing Liverpool was in our HA and as the prevention of HIV and drug services became a regional priority, we employed a wider range of staff including outreach workers, and counsellors at Rice Lane. Relationships with Mersey Regional Health Authority drug prevention leads were strong, and we were eager to support new initiatives, including syringe exchange schemes. Our priority was the protection of the community, the reduction of syringe use and early diagnosis for people found to be HIV+.

Through successful community work we took a new budget line on the HA finance papers – for the purchase of condoms. These were the first times I met with the RHA Chairman Sir Donald Wilson, who arranged for us to receive Mates condoms. Sadly, they could not be issued in the community, as at that time they were not kitemarked. The board members of the HA gave great support for these initiatives, and I attended regularly to give updates. I got the distinct impression that a young woman attending the Board to talk about sex and condoms was an interesting diversion from financial matters. We were able to take the initiative by meeting in London with Durex to discuss rebranding their condoms as they were not meeting the needs of our clients. Our request took a couple of years to bear fruit, and in the meantime new brands came on to the market targeting 'at risk' groups.

I was surprised in those first three years in the NHS that relationships with GPs were somewhat distant, as I had worked closely with them at the local authority. In South Sefton the Family Practitioner Committee (FPC) as it was then, was based in a separate building in Crosby with their own management structure and was far removed from HA activities. Part of my work to embrace them in our agenda included working with the HA pharmaceutical lead to run a 'dump' campaign to collect drugs and take them off the streets – the aim being to dissuade drug users from burgling homes. The scheme attracted high levels of publicity and over one ton was collected and disposed of safely. It was shocking to see how many packets of prescribed drugs had never been opened. This was fed back to the FPC so they could raise this with GPs.

During that time, I was encouraged to become involved in the National Management Training Scheme as an assessor, a role which continued throughout my career in the NHS. There was also a regional training team which was supportive and enabled me to gain a wider knowledge of how the region operated. One of the enormously positive things about the Graduate Management Training Scheme II was that it gave those already in the NHS an opportunity to have placements which stretched their understanding about other services. It is fair to say that via this route we attracted some first-rate people to step out of their traditional secondary hospital setting to work in the community.

Within the Region there appeared to me to be a strict professional hierarchy of medical and nursing leads which were mirrored at HA and Unit level. The HA also had a Medical Officer responsible for public health who should have led on HIV and drug prevention services, but it was acknowledged they were better addressed in a community led service. In my first couple of years I was only vaguely aware of these Regional Officers; but the one I had most links with was Professor John Ashton. He held development budgets for the services I was interested in extending in South Sefton, and we were keen to align ourselves with his priorities. Throughout these developments we received numerous visitors from Europe interested in the Mersey approach including the Swedish Minister of Health. Some months after their visit they extended an invitation to speak at the Council of Europe in Strasbourg to outline the Mersey approach on HIV prevention. Such visits were perceived as enhancing the work and status of the RHA, and I was supported to attend. This seemed very distant from the local authorities I had worked for previously, and I found the environment exciting. We were given real opportunities to design services which were meaningful for patients: the mantra was there were no hard to reach patients, just hard to access services.

By 1989 I had a greater appreciation of the power and leadership of the RHA, and its influence over peoples' careers. Vacancies were perceived as already being earmarked and there was a definite feeling of certain people being in favour, whilst others were certainly not. I had support from David Wood[1], my HA District General Manager, and he encouraged me to attend meetings on his behalf and to meet other professions. My secondary care knowledge was then underdeveloped, but my network within community services – including general practice, housing and third sector organisations – was extensive. I was not seeking a new role as the feeling within the Unit was that we were seeing some successes in our expansive agenda. I completely missed the first advert for someone to work at the RHA to cover the development of first wave GP fundholding in the north of the patch covering the Wirral, Sefton, Liverpool, St Helens and Knowsley. I was surprised to receive a summons to the RHA to discuss this new role; they thought that I knew about the work of GPs and I was 'encouraged' to take a year's secondment to work with Mary McVerry's new primary care team to sign up twenty GP practices to become first wave fund holders as part of the reforms announced in *Working for Patients*.

The role included working with the FPCs to identify potential practices, assess their capability and capacity to hold funds to commission defined services, and to support them to meet the 12-month deadline. Val Vernon was appointed to cover the southern patch, mainly Cheshire, and we formed part of a tiny regional team. Although targets had been set by the Department of Health, it was clear early on that they had little idea how to implement fundholding. Mary had

[1] David Wood was Finance Officer (1974-82) and Treasurer (1982-85) for Chester HA before becoming District General Manager of Halton HA (1985-88) then South Sefton HA (1988-91) and Chief Executive of Aintree Hospital NHS Trust (1991-2000).

worked as a senior civil servant in the Department of Health and Social Security for some years and had many contacts who were undoubtedly receptive to our experiences.

One of the major issues Val and I encountered was that practices had already received substantial investment in their practice IT systems and were, understandably, reluctant to change them. This was a bugbear throughout the whole year, and remains a problem still, all these years later. There was little connectivity with hospital systems and relatively few had fax machines. Looking back, I find it quite astonishing that we achieved the target. Initially nearly thirty practices were identified, and I spent time frequently visiting them and gauging a sense about why they were interested, and what they hoped to achieve or gain. The range of responses was extremely wide. Some wanted to make a real change in how hospitals responded to patient needs; others saw it as a way of enhancing the practice, as development monies were available for successful candidates. The most heart-warming reasons were from those who wanted to improve the care of their patients in deprived areas, to 'bring them up to the wealthy' localities and improve their life chances. During that first year it was crucial to focus on systems, the ability of GPs to manage data and money, and to appoint fundholding managers capable of 'taking on' the challenge of *doing* business with experienced acute hospital finance directors.

GPs in Southport who I had recruited decided to form a coalition of practices together which became Triangle HealthCare, and I recruited Jon Dailey[2] as their business manager, someone who I was fortunate to know from my time at South Sefton. Jon saw the opportunities for fund holders and came with credibility to both protect the practices and develop their purchasing skills. I loved working with Dr Abhi Mantgani[3] and his wife on the Wirral, who have since gone on to make an enormous contribution. Their vision was one based on improving care, access to services, and identifying gaps in service; and they were enthusiasts who saw fundholding as the means to achieve these ends.

Not all practices were able to make the cut to go forward in the first wave, and some were very disappointed; one was certainly angry with me for not recommending them. We were conscious throughout that Mersey RHA was expected to lead the initiative ahead of other Regions. Our weekly team meetings typically consisted of us posing questions back to DH for answers, together with our suggested solutions. I was, however, quite naïve about the challenge GP fundholding represented to my hospital colleagues, and I was regularly getting negative comments about how the regional role would ruin my career, and how I would have been better taking a role in a hospital. I was once told by a senior director that I had 'swapped sides' and was 'letting GPs undermine his work'.

I attended numerous meetings in my own time throughout that year, often late into the evening, supporting staff who had second thoughts or who struggled to face the enormity of what they were attempting. It was clear that some practice managers did not want to do the job, and new people were needed with different backgrounds to undertake the fundholding role. Val and I spent weeks developing practice business plans for the interim assessment. For some this was quite challenging, and not all partners always agreed on the aims. In other practices relatively young partners took on the role as GP fundholding lead, with great enthusiasm.

[2] Jon Dailey was Management Accountant (1982-83) and Assistant Treasurer (1983-86) for South Sefton DHA, and Business Manager for Triangle HealthCare (1991-92).

[3] Dr Abhi Mantgani is a GP and founder of the Miriam Medical Centre in Birkenhead (1985-). He was a second wave GP fundholder who subsequently became Medical Director of Wirral PCT (2002-12) and Chief Clinical Officer for Wirral CCG (2012-14).

We undertook numerous meetings with hospital teams, to discuss what GPs wanted changing. These were frequently longstanding issues relating to discharge letters, prescriptions upon discharge, long waiting lists and, in some cases, a total lack of a responsive service. Where GPs and hospital doctors trained together on a regular basis, relationships were usually better. Where this had not happened, a couple of hospitals decided to start such a programme based on our reports which were fed back to Region. It seems strange now to see some of these issues like discharge letters are still a bone of contention in certain Trusts. By Christmas I received phone calls to say my embryonic fund holders were receiving, for the first time, Christmas cards from their hospital 'peers'. This seems now to be quite innocuous but at that time it was a cause for celebration.

Relationships with Local Medical Committees were, however, variable; much hinged on whether their leading GPs wished to be fund holders. We visited some early on, and I had one GP who deflected criticism from the LMC by stating boldly that his patients would benefit. Supporters were not always GPs. Some local politicians were outspoken about the opportunities offered, but others were very hostile. We urged practices to set up patient liaison groups early in their assessment period to discuss the aims of fundholding. Some had a rough ride with their patients who felt the service was being privatised. Those who already had good working patient groups found it easier and a couple co-opted patients onto their internal care pathway working groups. Initially the most opposition came from acute hospitals. Managers felt that they were losing money, with funds top-sliced from HA budgets, and being told by GPs how to run their services. Clinicians did not always see GPs as their peers.

By the end of the assessment period, and having hit our targets, we had the largest number of first wave GP fund holders in England. During this period, I had spent some time working with Chairs of the reorganised Family Health Service Authorities and I was offered a role at Wirral FHSA as Director of Primary Care and Deputy Chief Executive. Myra Pearce[4] was Chair and had been a supportive advocate of fundholding. Prior to my appointment, a trial to merge the FHSA and the HA on the Wirral had encountered difficulties and been abandoned, so I arrived as an incomer at a difficult time to an already established FHSA team. There was also an undercurrent with providers however, as commissioning supplanted purchasing. The subsequent appointment of David Fillingham as Chief Executive, coming from the RHA, was a real leap forwards, and we pursued dynamic primary care and public health improvement agendas supported by several GMTS students on placement for the first time. Relationships with social services were patchy, although there were real challenges which needed to be faced jointly.

HIV prevention and drug services remained high profile and the Mersey Region Health Start project led to the development of active rehabilitation, football tournaments, netball, self-defence, yoga and aerobics sessions for patients and residents. Focus on health as opposed to illness was also gaining some credence. Smoking policies across all health premises became contentious, a challenge which still exists today in some areas. I was incredibly fortunate to work alongside Sean Denyer[5], Wirral HA's Medical Director, and after I retired went regularly to work with him in Southern Ireland.

However, as sometimes happened within the RHA, people could move rapidly from their jobs. This happened at the Cheshire FHSA and I was asked by Mersey RHA to move and take over

[4] Myra Pearce (1941-2007) was Chair of Wirral FHSA (1991-96) and Wirral HA (1996-2003).
[5] Sean Denyer was Wirral HA Medical Director (1991-96) and Director of Public Health, North Western Health Board (1996-2004).

on the departure of the previous Chief Executive. Based in the same building as Cheshire HA, it supported over 1,000 independent contractors, GPs, pharmacists, opticians and dentists. A relatively small team managed the payments to all these businesses – a traditional function of the old FPC – processed patient complaints and developed community strategies to improve services. Whilst at Cheshire the significance of fundholding declined as that for commissioning grew, and the FHSA was asked to house the newly formed commissioning group for the county. I was able to do some innovative work there with staff, and we received the *Investing in People* Award.

It was clear that the role would change further, and I was fortunate to be offered the opportunity by Alan Doran at the RHA to attend the Kings Fund Programme for managers. Shortly after completing the course, the RHA was expanded to include the North Western RHA and Alan asked me to take a secondment at Manchester HA jointly with Salford HA to re-run the failed public consultation on neurosciences, which had collapsed at judicial review. On completion of this I remained at Manchester for a further three years to oversee the transfer of services to Salford and undertook reviews of secondary paediatric and renal service organisation.

Looking back, few people now remember the trauma of the introduction of GP fundholding, or the Community Care Act, but their importance is equally vital now, with stretched finances and hospitals full to bursting. I was fortunate to work with some amazingly gifted clinicians and managers, many of whom are still part of my network, and I am delighted that so many agreed to contribute to the research project. I was sorry not to be able to make the witness seminar, but what is clear from the transcript is that I was working in a parallel universe to many of those top leaders. Like Mac McKeever, I too loved working with Sir Donald Wilson and after a particularly difficult period on the Wirral, was proud to receive one of his memorable cheeses.

Appendix 5

Witness Statement by Michael Orme

I was Dean of the Faculty of Medicine and Health Sciences at the University of Liverpool from August 1991 to August 1996. Thus, I was in post for only about two years of the 20-year period under review in this witness seminar. For a considerable part of the period under review Professor Sir Alasdair Breckenridge was the most significant link between the University of Liverpool and Mersey Regional Health Authority, either as research adviser or later as Vice- and Acting Chairman under Sir Donald Wilson.

I met Sir Donald on only a few occasions during the final years of Mersey RHA. He often had clear and fixed views of what should be done about a particular matter, but he would still listen to different views. His views of the University were not always very positive! I know that Sir Donald Wilson was supportive of me both in my role as Dean and later as Regional Director of Training and Education in the North West Regional Office of the NHS Executive, even though he was no longer formally involved. Like Mike Pearson, I was one of the senior clinicians sent on a management course which I found very helpful.

Many individuals at the witness seminar have touched on personal recollections of Sir Donald and I wish to add my own. I was particularly touched when after my suspension from duties in January 2001 by the Secretary of State, Sir Donald was the first to write to me his commiserations. In a personal touch he said: 'If I had been in charge you would never have been suspended'.

During my tenure as Dean there were many discussions between senior clinical academic staff and NHS managers. This was true both at the RHA and when it became the North West NHS Regional Office. My impressions are that those senior clinical academic staff provided significant leadership, particularly at the local and hospital level. The impact at the Regional end of things was probably less clear. I never had to take action to revise opinions. I would be briefed by such staff and may have given advice. The only exception I know of concerned matters around the Alder Hey Enquiry.

After Dick van Velzen,[1] the new Professor of Paediatric Pathology was appointed in 1988 his clinical activities started to raise concerns. In retrospect, and echoes in comments in the witness seminar transcript, I understand that Mersey RHA was aware of these concerns. The then Professor of Pathology, as Head of the Department, would have been the person to whom the new professor was accountable. However, he failed to apply any control or authority over the new professor. Because of this, I then instituted a formal review of the work of the Professor of Paediatric Pathology, with an external assessor and NHS representatives from the hospitals where he worked. This review found no serious concerns, although recommendations were made for better practice in the future. This I felt, and still do feel, was an example of failed leadership at the interface between clinicians and management in the changing NHS.

The senior clinical staff (senior lecturer and above) employed by the University of Liverpool have (and had during the above period) three prime responsibilities: (1) to teach both undergraduates and post-graduates in the Faculty of Medicine and Health Sciences; (2) to

[1] See note 94 of the Witness Seminar transcript.

undertake Research, and this activity has become a more important part of their day to day activities; (3) those individuals who were clinically qualified at the consultant level and who held an honorary clinical contract with an NHS organisation were usually expected to spend 6 sessions per week (out of 11 per week in toto) in clinical duties. As Dean of the Faculty of Medicine and Health Sciences individuals were answerable, via their Head of Department to me for activities under headings (1) and (2). As far as clinical activities were concerned individuals would be answerable via the relevant clinical lead, to the Medical Director and thence to the Executive Board of the relevant NHS organisation. As Dean I would support this system and would be concerned about any clinical failings. My opinion would usually be asked for but I was not primarily responsible, in a leadership role, for those clinical failings. Don't forget that sometimes the Dean of the Faculty of Medicine and Health Sciences is a non-clinical scientist. It is this aspect of NHS responsibilities that was so fundamentally misunderstood by the Alder Hey Enquiry in 2001.

As far as Health Service reforms were concerned, most clinical staff would be more concerned with delivering good clinical care to their patients rather than worrying about reforms, particularly at the Regional level. At the local level their voices would be heard at the clinical directorate meetings and often their opinions were loudly held but the majority view would always prevail. Senior clinical professors would be involved as far as their clinical specialty was concerned and often their views would have been heard at the National level.

As an example, I well remember the particular debate about the reform of pathological services (though I cannot recall the exact timing of the discussions). The aim was to centralise all pathological services for the Liverpool hospitals on a single site. The Professors of Pathology, Haematology, Medical Microbiology and Chemical Pathology were very much involved in support of their local colleagues in opposition to this 'Reform'. This was as much a Regional as well a local reform.

As Dean I would have expected senior clinical professors to be initiators at the forefront of regional reforms as well as local reforms. Don't forget that some clinical professors were closely involved with discussions at Richmond House [Department of Health HQ in London], and often with the relevant Royal College.

Appendix 6

Witness Statement by Ian Williams

It is now twenty years since I was involved in running a Specialist Unit in the NHS. Much of the history of the organisational arrangements dates back more than forty years.

Specialties arose as understanding of diagnosis, techniques of investigation and possibilities for treatment expanded. It became difficult for a generalist to keep abreast with developments across the full range of specialties and to gain sufficient experience to achieve and maintain competence in practice across this range. The recognition of this issue was patchy within the NHS. In a conservative medical profession such change was seen to be threatening by powerful clinicians in many places. In response specialty services were often forced to develop away from teaching hospitals. Conflict, competition and jealousy were common.

In Neuroscience in the UK there were few specialist services, each serving large populations. In Neurology in particular, people with common conditions continued to be treated by generalists. Uncommon or complex presentations warranted referral onwards to specialists. The concept of tertiary specialties arose. National Hospitals emerged in London. When I came to Liverpool in 1977 it was not seen to be a good decision. Outside Liverpool, medicine in the city was regarded as insular and not of universally high quality. Paucity of consultant posts and fixed term junior staff contracts forced the issue for me. I received copious commiserations.

There were important reasons for the development of tertiary centres:

- Uncommon diagnoses, e.g. subarachnoid haemorrhage or motor neurone disease, were only seen frequently if a large population was served.

- Some common disorders are frequently managed badly by generalists, e.g. epilepsy.

- Development and maintenance of expertise in diagnosis and treatment requires large numbers of patients to be seen.

- Training of staff requires large numbers and a wide variety of patients.

- Diagnostic and treatment equipment and facilities are expensive and need to be used efficiently

- Progress is constant. Roles change and new techniques have to be introduced. This is often dependent on close cooperation among and between specialists.

- The development of new thinking is dependent on the same cooperation and stimulation.

It has always been difficult to define the boundaries of a tertiary specialty. Prior to changes in the structure of the NHS this was of little consequence, but with the development of Area, District and Regional organisation, funding and accountability became important issues. With the further introduction of contracting in the purchaser/provider split it became an even more contentious issue. The population served by specialist units was necessarily much greater than

that served by the host Area or District Health Authority. It was difficult for them to prioritise funding and they had no relationship with other Area or District HAs obliging them to consider specialist services jointly. The concept of a District Managed Regional Unit was devised to overcome this while separating the RHA from direct management. Funding was 'top-sliced' from the amount allocated by Region to Districts. This was not popular. District accounting was not always transparent. DMRUs did not feel sufficiently involved in discussion with the RHA. In the Neuroscience Unit a Medical Manager along with a Project Accountant were appointed by the RHA to trial a different approach. This was successful in terms of service improvement, recruitment and financial accountability. The external review of The Walton Centre around 1994[1] confirmed the relevance of the above factors and also the subsequent success in growing the Walton unit and its reputation.

The purchaser/provider split arose at this juncture. After some discussion it was agreed by RHA that the DMRU would negotiate its own contracts. This further displeased the DGH. However the impossibility of negotiating contracts with each purchaser forced a review of the relationship. Consortia of practices or HAs were given the task of negotiating with the Specialist Trusts on behalf of GPs. Initially this was sometimes macho behaviour and patients or service rarely seemed to figure. The situation also made it necessary to define what should be a tertiary service subject to the separate contracting processes. This was particularly difficult in Neurology where different models of care existed in different parts of the country and Neurologists worked in both DGH and Tertiary Centre settings. DH convened advisory groups and commissioned reports which provided definitions which were never universally popular and cost time and money. I gather that the pricing of episodes has made the definitions tighter but not tackled the underlying problem, but that is hearsay.

My direct involvement ceased at around this time. The changes brought about by introducing competition through contracts between purchaser and provider resulted in a seemingly enormous increase in administrative cost and a marked diminution in interest in the resulting outcome for patients. Information systems were developed to cost and monitor contracts with little or no thought given to clinical information. At the Trust level the medical/clinical influence was greatly reduced by the introduction of lay members and a Chair, who were in the majority and were appointed because of their allegiances and business expertise rather than heath care experience. Decisions were usually taken by the Chief Executive, Finance Director and Chair. The Medical Management introduced so successfully at The Walton Centre was gradually destroyed. Political and financial imperatives, managed top down by managers selected because of their willingness to conform, replaced serious analysis of need and possible responses. Management in the service appears to have become all about control and not at all about facilitation or enabling, and is generally in the hands of people with little real experience of providing care. I cannot find much to commend the way in which general management was introduced into the NHS. I believe that much of the current disillusionment of staff is a direct result of these changes. We showed that with clinical leadership it was possible to deliver a successful, innovative and financially responsible service in a deprived city in the face of some sustained opposition, without the current level of bureaucracy.

[1] Mersey Regional Health Authority (1994) *Review of the future location of the neurosciences services: the Walton Centre for Neurology and Neurosurgery NHS Trust*. Liverpool: Mersey Regional Health Authority.