

The 1974 NHS Reorganisation

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Instructions for Citation

References to this Witness Seminar should follow the format below:

[Witness name], in *The 1974 NHS Reorganisation*, held 9 November 2016 at the University of Liverpool in London, published by the Department of Public Health and Policy, University of Liverpool, 2017, web details [page number of reference].

Introduction

The National Health Service has been reformed many times. The basic principles which underpin it may remain the same, but its structures and processes have changed significantly. This witness seminar focused on the first major reorganisation, twenty-six years after the NHS was established in 1948. It was the outcome of nearly seven years of discussion and planning. Since 1974 there have been more than twenty reorganisations – on average one every two years. As Nick Timmins has highlighted, we have got 'to the point where "organisation, re-organisation and re-disorganisation" might well be dubbed the NHS disease'.¹

The tripartite structure established in 1948 that separated primary care, secondary care and local health services was soon a cause for concern. The 1962 Porritt Report called for a more unified service.² In 1967 Kenneth Robinson, Minster of Health in Harold Wilson's Labour Government, announced that the structure of the NHS would be studied alongside a potential reorganisation of local government.³ The first Green Paper, published in 1968, proposed replacing Hospital Management Committees and Regional Hospital Boards with forty to fifty Area Boards to unify and administer all health services in England and Wales.⁴

Among the objections to this proposed structure were fears raised by senior doctors of control of the health service by local government. It was abandoned in a second Green Paper, published in 1970 by Richard Crossman, Secretary of State for the new Department of Health and Social Security from 1968.⁵ Ninety Area Health Authorities were now proposed which would match local authority boundaries. These would be the main centres of administration, supplemented by fourteen new Regional Councils with a planning and advisory role, but which sat outside the main line of responsibility. There would also be two hundred local District Committees.

After Labour lost office in 1970, it fell to the Conservatives and Sir Keith Joseph to take on the reforms.⁶ A 1971 consultative document retained the idea of moving local authority health services into new Area authorities with coterminous boundaries with local government, along with a stronger, integrated, regional tier.⁷ Teaching Hospitals and community health services would also be under the control of the Area Health Authorities. However, local government was to retain its environmental health role and General Practitioners would remain separate as independent contractors under new Family Practitioner Committees. The aims were for unification of health services, better coordination between health and social care services, and greater managerial efficiency.

Ahead of the publication of a White Paper, the DHSS initiated a 'management study' and invited the US consultancy firm McKinsey & Co., which had opened a London office in 1959, to participate.⁸ A 'study group' was formed of McKinsey consultants, academics from Brunel University's Health Services Organization Research Unit, civil servants from DHSS, and

¹ N. Timmins, *Never Again? The Story of the Health and Social Care Act 2012, A Study in Coalition Government and Policy Making* (London, King's Fund and Institute for Government, 2012) p.13.

² Medical Services Review Committee, A Review of the Medical Services in Great Britain (London, Social Assay, 1962).

³ Kenneth Robinson (1911-1996) was Labour MP for St Pancras North from 1949 to 1970 and Minster of Health from 1964 to 1968; *Royal Commission on Local Government in England*, Cmnd. 4040 (London, HMSO, 1969).

⁴ The Administrative Structure of the Medical and Related Services in England and Wales (London, HMSO, 1968).

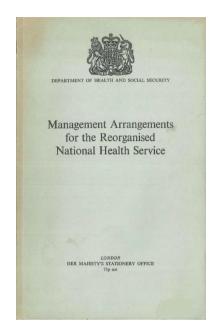
⁵ The Future Structure of the National Health Service (London, HMSO, 1970); Richard Crossman (1907-1974) was Labour MP for Coventry East from 1945 to 1974 and Secretary of State for Social Services from 1968 to 1970.

⁶ Sir Keith Joseph (1918-1994) was Conservative MP for Leeds North East from 1956 to 1987 and Secretary of State for Social Services from 1970 to 1974.

⁷ National Health Service Reorganisation: Consultative Document (London, HMSO, 1971).

⁸ National Health Service Reorganisation: England (London, HMSO, 1972).

representatives of hospital administrators, doctors and nurses. They reported to a similarly widely drawn Steering Committee (see Appendix). The result was *Management Arrangements for the Reorganised National Health Service* – the 'Grey Book' – which described in detail the functions of each new tier and the responsibilities of 27 new roles.⁹



Members of the Regional Health Authorities were to be appointed by the Secretary of State for Health and Social Security. Their proposed staff included a medical officer, a nurse, a works officer, a treasurer and an administrator. Their main function was planning.

Members of the Area Health Authorities were to be appointed by the RHAs and local authorities, and included members of nonmedical and nursing staff. The Chairman was to be appointed by the Secretary of State. Their proposed staff included a medical officer, a nurse, a treasurer and an administrator. They were to have planning and management functions and aimed to develop services with their corresponding local authority.

Most areas were to be split into Health Districts, with each District Management Team comprising an elected consultant and GP, a community physician, a nurse, an administrator and a finance officer. They would manage and co-ordinate everyday services.

The Grey Book outlined the philosophy underpinning the new management arrangements at each level. The multidisciplinary teams would follow a process of 'consensus management'. Each officer would be equal and decisions would be made collectively. If agreement could not be reached then issues would be passed up the chain: 'delegation downwards should be matched by accountability upwards'.¹⁰

The National Health Service Reorganisation Act reached the statute book in July 1973 and the new structures came into effect on 1 April 1974.¹¹ Barbara Castle, Secretary of State for Health and Social Services in the new Labour government formed in February 1974, had been more sceptical about the proposed reorganisation than her predecessors, but decided against stopping it altogether, opting instead to introduce small changes to make the structures more 'democratic'.¹²

However, the reorganisation did not prove a durable solution to NHS problems. A Royal Commission on the NHS was established in 1976 and heard evidence of increased bureaucracy, delays in taking difficult decisions, and strained relationships between administrative tiers. Following publication of the Royal Commission's report in 1979, and a return to a Conservative government, a series of further reorganisations took place. These included the abolition of Area Health Authorities in 1982, the replacement of consensus management with 'general management' in 1983, the creation of an NHS Management Board in 1985 and an NHS Executive in 1989, and the introduction of the internal market in 1991.¹³ Further local and regional reconfigurations

⁹ Management Arrangements for the Reorganised National Health Service (London, HMSO, 1972). ¹⁰ Ibid. p.10.

¹¹ National Health Service Reorganisation Act (London, HMSO, 1973).

¹² Barbara Castle (1910-2002) was Labour MP for Blackburn from 1945 to 1979 and Secretary of State for Health and Social Services from 1974 to 1976; *Democracy in the National Health Service: Membership of Health Authorities* (London, HMSO, 1974).

¹³ Report of the Royal Commission on the National Health Service (London, HMSO, 1979). For more detail on later reorganisations see R. Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford, Radcliffe, 2013) and G. Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London, King's Fund, 1998).

followed in the 1990s and 2000s. The most recent large-scale reform centred on the 2012 Health and Social Care Act, which introduced Clinical Commissioning Groups and relaxed barriers to external providers working within the NHS.

The aim of this witness seminar was to bring together those who were directly involved in the 1974 reorganisation or experienced it first hand, and re-examine this important moment in the history of the NHS.

Contributors

Convenors

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

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Witnesses

Dr Eric Caines: Secretary of Management Study Steering Committee. Principal, 1966-73; Assistant Secretary, 1973-1977, DHSS. IMF/World Bank, 1977-79. Under Secretary, 1979-81; Director of Regional Organisation, 1981-84, DHSS. Director of Personnel and Finance, Prison Department, HO, 1984-87. Director of Operational Strategy, DHSS, 1987-1990. Director of Personnel, NHS, 1990-93. Professor of Health Services Management, University of Nottingham, 1993-96.

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1986-87. Director, Boston Consulting Group, 1987-92. Chairman, Performing Arts Labs Trust, 1989-99. Non-Executive Director, Pearson Television, 1993-2001. Non-Executive Director, Phoenix Pictures Inc., 1996-2004. Chairman, Scottish Screen, 1998-2002. Non-Executive Director, Nation Media Group, Kenya, 2001-10. Director, Film Council, 1999-2004. Chairman, Maidstone and Tunbridge Wells NHS Trust, 2003-07. Chairman, Bureau of Investigative Journalism, 2010-.

Dr John Marks: Member of Management Study Steering Committee. GP, Boreham Wood, 1954-90. Chairman, Hertfordshire Local Medical Committee, 1966-71. Chairman, Hertfordshire Executive Council, 1971-74. Chairman, British Medical Association, 1984-90. Medical Director, National Medical Examinations Network, 1992-2003.

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Western Region, 1981-83; Gwilym Gibbon Fellow, Nuffield College, Oxford, 1983-84; Under Secretary, Supplementary Benefits Division, 1984-85, DHSS. Director of Social Services, Kent CC, 1985-91. Managing Director, Warner Consultancy and Training Services Ltd, 1991-97. Adviser to Government on Family Policy, 1998-2001. Parliamentary Under-Secretary of State, 2003-05; Minister of State, 2005-06, DH. Children's Social Care Commissioner, Birmingham CC, 2014-15.

In Attendance

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Professor Nick Black: Professor of Health Services Research, London School of Hygiene and Tropical Medicine.

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Mr Timothy Nodder: Under Secretary, 1972-78; Deputy Secretary, 1978-84, DHSS.

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Professor Martin Powell: Professor of Health and Social Policy, University of Birmingham.

Dr Stephanie Snow: Senior Research Associate, University of Manchester.

Professor John Stewart: Emeritus Professor of Health History, Glasgow Caledonian University.Professor Mathew Thomson: Professor of History, University of Warwick.



Areas for Discussion

The Origins

- How did NHS reform arrive on the policy agenda by the mid-1960s?
- To what extent was reform widely recognised to have been necessary?
- Had the settlement reached in 1948 become unworkable on the ground?
- Was reorganisation seen as a major upheaval or part of an evolutionary process?
- What were the aims of reorganisation?

The Design

- How important were the political dynamics of the period in determining what shape the reorganisation would take?
- How significant were the changes made to official proposals between 1968 and 1974?
- What were the aims of the management study?
- How did McKinsey & Co. come to be involved and what was their role?
- What was the role of the Health Services Organization Research Unit from Brunel University?
- How was the 'Grey Book' produced?
- How was the impending reorganisation then explained, and how did it appear, to those working in the NHS?

The Outcome

- Can we consider the reorganisation a success?
- Were the original aims met?
- What challenges were faced by those on the ground and how did they respond?
- How did 'consensus management' work in practice?
- Why did opinion apparently turn against the reorganisation so quickly?
- Could some of the problems have been anticipated?

The Legacy

- What lessons might we learn from the reorganisation?
- Why did so many subsequent reorganisations follow?
- To what extent was the reorganisation a missed opportunity?
- Should all health and social care services have been fully integrated in 1974, and should they be today?

Witness Seminar Transcript

The 1974 NHS Reorganisation

Professor Sally Sheard

Welcome to the University of Liverpool in London campus. I am pleased to see everybody here today. This is the first of the witness seminars for the project that is funded by the Wellcome Trust on the 'Governance of Health'. I am leading the project and I have two researchers here with me, Eleanor MacKillop and Phil Begley, who some of you have been in contact with. We will be recording and we have been asking people on arrival to sign consent forms, so if you have not yet signed a consent form could I ask that you do so before you leave. This will give us permission to transcribe the recording and then to publish it later.

A witness seminar is slightly different to just taking one oral history interview. They are excellent devices for bringing together groups of people who were involved with a particular point in history – an event, a crisis – and we have discovered that witness seminars have the ability to tease out bits of history that individuals may not know on their own, but through the process of discussion we can actually build a more nuanced analysis of the process and the event.

This project is concerned with the evolution of the policy expertise in Britain, moving from a domination by the medical profession at the start of the National Health Service in 1948 through to the creation of health economists and the intervention of management consultancy and the professionalisation of hospital and NHS administration and management that happened from the 1960s onwards. We are interested in the shifting expertise, and the tensions between different sorts of expertise. I thought I would give a brief contextualisation of 1974 and the NHS reorganisation because, for me, this is one of the first times in which we see that tension emerging because it is the first time that the NHS uses an external consultancy firm, in this case McKinsey. We have three people from McKinsey here with us today to speak about their involvement and the company's involvement.

1974 was the first reorganisation. It had taken nearly twenty-six years from when Bevan had created the NHS.¹ They had let it run before they began to think about serious changes. The first indication of issues with its structure and its performance came in the 1960s. So the first time we have an indication of a desire for reform in the National Health Service comes in 1962 with the Porritt Report.² When Kenneth Robinson became Minister of Health in 1964 he started a long-term study group.³ We are very fortunate that we have Tim Nodder here with us today, who was a member of that group. Between Robinson's initiation of that desire for reform and the actual installation of a new system we have eight significant policy documents. Kenneth Robinson handed over to Richard Crossman in 1968, who came into a much larger department, the Department of Health and Social Security; known to insiders as the 'Department of Stealth and Total Obscurity', because the two

¹ Aneurin Bevan (1897-1960) was Labour MP for Ebbw Vale from 1929 to 1960 and Minster of Health from 1945 to 1951.

² Medical Services Review Committee, A Review of the Medical Services in Great Britain (London, Social Assay, 1962).

³ Kenneth Robinson (1911-1996) was Labour MP for St Pancras North from 1949 to 1970 and Minster of Health from 1964 to 1968.

sides did not talk to each other.⁴ Crossman handed over to Keith Joseph on the change of Government in $1970.^5$

There was a political consensus that there were two objectives behind the first reorganisation of the National Health Service. The first one was unification of those three strands: GP services, hospital services, and the public health services that were with local government. The second objective was a new organisational structure perhaps coterminous with that of the reformed local government, which was going through its own evolution at the time. These two goals were seen as mutually incompatible by the medical profession and by local government. Over the course of that seven year period from when Robinson initiated the reform there were various permutations that were considered and discarded and then readopted.

1974 for me barely registers in my memory. I was a school girl in Cyprus and I was listening to ABBA. I am hoping that the majority of people that we have invited today are going to have a slightly better recollection of April 1974, which is when the Act took effect. It was the first of many reorganisations in the National Health Service. Nick Timmins has written that 'organisation, reorganisation and re-disorganisation' are dubbed the 'NHS disease'.⁶ Since then we have over twenty significant reorganisations. That is one, on average, every two years. The 2012 Health and Social Care Act is but the latest and probably will not be the last.⁷

The public understanding now of the NHS is phenomenal. People are au fait with STPs [Sustainability and Transformation Partnerships], CQCs [Care Quality Commission], CCGs [Clinical Commissioning Groups], and all the rest of it. In 1972, the public had no interest and very little awareness. In fact, the BBC had to be prodded several times to run any coverage of the reorganisation. They did so with a Radio 4 programme in September 1972. When they were asked if it should appear on television they said 'No, because the public will not be interested'.⁸

Charles Webster, the official historian of the National Health Service, has a great quote. When he gave the Office for Health Economics annual lecture in 1998 he said that, 'Indicative of the huge cultural change that has occurred since 1974 it is now virtually inconceivable that any role for local government would be considered in the administration and management of the health service'.⁹ But of course, as we know, we are now witnessing 'Devo Manc', and other regions are also looking at these policy permutations and the re-joining up of health and social care, perhaps under local government control.¹⁰

So, after the news from the US this morning, I hope that we are going to enjoy this virtual retreat this afternoon into the early 1970s and I think that there may well be useful lessons that can help us

⁴ Richard Crossman (1907-1974) was Labour MP for Coventry East from 1945 to 1974 and Secretary of State for Social Services from 1968 to 1970.

⁵ Sir Keith Joseph (1918-1994) was Conservative MP for Leeds North East from 1956 to 1987 and Secretary of State for Social Services from 1970 to 1974.

⁶ N. Timmins, *Never Again? The Story of the Health and Social Care Act 2012, A Study in Coalition Government and Policy Making* (London, King's Fund and Institute for Government, 2012) p.13.

⁷ Health and Social Care Act 2012 (London, HMSO, 2012).

⁸ G. Rivett, From Cradle to Grave: Fifty Years of the NHS (London, King's Fund, 1998) p.265.

⁹ C. Webster, *National Health Service Reorganisation: Learning from History* (London, Office for Health Economics, 1998) p.15.

¹⁰ In April 2015 it was announced that £6bn of health spending would be devolved to a new Greater Manchester Health and Social Care Partnership, made up of 37 NHS organisations and local councils in Greater Manchester. This formed part of the wider city-region devolution agenda instigated by the Chancellor of the Exchequer George Osborne in 2014. The new arrangements began in April 2016. See K. Walshe, A. Coleman, R. McDonald, C. Lorne and L. Mumford, 'Health and Social Care Devolution: The Greater Manchester Experiment', *BMJ*, 2016; 352:i1495.

cope with what lies ahead. Thank you very much. I am going to hand over now to Nick Timmins, who will talk you through the practicalities of how we are going to run the witness seminar.

Nicholas Timmins

It is great to be here and it is great to see you all here. I hope this is a lot of fun. Sally has made a couple of points that I would have made by way of introduction, but one I will make – which I am sure will come out in the discussion – is that this period, roughly 1968-74, was the apogee of faith in planning, under both the Wilson and the Heath governments.¹¹ So, this reorganisation of the NHS took place against a background where much else was also being reorganised and re-planned. There was the Royal Commission on Local Government.¹² There was the Seebohm Report on Social Services with the arrival of generic social workers, which of course threatened the role of the Medical Officers of Health in local government.¹³ There was Salmon.¹⁴ All these had an influence, and some a pretty decisive influence, on the 1974 reorganisation.

My only other points are procedural. Those of you who have been to one of these witness seminars before know that we try to divide them up into chunks and put people on a panel who are most closely involved with the chunk we are discussing. This one is a bit different because a lot of the people here in the room who have memories of this cover the whole period. So, the fact that there are some people on the panel at the moment and some in the audience does not mean they know more or are more important, and I will try to make sure that that works out well in the discussion. I trust you all got the background documents. There is a long list of who is here and where they come from, so I am not going to go around the room explaining that; I am sure most of you know each other. If anybody suddenly sees someone speaking and they have no idea who they are, wave a hand and we will get them to identify themselves.

This is divided into four sessions: the origins, the design, the outcome and the legacy, which gives us only half an hour on each of these, which is not all that long so we need to be quite disciplined and not talk for too long. Let us start with the origins and with the clinician on the panel. The first question is: was this reorganisation needed? There had not been one for twenty-six years; the thing had muddled on OK. Was it actually necessary?

Dr John Marks

Desperately. We had a tripartite system and one third did not know what the other two thirds were doing and vice versa. I was up in Hertfordshire where we were building new towns; I was Chairman of the Executive Council [for General Practitioners] looking after the contractors and I did not have a clue what was going on in the hospitals, and as for the public health, they were a different world. It was completely separate and it needed to be integrated.

Nicholas Timmins

And that was visible in the way that services worked?

¹¹ See for example G. O'Hara, *From Dreams to Disillusionment: Economic and Social Planning in 1960s Britain* (London, Palgrave, 2006).

¹² Report of the Royal Commission on Local Government in England, 1966-69, Cmnd. 4040 (London, HMSO, 1969).

¹³ Report of the Committee on Local Authority and Allied Personal Social Services, Cmnd. 3708 (London, HMSO, 1969).

¹⁴*Report of the Committee on Senior Nursing Staff Structure* (London, HMSO, 1966).

Dr John Marks

We could not plan anything. We were looking for GPs, the hospital was not built, no one knew what was going on, and you could not cross-fertilise at all.

Nicholas Timmins

The civil service view – Eric.

Dr Eric Caines

Let me just talk my way into it for a second. My elevated position here is because I am the only surviving member of the actual study group. 'Surviving' is a term I use loosely. I am very sorry FDK Williams and Elliott Jaques cannot be here.¹⁵ They were great colleagues and real friends. Elliott invented the term 'mid-life crisis' and by the time we had finished this exercise that is what we thought we were all suffering from.

Question four in the first section asks whether this was part of an evolutionary process. I want to say immediately that I think it was. You only have to look at how things have moved to realise that it was a stage in an evolutionary process. It is brought out at the bottom of page two and the top of page three of the document, but if you concentrate you can see how it moved.¹⁶ It has moved over the years from a system based on various forms of consensus – I have grown to hate all these 'C' words: consensus, conciliation, consultation, coordination. I spent my life dealing with the unions and I wrote an article saying how inappropriate these were to the game I was in – but it moved from that to a business-driven service, which is what it is now. It is a business-driven system. It was concerned with how to fund certain levels of requirement in terms of treating patients. We have moved from that, which was a production line process, to a process which is about productivity. How do you get more for less? How do you get value for money? These are political moves from the collective approach to the individual approach. Look at the names applied to people; we started off with administrators, then we went to managers and general managers and we are now at chief executives. Wherever you look there is this move apparent across the spectrum from a consensusdriven, left-wing – again using the term loosely – system to one which can be seen as a right-wing, business-driven system. It is important to get those in perspective. In the 'Grey Book', at number 1.16, there is an outline of a typical District with all the different types of patients that can be expected, and the numbers in each category.¹⁷ If we were to redo that today, it would give a clue as to why that move across the spectrum has been necessary.

It was thought by-and-large in 1964 – and this was what David Williams and I used to talk about a lot – that the health service was there to stay pretty much in the form in which it had been created, despite lots of pressure all the time, mainly from the right, for insurance-based schemes, for more private health care, for pay beds, all the things you can imagine. There was even a proposal at one time for a hypothecated national insurance tax devoted to health which would pay for it. None of those things came to fruition but health had traditionally been given low priority in Whitehall. It was a 'Cinderella service'. The Ministry of Health was regarded as a mini-ministry. The health service was run by experts. Treasury did not understand experts and they thought that that brought a lot of internal inertia; these experts did not know what they were doing so why throw more money at it when it was clearly all being wasted? It was not helped either by the fact that Health was

¹⁵ Francis (David) Williams was an Assistant Secretary in the Department of Health and Social Security, and Chairman of the Study Group. Professor Elliott Jaques (1917-2003) was Professor of Sociology and Director of the Institute of Organisation and Social Studies at Brunel University and was a member of the Steering Committee. See appendix.

¹⁶ Reference to briefing document prepared for the witness seminar. Key details reproduced above.

¹⁷ Management Arrangements for the Reorganised National Health Service (London, HMSO, 1972) p.13.

amalgamated with Social Security in 1968. One of the things that I remember clearly is that I was moved off the [Management] study the second it ended, on promotion to Social Security, and of course I got Keith Joseph in both of these manifestations. So, I talked to him about the study itself as we went to briefing meetings, and then every Friday I would accompany him on a visit to a local office as he went to his constituency. He used to say to me on the train as we went to these visits, 'How is this thing you have been involved in going to work? What is it going to give me?'

Nicholas Timmins

That is jumping ahead, Eric. The question is: was it needed? Was it necessary?

Dr Eric Caines

It was necessary and there was a force which was pushing us that way. By the time we had started there had been endless reports. The main tension was between the Porritt Report and the Redcliffe-Maud Report which had got doctors, of course, in a twist because they did not want to go to local authorities and Porritt wanted an integrated service.¹⁸ But there were all sorts of other pressures.

Nicholas Timmins

We will come onto some of that later. David; politically, I found a quote of yours from 1966 which said it was a 'tripartite monster' that has frozen the pattern of care since 1948.¹⁹

Lord Owen

Yes, I wrote a book called *The Unified Health Service* published by Pergamon Press with Bernie Spain and Nigel Weaver and we strongly criticised the tripartite system.²⁰ That was my personal view. What I did work on was a paper in June 1971, which compared the Conservative consultative document and Labour's second Green Paper, which was produced by the Labour Party Regional and Local Government Subcommittee, and that will go to people if they wanted to look at it.²¹ Then there was another paper by the Labour Party in October 1972, which was pretty critical of the proposals: 'It is fair to say there is little in the White Paper to find favour with, apart from the proposal to unify health services'.²² We were all agreed on that but it goes on to say unification alone will not save the problems of the NHS. There is a rather good quote from Shirley Williams.²³ I do not normally quote her these days but at the time of the Commons debate on the consultative document, she referred to the Community Health Councils as 'the strangest bunch of administrative eunuchs any Department had yet foisted upon the House - a seraglio of the Secretary of State of utterly useless and emasculated bodies'.²⁴

¹⁹ Hansard, HC Deb 08 August 1966, Vol, 733, Col.1151.

¹⁸ Medical Services Review Committee, *A Review of the Medical Services in Great Britain* (London, Social Assay, 1962); *Royal Commission on Local Government in England*, Cmnd. 4040 (London, HMSO, 1969).

²⁰ D. Owen, B. Spain, and N. Weaver, *A Unified Health Service* (Oxford, Pergamon Press, 1968). Bernie Spain was a 'psychologist-researcher in social and community studies', and Nigel Weaver was a hospital administrator: W.J. Curran, 'A Unified Health Service', *American Journal of Public Health*, Vol. 59, No. 5, 1969.

²¹ National Health Service Reorganisation: Consultative Document (London, HMSO, 1971); The Future Structure of the National Health Service (London, HMSO, 1970); Labour Party, Regional and Local Government Subcommittee Paper, 'The Consultative Document on National Health Service Reorganisation', June 1971.

²² Labour Party, Research Department Information Paper, 'Reorganisation of the National Health Service – England', October 1972. The White Paper referenced is *National Health Service Reorganisation: England* (London, HMSO, 1972).

 ²³ Shirley Williams was, in 1971, Labour MP for Hitchin and Shadow Secretary of State for Health and Social Services.
²⁴ Hansard, HC Deb 1 July 1971, Vol, 820, Col.599.

Nicholas Timmins

We are jumping ahead again. I want to get back to why this is necessary. Geoffrey.

Dr Geoffrey Rivett

Was it necessary? In 1968-69 I was a General Practitioner in Bletchley. A small village nearby was called Milton Keynes. The Medical Officer of Health at Buckinghamshire, John Reid, subsequently Department of Health Deputy Chief Medical Officer, moved from Northamptonshire to Buckinghamshire.²⁵ Knowing that Milton Keynes was there he pulled together a group that involved local General Practitioners, of which I was the representative, local health authority and regional hospital ward people – Rosemary Rue's folk.²⁶ Over the next year or two, a plan was produced for a medical service for Milton Keynes which involved all three branches of the service. This was done by the leadership of John Reid. Whatever the situation was in other places, I do not think planning a new health service for a large new city required a reorganisation. It was the leadership of John Reid.

Nicholas Timmins

Norman, you were Kenneth Robinson's Assistant Private Secretary when all of this was knocking around. Like a good boy, I reread my Webster.²⁷ He [Robinson] was not very keen on all of this at the beginning, was he?

Lord Warner

Let us go back, because I was on the secretariat of the Salmon Committee on nurses and that was a symbol of trying to 'modernise' the NHS.²⁸ There was a feeling that nurses had been knocking around and had not been used to best effect at the higher levels in running hospitals. A lot of the leading nurses wanted a bit more status compared with doctors. There were three matrons on the Salmon Committee and a slightly eccentric Professor of Management from Strathclyde called Tom Paterson, and they were all very keen to modernise the way hospitals were run, by giving more power and turning senior nurses into managers.²⁹ So that started. When I worked for Kenneth Robinson, he and Richard Crossman were both actually very preoccupied with mental health services. People had forgotten the kind of scandals that were knocking around in psychiatric hospitals.³⁰ Keith Joseph, to be fair to him, was one of the first Ministers to really be interested in services outside the hospital and actually dealing with chronic and longstanding diseases – the Cinderella services. There was a mood around that there was something wrong with this organisation but we were not quite sure what it was. The flag they all flew under was 'integration'.

²⁵ Sir John Reid (1925-1994) was County Medical Officer of Health in Buckinghamshire from 1967 to 1972 and Deputy Chief Medical Officer in DHSS from 1972 to 1977.

²⁶ Dr Rosemary Rue (1928-2004) was Assistant Senior Medical Officer to the Oxford Regional Hospital Board from 1965 to 1973.

²⁷ C. Webster, *The Health Services since the War. Vol. 1. Problems of Health Care. The National Health Service before* 1957 (London, HMSO, 1988); C. Webster, *The Health Services since the War. Vol. 2. Government and Health Care. The National Health Service 1958-1979* (London, HMSO, 1996).

²⁸ Report of the Committee on Senior Nursing Staff Structure (London, HMSO, 1966).

²⁹ Professor Thomas Paterson (1909-1994) was Professor of Industrial Administration at the University of Strathclyde from 1962 to 1974. In fact there were four Matrons on the Committee: See Hansard, HL Deb 26 July 1963, Vol.252, Col.980WA.

³⁰ See S. Sheard, 'Why we Never Learn: Abuse, Complaints and Enquiries in the NHS', *The Conversation*, 26 February 2015.

I see Tim Nodder over there and I worked for Tim on producing this very slim Green Paper and what people thought for the most part was that if you somehow integrated the organisations you would integrate the services, and all the things would flow from tackling the organisational silos.³¹ That was the mood music. What happened when we get to what led to the Grey Book is the background in which people had signed up for integration, they were not quite sure what it means but they want to reorganise in some way. They signed up for some kind of concepts about modernising the NHS as a feeling it ought to be modernised, because it was created in 1948 just after the war. People forget about the context; at that time the Heath Government was very keen on modernisation and management. This was the idea of the small cabinet with these 'super Ministers'. Peter Walker was one was the super Ministers.³² That culture was around and was driving the idea that we better find out about management. We were not quite sure what it meant and very few of the people who were involved in this had ever managed anything in their lives. That was the striking feature when I came into this particular story.

Dr Eric Caines

Keith Joseph understood what the pressures were but he was not a man who was big on culture in that sense. He wanted management savings. He was handling a big budget on Social Security and an insufficient budget on Health and it was a time of financial crisis. There was a real practical edge to his desire to get this thing moving, and that has continued ever since and that is what has driven us across this spectrum, and so I would not go for the soft stuff too much. There is a lot of hard stuff there as well.

Christopher Stewart-Smith

I was the McKinsey consultant who was the engagement manager [for the Management Study]. In the summer of 1971, was it necessary? It was very clear that Sir Keith Joseph thought it was necessary and very unusually for McKinsey he hired us to implement what he had already decided to do. We were used to studying something, coming up with recommendations, and then being asked to implement them. On this particular occasion we were told what it was we were to implement before we started, and after about three or four months of being in charge of this subsection of what was going on, I came to the conclusion that it was wrong in two ways. The first was we needed to save money and have a cost-effective structure. It was perfectly plain from the very outset in that Green Paper that there were too many tiers involved in what was being proposed. The second thing was we had a little bit of experience, through work in hospitals in Oxford, of the idea that you taught professional medics how to manage a business, rather than imposing and bringing in management from outside.³³ We had done a bit of a pilot study there and were reasonably convinced that if one took that approach gently, you could achieve something that way. It was perfectly obvious to us also that to impose a huge structure on the whole thing of a completely new kind was an enormous risk. It always is when you do that without piloting it.

I had spent a year devising the national structure of the National Westminster Bank, which is one of the reasons why I was involved in the thing, and we concluded certain things about how you did that. One of them certainly was that you kept all the best bankers and motivated them and taught them how to manage the business. We tried to get those ideas brought into the equation at the time.

³¹ The Administrative Structure of the Medical and Related Services in England and Wales (London, HMSO, 1968).

³² Peter Walker (1932-2010) was Conservative MP for Worcester from 1961 to 1992 and Secretary of State for the Environment from 1970 to 1972.

³³ In 1968 McKinsey & Co. had conducted a study, led by Robert Maxwell, for the United Oxford Hospitals. As well examining the hospitals' finances, a new organisational structure was designed and introduced. See R. Maxwell, 'Health Policy, Management and Gardening' in A. Oliver (ed.), *Personal Histories in Health Research* (London, 2005).

I went to Sir Keith Joseph and said, 'Look, we have got a problem with these two aspects and in particular the cost of the structure and the fact we are not piloting anything', and he said, 'I have decided what we are going to do', and he gave me all the reasons why he believed in management and planning and all these things that people believed in at that time, and he said that if we did not want to do the job, basically he would find somebody else to do it. I took the view that McKinsey were very good at doing this sort of thing so they could do it but I was not going to be part of it. It was just based on those two doubts that we had.³⁴

Nicholas Timmins

I particularly want to explore the second of those doubts later on. Gillian.

Dr Gillian Ford

One really quaint feature of the NHS prior to the '74 reorganisation was that the Boards of Governors of hospitals were quite separate from regional health Hospital Boards and many of them still had substantial funds of their own and could do their pioneering thing of deciding to develop a service without a yea or nay from anyone else. It made a great deal of sense in the organisation of hospital specialist services that the Regional Health Authority had the power over both Boards of Governors and the others. I think it was really quaint that it remained outside for so long and they did have a rather cosy relationship with the Department [of Health and Social Security], I believe.³⁵

Nicholas Timmins

Everybody wants to talk about the implementation but just to stick with the origins; I have one other question. It was about integration of the hospitals, GPs and the local government health services. There was some discussion about moving social services over to what we would now call social care and trying to integrate that. It did not happen and I can understand why, but I am interested to know whether there were any powerful voices arguing for that.

James Lee

I was the junior member of the McKinsey team and I spent quite a bit of time in the field up in Birmingham with a doctor who I think was called Gordon Cumming, who was the Medical Director of the District General Hospital.³⁶ It was very clear that the medical wards in the District General Hospital in Birmingham were stuffed full of elderly people who should not have been there. In fact, this is what really annoys me about the current debate about integration because you listen to people talking as if this was a new phenomenon, but I understood that a big part of what integration meant at that time: to get these old people out of hospital. So, I was very clear there was a need for joint planning between the social services, even if we could not get integration.

We will talk later about the origins of the 'consensus management' idea, but there was a considerable welling up of professional pride in the nurses following the Salmon Report and also, though I hate to say this, there was a fairly poisonous atmosphere between the GPs and the consultants in the hospital. So, the District concept seemed to be the obvious location to sort this

³⁴ Christopher Stewart-Smith worked on the Management Study during July and August 1971, before being replaced by Roderick Taylor.

³⁵ The settlement reached in 1948 had brought together individual Hospital Management Committees under Regional Hospital Boards. The major teaching hospitals remained separate with their own Boards of Governors. In 1974 they were largely brought into the new regional structure.

³⁶ Dr Gordon Cumming (1922-2001) was also a member of the Steering Committee. See appendix.

problem. I will explain later that we were of course then forced to absorb the Area concept because it had come out of the evolution that you are describing. There was never a true need for both an Area level and a District level.

Nicholas Timmins

To pick up on that, at the end of the day there was nominally some joint planning between health and social services, but what there was not was anything you would describe as integration.

James Lee

It was not just the local authority services; it was the district nurses, the health visitors, the community services and health services which were also outside. I was straight out of Harvard Business School; my only skill was as a problem-solver. My previous engagement was with the Vatican to sort out problems in the Roman Catholic Church. It was very obvious that integration was absolutely necessary.

Nicholas Timmins

Which was more opaque: the Vatican or the NHS? Tim.

Tim Nodder

Just to stick to the question of need, when the first Green Paper came out, having been involved in the preparation of it I was able to go around and talk to a number of professional groups about it.³⁷ The thing that I was able to emphasise which was perhaps not in the paper exactly was that the Royal Commission Report on Medical Education had made it quite clear that medicine was going to be changing – not just medicine doctors but the whole concept of what could be done for patients – and that services would have to be therefore very much more flexible in meeting these changing needs.³⁸ It was not population change; it was clinical abilities that were changing. To pick up what has already been mentioned; there was a welling up of professional pride.

You mentioned the Milton Keynes example where the local people wanted to push something different and were finding it at first rather difficult to do that in the existing structure, but that was not a unique situation. One of the areas that we studied for the Green Paper was what had been going on in Liverpool where there were reports of people who were changing the way that orthopaedic service implementation was being organised. These had been promoted by people at the local professional level and finding it difficult. I think it was a pity that we lost the focus on where the need for change was coming from. There were people with ideas in the clinical settings, both in the community and outside.

Dr John Marks

On the views of the medical profession I can tell you that a large number of the profession were against it and there was a special conference of Local Medical Committees to effectively say, 'We do not want this because there is a risk that GPs will become employees'. The Hertfordshire doctors – bless their cotton socks – who were seeing the need for it pressed it and we actually got it. That's on record. We actually modified the opposition to the stage where they would look at it carefully

³⁷ The Administrative Structure of the Medical and Related Services in England and Wales, (London, HMSO, 1968).

³⁸ Report of the Royal Commission on Medical Education, Cmnd. 3569 (London, HMSO, 1968).

provided the GPs did not become a salaried service. The doctors of Hertfordshire who saw the need actually pushed it forward.³⁹

Lord Warner

I think Keith Joseph was pretty seminal in the idea of actually transferring functions away from local government, because I was an Assistant Private Secretary to Dick Crossman and he always had behind his desk this fantastic map of Britain and all the health centres that had been built or were going to be built. He [Crossman] had been a councillor on Oxford City Council and he was pretty keen on some of the stuff that local government were doing. Given his [Crossman's] enthusiasm for a lot of what was going on in local government and that he quite liked MOHs [Medical Officers of Health], he [Joseph] did change the agenda in terms of wanting to get stuff out of local government.

Dr Eric Caines

Except, of course, it was realised that there had to be a sop given to the local authorities in return for what was being taken from them, and social services was the untouchable sop that had to be left behind. I disagree with Christopher Stewart-Smith that Keith Joseph knew what he wanted to do. He knew what he wanted the end result to be. He had no idea that anything like this, as a matter of process, would emerge. He would never, if it had been put to him, have signed up to a document which says management plays only a subsidiary part in improving healthcare – he would have died rather than do that.

Dr Robert Maxwell

There was a longstanding and deep seated hostility, on the part of the hospitals in particular, to being taken over by local authorities. Geoffrey [Rivett] will know the history within London. For the part of London that fell within Middlesex, County Council administration seems to have worked well, but the record elsewhere was variable. At the time we are talking about, 1974, a given was that hospitals, and hospital doctors in particular, were dead against any idea of local authority control.⁴⁰

Nicholas Timmins

And GPs likewise. They were terrified of being local government employees.

Dr John Marks

I worked as a student in a London LCC [London County Council] hospital, which was brilliant, and I worked in one in Hertfordshire run by Herts County Council, which was disgusting.

Nicholas Timmins

In a sense the traffic was always going to be one way from local government to the health service. There was never any real possibility of it going the other way.

³⁹ See J. Marks, *The NHS: Beginning, Middle and End? The Autobiography of Dr John Marks* (Oxford, Radcliffe, 2008).

⁴⁰ See G. Rivett, *The Development of the London Hospital System*, 1823-1982 (London, King's Fund, 1986).

Dr Robert Maxwell

Precisely.

Dr Eric Caines

Particularly since this had been achieved in Scotland by the Scottish reorganisation. That is what happened then and that was a model which we had to keep in mind all the time.⁴¹

Lord Owen

The Labour Party did actually produce its own Green Paper in 1973 and quite clearly ruled out the regional concept which had been building up under Keith Joseph.⁴²

Nicholas Timmins

OK. Is there anything more anyone wants to say about stuff prior to 1970, before we get to the Joseph period? Because there were these endless different numbers coming out: forty-five Area Health Authorities, ninety Area Health Authorities; pluck a number from the air, double it, divide it by two and come up with a different answer. John.

Professor John Wyn Owen

I have an observation around whether it was necessary. People have argued and explained why but if you go back to the original construct, the hospital service was a specialist referral service and therefore the separation of general practice, which would refer patients, was an extraordinarily important element and much of the integration we now see has seen a dilution of that. Therefore, as people are emphasising the importance of a primary care health service today, maybe integrated, and also the fact that we have public health in England in local authorities, there is something about the original model that was quite an important element. Everyone sitting around the table has been talking about tripartite but those of us on the NHS training scheme only thought about tripartite administration within hospitals - the Bradbeer Report on the internal organisation of hospitals.⁴³ I just want to highlight the importance of general practice being able to refer for specialist advice and a very clear separation of function between what I would call primary and more specialist care.

Nicholas Timmins

One of the things that had happened prior to this had been something of a revival of general practice following the Family Doctors' Charter in '66.⁴⁴ Was any of the drive for integration the fact that general practice was more self-confident about its role?

⁴¹ Reorganisation of the NHS in Scotland also took place on 1 April 1974. It had been preceded by a separate White Paper in 1971 (*Reorganisation of the Scottish Services*, Cmnd. 4734 (Edinburgh, HMSO, 1971)) and Act of Parliament in 1972 (*National Health Service (Scotland) Act* (London, HMSO, 1972)). See R. Levitt, *The Reorganised National Health Service* (London, Croom Helm, 1976).

⁴² Labour Party, Opposition Green Paper, Health Care. Report of a Working Party (London, Labour Party, 1973).

⁴³ Reference to the National Administrative Training Scheme for hospital administrators established by the King's Fund in 1956; Central Health Services Council, *Report of the Committee on the Internal Administration of Hospitals* (London, HMSO, 1954).

⁴⁴ See Rivett, Cradle to Grave.

Dr John Marks

I personally do not know that and I do not think that. We are talking about two different things: clinical referral, which was right and should continue, and management integration, as we needed to have the hospitals and the GPs and the local authorities planning things together. In our practice in Hertfordshire we took in one hundred patients a day. The thing was growing and there was no possibility of planning.

Professor Brian Edwards

Just a brief word about Humberside, which was acquiescent to the changes and then latterly enthusiastic. I well remember meetings of doctors from Grimsby, doctors from Goole, coming to Hull for a meeting and talking to their colleagues at the Hull Royal Infirmary. They had never met before but once they started to talk, they actually began to get excited about it. The GPs then started to join in. I remember an environment in which people were keen to integrate and saw benefit for their local community, in the early '70s – 1971-3.

Professor Nick Black

May I ask a question? Was there any consideration of public and patient views at that time about any of this? What we are hearing is views of politicians, civil servants, the profession, etc. Was that just not part of the discussion?

Professor Walter Holland

Certainly in Lambeth there was a discussion of patient views and there was great pressure to create a Lambeth community centre when the Lambeth Hospital closed, and that was driven largely by the community.

Nicholas Timmins

We did get Community Health Councils out of this, but that is not the same as them being consulted about it.

Sir David Nicholson

I was the Chief Executive of the NHS from 2006 until 2014, so I am looking forward to forty years hence explaining the Health and Social Care Act to you all. I am really disappointed with this conversation because I had always believed that it was a much more rational process to deliver the Grey Book, and it was one of the things I held up, as the two big things that were going on at the time were first of all the hospital plan in the early '60s and the idea of the DGH [District General Hospital] and the idea that this system would be better at delivering a DGH for every district, and secondly the closure of the big asylums, where this plan would be better at integrating mental health services at a local level and closing the big asylums. Perhaps I imagined it but I thought that was part of the rationale for it; are people saying that was not part of the rationale for it?

Nicholas Timmins

There are a lot of shaking heads around here.

Bob Nicholls

I was a bright young thing back then. On the public, I think Sally [Sheard] gave us that. It is quite amazing looking at the history - Geoffrey [Rivett] has written about it. There was no interest at all and no engagement; it was extraordinary. The pattern of disease has been mentioned by some and that more as a question was changing. The killers had been knocked out; therefore, it should have been mental illness, connecting longer-term care, chronic disease management. As you said at the beginning, there is a feeling that if you could get 'coterminosity', even when it was not integrated you could plan better. As a bright, keen, ex-national trainee, I thought this was important and necessary and that underneath it was the need for planning integrated care even if it could not be managed.⁴⁵

James Lee

It is a long time since I have read the Green Paper but my memory was that the definition of a District was the smallest possible unit in which planning could take place across the boundaries between the general hospital, mental health, community services and social services. It happened that it coincided with the way the District General Hospitals had been evolving but that was actually the essential definition of the unit. So, it was a unit chosen to plan.

Dr John Marks

Not true. The original plan was for Areas and Regions and it was the Steering Committee [of the Management Study] that insisted on Districts because Areas were too far removed. That is the fact of life.

James Lee

I wrote the paper for the Steering Committee proposing this; that is how I know about it.

Dr John Marks

I was there...

Lord Warner

David's [Nicholson] point is quite an important one, actually. In that period in the late '60s and early '70s, I did a lot of work with BMA [British Medical Association] negotiations and I was in two Ministers' private offices. I think the Hospital Plan and the modernisation of hospitals was seen as one project. There was another project all to do with the scandals in the psychiatric hospitals.⁴⁶ My memory of the papers and submissions coming up to Ministers is that they came up as isolated separate programmes. They were not actually in this other integration project. Sorry to disappoint you, David, but it was not holistic policy. It was separate streams of work that were floating around as you approached this change in the NHS.

⁴⁵ Reference to the National Administrative Training Scheme.

⁴⁶ The abuse of long-stay mental health patients in the Ely Hospital, Cardiff, was exposed by a member of staff in 1967. See S. Sheard, *The Passionate Economist. How Brian Abel-Smith Shaped Global Health and Social Welfare* (Bristol, Policy Press, 2013) for discussion of how Keith Robinson and Richard Crossman addressed hospital scandals.

Dr Eric Caines

There is a lot of post-rationalisation going here. People saw what their own problems were at the time and are attaching the rationale for the reorganisation to those problems. We were in a terrible state financially. We had devaluation [1967], the oil crisis [1973], a Conservative Government trying to keep unions in check, large-scale spending on NHS pay, and an NHS strike in 1971.⁴⁷ It was all going pear-shaped in terms of the gap between supply and demand, and Joseph was obsessed about that. The theorising that is going on now could never have emerged in his mind as I got to know him. It just was not there. He used to say to me, 'This is a disaster; what are you going to do with this? What do you expect me to do with this?'

Professor John Wyn Owen

My comment is about the time up to 1970, and is probably related to some of the people who were non-departmental members of the management study, such as Philip Rhodes, who was the Dean of St Thomas' [Hospital, London].⁴⁸ This may sound contradictory to my earlier intervention clarifying general practice and specialist practice, but it was quite clear, as I understand it from my colleagues at St Thomas' at the time, that this general direction of travel related to better planning was absolutely essential. It was based on the work that Walter [Holland] had been doing on 'needs analysis' in Lambeth and establishing what and how big the new St Thomas' would be and then some of the clinical developments – very early activities in day surgery which required people to be assessed at home and then being able to be discharged, shared care in obstetrics and diabetes, and then a constant battle as to whether we had enough beds for geriatrics because no patient was admitted to the South Western Hospital [Stockwell, London] until they had been assessed at home by the Consultant Geriatrician and on the site there was a joint development of a day and in-patient unit with Lambeth.

Walter chaired a committee which actually was involved in planning the relationships between general practice and the Medical Officer of Health's functions in that berth plus St Thomas's. Someone made the comment about what direction medicine was going in and what and how it would prepare students for the practice of medicine in the future. This was seen as a logical development but many of the things could have been done by simply putting planning mechanisms in place. We must not forget that different things happen in Wales and very different management consultants were employed in Northern Ireland, but this English solution, particularly around the future of the teaching hospitals and their incredible wealth at a time of austerity, was actually quite a logical step forward, and rational.⁴⁹

Frank Dobson

In any system that exists some bits of it work and some bits of it do not. Was any effort made to identify the bits that were working and strengthen them?

⁴⁷ For more context see R. Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford, Radcliffe, 2013).

⁴⁸ Professor Philip Rhodes was Professor of Obstetrics and Gynaecology at St Thomas's Hospital Medical School from 1964 to 1974, and Dean of Medicine from 1968 to 1974. He was a member of the Management Study Steering Committee. See appendix.

⁴⁹ The NHS in Northern Ireland was reorganised along different lines in 1973. The new management structures there were designed by the consultancy firm Booze, Allen & Hamilton. See *Four Decades of Public Health: Northern Ireland's Health Boards 1973-2009* (Belfast, Public Health Agency, 2009).

Lord Warner

I have to say I am stretching my memory here Frank, but I do not remember people putting to Ministers, when I was around as a Private Secretary, bright ideas that should go to scale. I just do not remember that being part of the political dialogue. That is not to say that Ministers did not see it, because the NHS liked to show them on ministerial visits the good things that were going on, which is natural. So, Ministers would see some of these things but whether they would actually then go back to the ranch and say, 'We have got to do more of what I have just seen today', I am sceptical about. The report would go back but I do not have any sense that there was a grand plan to go to scale with some of the brilliant things that were being done.

Sir Cyril Chantler

David Owen mentioned Peter Draper, who sadly died recently.⁵⁰ Peter wrote a paper in the *Lancet* in 1967 saying the consequence of creating District General Hospitals and closing small hospitals was going to be that there would be no place in the service between general practice and the large hospital where specialists and generalists could meet and discuss patient care.⁵¹ Walter [Holland] mentioned Lambeth Community Hospital. Was there any conversation at that time that one of the consequences of the hospital building programme was that they were creating this gap in the organisation's service and picking up Peter Draper and Walter's idea?

Dr Geoffrey Rivett

Just to remind people that one of George Godber's major developments was the District General Hospital Post-Graduate Medical Centre.⁵² George was alert to this division very early on and in Oxford to begin with and then almost nationally post-graduate medical centres were developed because it seemed to George that it was a good idea to bring doctors together. I do not think it was part of a massive, overarching plan but it was a bright idea which emerged in many parts of the country – London later than almost anywhere else, because in London the division between general practice and hospitals was worse than almost anywhere else in the country. The provinces got there much faster.

Nicholas Timmins

I am going to move on slightly and get to Keith Joseph arriving. Is there anything we have not covered about pre-Joseph that anybody wants to say?

Professor Martin Powell

History books often point to the idea of the 'democratic deficit' in the NHS, particularly on the Labour left. At least for some people, in theory there were some attempts to try to get some measure of a vaguely and variously defined democracy into an appointed, non-elected service. For example, people in the Socialist Medical Association had the idea that some measure of democracy would address the democratic deficit, one of Bevan's compromises, that there had to be an elected, not an

⁵⁰ Dr Peter Draper (1933-2016) was widely regarded as an important figure in the development of health policy.

⁵¹ P. Draper, 'Community-care Units and Inpatient Units as Alternatives to the District General Hospital', *Lancet*, Vol. 290, No. 7531, 1967.

⁵² Sir George Godber (1908-2009) was Chief Medical Officer for England from 1960 to 1973. For more on his approach to NHS planning see S. Sheard and L. Donaldson, *The Nation's Doctor: the role of the Chief Medical Officer 1855-1998* (Oxford, Radcliffe Medical, 2006).

appointed service. When we talk about any sort of public interest, engagement, or whatever, at least for some people, did that 'D' word ring any bells for anybody?

Nicholas Timmins

In the Labour Green Paper prior to '70, councillors would have been members of health authorities, just fewer of them as it turned out in the end.

Lord Warner

David [Owen] may correct me but my memory of this was that there was a stream of thought at the senior levels of the Labour party, which was that you could solve some of these problems by making local authority members part of health authorities. That was their solution to the democratic deficit.

Lord Owen

Well again, in our paper in 1972, as I mentioned with Shirley's [Williams] comment, there is a whole section on democratic control and it was quite strongly believed in and it comes through all the criticism of the comparison of papers.⁵³ We will come on later to the absence of democracy.

Professor Walter Holland

About that last point, certainly with the Medical Officers of Health, their relationships to their local authority were very different in the country compared to London and the big cities. I remember very distinctly the county Medical Officers of Health told me that if they were county medical officers they were treated as gentlemen whereas if they were metropolitan, they were treated as servants and that was part of the antagonism between public health and local government.

Nicholas Timmins

I want to pick up the point you made earlier about whether Joseph arriving was the moment when integration had been pulled across and more had been pulled out from local government.

Lord Warner

My sense is like Eric's [Caines]: that he wanted to do something, which was modern, which was management and would make the thing more efficient. That was the driver. The Home Office had made such a pig's ear of the children's services that something had to be done about those anyway. It may just have been a happy coincidence that they ended up going there but my sense was that the driver was efficiency.

Dr Eric Caines

You had to keep hospital doctors onside. Hospital doctors hated the thought of more local accountability and laymen poking their noses into what they were doing. They were the experts. How could these people who sat on local authorities have any understanding of what it was all about? That was a really strong point.

⁵³ Labour Party, Research Department Information Paper, 'Reorganisation of the National Health Service – England', October 1972.

Nicholas Timmins

So we have all these tensions. It seems clear from what I have read of the histories that have been written about it that you are absolutely right that Joseph was focused on efficiency and getting better value for money out of this in a way that probably Crossman and Robinson had not been, in that management efficiency became one of the central drivers of the reform.

Dr Eric Caines

There is a huge irony there because he was spending huge amounts on social security. He invented two or three new benefits, he tried to reorganise the state pension system.⁵⁴ He was known as the Government's statutory humanitarian at the time, which is ironic given that with his monetarist inclinations he should later be the one who not only wanted to limit the money supply but to cut public spending.⁵⁵ There are all sorts of ironies here.

Lord Owen

He was a hugely ambivalent figure. He was both an intellectual and PR-driven. I've never forgotten that I went to see him in 1973 with a Private Members Bill to implement all the adoption, guardianship and everything and he said to me 'This is crazy; you are not going to get this through'. Here is a nine-clause bill. I refused because I told everybody I am going to implement the whole of this report and he looked at me amazed. He said, 'You will not get this through', and I said 'You lay the foundations'. And up until then I had thought he was a very intellectual person and I realised that he is an intellectual dabbling in politics. He had this other sort of conflict. Look at all the research he set going on family and poverty, some of which was very interesting.⁵⁶

Lord Warner

He never had any interest, because I was the official in charge of Executive Councils when he came in, and I used to have a fairly steady flow of informal notes coming down to me from him and he never really had any interest in bringing the GPs into this system. He was quite comfortable letting that system of Executive Council types or their successor bodies run on. He was not looking for a fight with the GPs over disturbing that particular structure that had existed since 1948.

Nicholas Timmins

Right. We talked about the broader context and the influences of this. One of the bigger influences was of course the Royal Commission on Local Government, which was playing around with boundaries until the cows came home and its interim recommendations and recommendations kept moving which clearly had an impact on the boundaries that were being set for the NHS, given this desire for coterminosity.⁵⁷ So, that clearly mattered. How far did it mess things up on the way through? Was it just a question of every time that the Redcliffe-Maud Commission changed its mind the NHS changed its mind?

⁵⁴ See S. Ball and A. Seldon (eds.), *The Heath Government 1970-1974: A Reappraisal* (Routledge, Abingdon, 2013).

⁵⁵ Sir Keith Joseph's adoption of monetarist ideas by the mid-1970s has often been seen as an important influence on then Leader of the Opposition Margaret Thatcher and the direction of future Conservative Party economic policy. See, for example, A. Williamson, *Conservative Economic Policymaking and the Birth of Thatcherism, 1964-1979* (London, Palgrave Macmillan, 2015).

⁵⁶ By the mid-1970s Joseph was also well known for the controversial views on poverty he expressed in a speech at Edgbaston in 1974. See A. Denham and M. Garnett, *Keith Joseph* (Chesham, Acumen, 2001).

⁵⁷ Royal Commission on Local Government in England, Cmnd. 4040 (London, HMSO, 1969).

Dr Robert Maxwell

It certainly changed the number [of Area Health Authorities] to ninety.

Dr John Marks

I think quite honestly coterminosity was the biggest problem we faced. I went up on the roof [of Alexander Fleming House, the Department of Health and Social Services headquarters at Elephant and Castle] with the McKinsey [people] one night: [to discuss] the map. 'The practice is in Boreham Wood, John?' 'Yes, in Hertfordshire but four hundred of my patients, including myself, live in the county of Middlesex'. 'Oh, where does your work go?' 'Well, most stuff goes to Barnet [Hospital], which is in the London Borough of Barnet. But Obstetrics goes to Edgeware [Hospital], which is in the county of Middlesex, but when they are delivered they are in Bushey [Hospital], which is in the county of Hertfordshire, and I send all my surgery to the Westminster [Hospital]'. 'Why the Westminster?' 'The Professor there is a mate of mine and has no waiting list'. Coterminosity, I thought, was the biggest problem we had.

Nicholas Timmins

Do you mean creating it?

Dr John Marks

It was the beginning of it being laid down.

Dr Eric Caines

We had accepted it as a given, except it proved very difficult in London, of course, and that caused endless problems. It had worked in Scotland beautifully and they came down to eighteen coterminous AHAs [Area Health Authorities].

Nicholas Timmins

But their geography lends itself to that; there is no city the size of London, for a start. Walter.

Professor Walter Holland

Certainly, coterminosity was an enormous problem in Lambeth, Southwark and Lewisham, which was known as a no-go area. We were trying to work out how to do this. I still remember George Godber talking to me and saying he was absolutely adamant that we should not have coterminosity in Lambeth, Southwark and Lewisham, because if there was at least one place where there was no coterminosity future governments would have the greatest of difficulty in making the NHS part of local government. That is a direct quote from George.

Nicholas Timmins

So, coterminosity is a given and the boundaries are getting set.

Dr Eric Caines

And the date for implementation is set. It was dictated by Redcliffe-Maude.⁵⁸

Nicholas Timmins

Right. Yes, and that leads to a rush at the end doesn't it. When did the McKinsey involvement start? Although everyone remembers the 1974 reorganisation and McKinsey's involvement, it was the relatively narrow management bit that you were looking at, wasn't it? In other words, it was how to manage this idea of integration.

Christopher Stewart-Smith

The firm was already involved with the Department [of Health and Social Security] under Robert Maxwell before this, so we were already embedded – if I can use that term – in the health service.

Dr Robert Maxwell

That's right. I am not sure when our involvement in the Department started but it had been going for six or nine months, or even longer, before the NHS Reorganisation study was brought to us at all. That was a joint team between Ron Matthews, who was an Under Secretary in the Department, and me, to try to sort out the Department so that it would be ready for the task of managing the NHS in a way it had not managed it in the past; that was the concept.⁵⁹ I was not the Engagement Director but the Engagement Manager for that. Henry Strage could have answered your question much better than me if he was here.⁶⁰ But I rather assume that what happened was the Department must have gone out to more than one firm of management consultants to see how they would have approached this task, and I suspect that there was some discussion with Brunel [Health Services Organization Research Unit] also at that stage, which is how it came out that both were involved, but I do not know that for certain or how it went on. I assume the Department decided on the basis of discussions and written contributions from different consulting firms – I think the fact that we were a known body to the Department at that stage and the work at Oxford which I had been involved in had been viewed as a success played a part in it being handed to us rather than to somebody else.⁶¹

⁵⁸ Ibid.

⁵⁹ Ronald Matthews (1922-1995) was an Assistant Secretary in DHSS from 1968 to 1973, and an Under Secretary from 1973 to 1976. Robert Maxwell later kindly provided further details of the DHSS study undertaken by McKinsey: 'The first study was to prepare the Department for the task of managing the NHS in a new way. While there was absolutely no doubt that the DHSS managed Social Security, its stance towards Health was radically different. The strongest influences were Finance and, particularly through Sir George Godber, Professional. The professional staffs answered to their professional heads. The main administrative civil servant groupings were in policy divisions, defined by topics. They were well set up to advise Ministers on any topic, but not so well equipped for achieving executive action. The main recommendations were about establishing a part of the Department to deal with translating national policy into NHS action (the Regional Divisions), to align professional staffs with non-professional in terms of joint working, and to strengthen the Top of the Office (e.g. by creating a Central Planning Unit) in drawing it all together'.

⁶⁰ Professor Henry Strage, who worked for McKinsey for more than thirty years, was the Engagement Director for the Management Study. He sent his apologies for being unable to attend the Witness Seminar.

⁶¹ Robert Maxwell later sent a helpful clarification to these remarks, highlighting that, as the convenors understood, and indeed as Eric Caines confirms below, there was no process of competitive tendering and McKinsey were invited to undertake the second management study because of their ongoing work in DHSS: 'I understand that Ken Stowe persuaded the Civil Service Department that the new contract should be awarded to McKinsey because we were already involved in the related work in the Department. Separate discussions went on between DHSS and Brunel about their involvement in the new study. Professor Jaques's Unit there was well known to the Department and was partly funded through the Health Services Research programme'. Kenneth Stowe (1927-2015) was an Assistant Under Secretary of State in DHSS between 1970 and 1973, and later Permanent Secretary from 1981 to 1987.

Nicholas Timmins

What did Brunel bring to the party that was different to what McKinsey had to offer?

Dr Robert Maxwell

It had done a lot of detailed work on relationships in complex organisations like the NHS, for example 'sapiential authority', which is where somebody has the knowledge and wisdom but their relationship is different from a line relationship. He [Elliott Jaques] was also a very persuasive person and, with some backing from the professional sides of the Department, it was thought that this thinking was important in relation to the management of the NHS, and it clearly is relevant.

Nicholas Timmins

Right. And with this comes the idea of consensus management, which comes partly out of the McKinsey study?

Dr Robert Maxwell

I don't think McKinsey would ever have come up with the idea of consensus management. I think it was an idea that appealed to the Steering Committee and to people like George [Godber] and the other professional heads in the Department, because it reflected some of the complexity that they knew was there and which might otherwise have got ignored.

James Lee

This was unlike any other engagement that the firm got involved in because normally we were given a clear brief, we wrote a report and we owned the recommendations. As I mentioned earlier, I was exceptionally young and junior at this point. I certainly remember learning very quickly that the only way we were going to influence this process was if we joined the team and saw ourselves as part of it, and were prepared to make concessions. On both the definition of the District and the composition of the District Management Team and the question of consensus management, it was an evolutionary process. Remember that McKinsey at that time were seen as management experts from America, although, except for Henry Strage, we were all Brits. The Chief Executive was already a well-established principle in the US but it was very clear to me that the hospital administrators and the managers in the health service at the time did not command the respect of the other professions, so for us to recommend a normal, hierarchical process with a single executive in charge was absolutely impossible.

So, although I cannot remember who invented the idea of consensus – it might have been Dr Marks...

Dr John Marks

No way.

James Lee

...it emerged out of this consensual process and seemed to be a workable compromise given all the other forces at work. As I was just saying, the nurses were a big part of that. They were represented very powerfully on the Steering Committee, within the Salmon Report, so it was not just a medical

administrative exercise; the nurses were part of this too.⁶² But Eric, you eventually put all this together; what is your recollection of this?

Dr Eric Caines

Just to go back a step, I do not think there was any bidding process. You [McKinsey & Co.] were doing work elsewhere; I know you were British but you had an American flavour. You were the management gurus. You knew about management and the Department did not know about management. That was the thinking at the time. So far as Brunel were concerned, we had sapiential authority, we had 'time span of discretion'. There was a sort of academic objectivity brought to bear, it was thought. I am not sure how influential it all was at the end of the day. The consensus management idea was a natural offshoot of the flavour of the times. It matched what people were looking for. It is a contradiction in terms, in a sense. In my view, in terms of accountability, when everyone is responsible no one is responsible, but that is how it emerged.

John Wyn Owen

Maybe Bob Nicholls can help me out on this, picking up on a management theme, because he would have been part of a thing at St Thomas's [Hospital] called DART, which was a Development and Research Team. Philip Rhodes and similar people who were DHSS members were quite close to the management and the Board of Governors and St Thomas's Medical School. Walter [Holland] can verify whether I am making this up but we had an organisation headed across the hospital and trustees and the medical school called the Principal Management Team, and they operated in a way that required the agreement of the medical school plus the trustees, which were incorporated into the Board of Governors, to actually begin to plan and move ahead. That was the result of a deliberate way of looking - I have to say this because I was not there at the time; I actually think that the governance of St Thomas's and its quite clear focus on the distinction and contribution of the Florence Nightingale spirit was in the room where we held our management team – that notion of working together to be able to take business forward was seen to actually work.

We were also delivering on a major re-development and building of the new St Thomas's Hospital opposite Parliament, at a time when hospitals were overrunning on costs and never finishing on time, but the tight management between the Board of Governors and the executive management of St Thomas's operated on a consensus basis. Given that a few of the people who were in the process were able to give some indication that this might actually be a very effective way of bringing professional people like nurses and doctors to actually be able to secure change. Some of the clinical practices, as I said earlier, were ahead of their time, such as day surgery, shared care and diabetes moving from specialist care to general practice. The hospital and the medical school had a department for primary care and a health service research unit. It was a logical direction of travel.

Dr Geoffrey Rivett

I would like to take it back to 1950 – Bradbeer, Central Health Services Council.⁶³ The NHS inherited two hospital management systems. In the local authority hospitals, which were the majority of hospitals, autocracy ruled. If you wanted to change a lightbulb in an LCC hospital, you invoiced County Hall. In the voluntary hospitals there was this triumvirate of the Chief Executive, the Secretary of the Board of Governors, the Matron, a senior doctor, and it worked very well.

⁶² See appendix; Report of the Committee on Senior Nursing Staff Structure ((London, HMSO, 1966).

⁶³ Central Health Services Council, Report of the Committee on the Internal Administration of Hospitals (London, HMSO, 1954).

Bradbeer looked at the two; he opted for the voluntary system and encouraged that for general adoption. That was probably the first breath of consensus.

Nicholas Timmins

They were a triumvirate but they were not all equal.

Dr John Marks

No way.

Dr Geoffrey Rivett

In that sort of triumvirate, a House Governor and a Matron and the senior doctor either swum together or sank together. It was more consensus than one would imagine.

Lord Owen

In the documents on NHS Reorganisation Circular in January 1973, paragraph 127 - 'the team being made up of equals, each member will coordinate the team on matters of particular relevance to his own discipline and functional coordination'.⁶⁴ This was the Bible; I had it thrown at me non-stop from 1974 onwards. Philip [Rogers] really absorbed these two documents. I have them here if people want to look at them.⁶⁵

Lord Warner

I have a terrible feeling I wrote some of that, David. I must have a look at that to refresh my memory. I just want to jog Robert's [Maxwell] memory. I can remember having lunch with you Robert, I think at the suggestion of Ron Matthews. It was when you were still trying to sort out the Department of Health as well as actually going to this area. I cannot remember what we discussed but I remember your parting comment which actually tells me quite a lot. You said, 'I have got to go now. I am back to wrestling with the jellyfish', meaning the Steering Committee. That might give you some clue as to consensus management. I have just been looking at the list of the members of the Steering Committee. It tells its own story: that many people in the Department were in a state of great anxiety about what these strange people called McKinsey were going to do to their lives and their jobs. I suspect that consensus management comes out of them not wanting to put anyone in charge. Is that a fair interpretation?

Dr Eric Caines

I think it is. We were prepared with catchphrases: consensus management, delegation downwards, accountability upwards. They all tripped off the tongue nicely. They accorded with the flavour of what the Steering Committee felt about how it should be run. We spoon-fed it to them. We went to great lengths to set up the outcome of meetings before we ever went to them. We briefed Philip Rogers. We talked to Philip Rhodes and John Marks endlessly. When we went there we knew what we wanted and we knew what we were giving them. It went relatively smoothly as far as I am concerned.

⁶⁴ HRC(73)3, 'Management Arrangements for the Reorganised NHS', January 1973.

⁶⁵ Sir Philip Rogers (1914-1990) was Permanent Secretary of DHSS from 1970 to 1975. He was also Chairman of the Steering Committee. See appendix.

Dr Robert Maxwell

The jellyfish is a fair reflection of how I reacted to the Steering Committee. Remember I was in a sense an outside observer because my responsibility was the work on the Department. Christopher, initially, and then Rod Taylor were responsible for the management of the NHS team. I only went there by invitation and I thought it was a difficult organisation to deal with as a client.

Nicholas Timmins

[To John Marks] As a jellyfish member...?

Dr John Marks

There are three items that have been brought up that I'd like to deal with. The first one is consensus. That was written in Keith Joseph's document. It was a nonsense. Everyone can see you cannot consensus-manage with six people, but it was also laid down that if they could not agree it would be referred up to the next tier and there was some nonsense about accountability, upwards and downwards.

Nicholas Timmins

Maximum delegation downwards, maximum accountability upwards.

Dr John Marks

So that was laid down. The next thing was the concept of the District. That did come from the Steering Committee. The original government documents had two tiers: Regions and Areas. We could see that it was much too big and it would not and could not work. There is then the question about the teaching hospitals and Boards of Governors and their money; sitting on that Steering Committee were two NHS consultants. You must remember there were not two sorts of hospitals; there were three: the old municipal hospitals which were effectively workhouses, the old voluntary hospitals which were sub-divided into the poor relatives, and the teaching hospitals with their Board of Governors and their masses of money. Clifford Astley, the Chairman of the BMA consultants committee, was determined to cut them [teaching hospitals] down to size, and I think he succeeded.⁶⁶ They were going to be dragged screaming into the real NHS.

Nicholas Timmins

Which of course reflected the internal tension within the BMA between the regional consultants and the London ones.

Dr John Marks

And John Walton, who became President of the BMA, never forgave him or me for doing that.⁶⁷

⁶⁶ Dr Clifford Astley (1915-1995) was Chairman of the BMA Central Committee for Hospital Medical Services between 1971 and 1975.

⁶⁷ Professor John Walton (1922-2016) was Dean of Medicine at the University of Newcastle from 1971 to 1981 and President of the BMA from 1980 to 1982.

Professor Brian Edwards

We have a useful distinction emerging now. Teamwork in the NHS was commonplace. John Wyn Owen has talked about it. I serviced a multidisciplinary team in a Hospital Management Committee in the '60s where the Matron, the Senior Consultant, the Treasurer and the Group Secretary were there and they ran it as a team. That is commonplace and pretty routine in the best bits of the NHS. The additional bit was the consensus bit. You are right; there was a lot of consensus in those teams, but it was not required. We ought to concentrate, as we have done, on how the consensus bit got added to the teamwork bit.

Bob Nicholls

John Wyn Owen was paying credit...of course Walter Holland and I wrote the job description that led to John Wyn Owen's appointment [at St Thomas' Hospital] – so we need to put the baggage on the table. Where you stand depends on where you wanted to sit at the time. I am with Brian [Edwards], really. The context that some are painting is – it is partly context and partly a question: why did the Department think they had to get into the detail, the minutiae and the analysis of each role, and the sapiential authority? You had a District but actually you did not have a statutory authority. We District people were all appointed by the Area authority and I could not say boo to my Finance Director, let alone my nurse, because they had a sapiential boss at Area. Why did you get into all that? I think Brian is right in emphasising that an informal form of consensus management operated in the best hospitals before the Grey Book and that it was encouraged by the national training scheme, certainly if you were [trained at] Manchester with Teddy Chester.⁶⁸ I went in slightly starry-eyed, thinking as an administrator that my job is to help the doctors and the nurses deliver the best care with however much money we could squeeze out of the tier above. That was fairly simple.

Dr Eric Caines

Which is a fairly loose definition of management, you must admit.

Bob Nicholls

And actually, we had to do that together collectively -I am trying to avoid the word 'consensus' - you made that explicit. But why the hell was it felt necessary to do a detailed Grey Book of over 100 pages on each little bit? Politicians would not go near it now.

Dr Eric Caines

I agree with you now but at the time it felt very different. You've got sets of relationships which you have to define and each discipline was asking 'what's our role', how it fitted in and how it related to other people. In a sense it got out of hand. Delegation downwards, accountability upwards, when looked at against the structural diagrams drawn from Region downwards, where at least twelve levels of management could be isolated, is like devising a game of snakes and ladders. You go up; you go down. Whatever comes out of all of it? You are right: who would do it in that way now? But it was so loose and ill-defined and undefined at the time that we were pushed into doing it.

⁶⁸ Professor Theodore (Teddy) Chester (1908-1990) was Professor of Social Administration at the University of Manchester from 1955 to 1975. He helped to establish and lead the National Administrative Training Scheme for hospital administrators at Manchester from 1956.

Bob Nicholls

Was it to do with professional anxiety about we wicked managers - a term I never heard? Secretaries had an important administrative task which has now been devalued. [To John Marks] Were the professions scared that we were suddenly going to take over and start bossing you about, John?

Lord Warner

The professions started bidding, did they not? I can remember coming back from America to have to sort some of this stuff out. My abiding memory of this is the bid to have an Area remedial gymnast. I am not making that up. They were coming out of the professions. They were wanting to have a bit of the gravy, if I may put it that way, that Eric [Caines] was enabling them to consume.

Dr John Marks

As an ignorant clinician, I did not know the difference between administration and management, so I asked somebody from McKinsey. They said to me, 'If you go to India they have trains running to a timetable; that has not altered for one hundred years. That is administration. Change the time of one train; that is management'. That is how they defined it to me, and I think it is right. Management involves change and administration involves running something that is.

Stephen Davies

I am doing research into the history of the Department's R&D [Research and Development] programme between 1961 and 1986. In the course of that project, I recently read the Grey Book for the first time. I was too young to remember these events. My background is in NHS management, and reading the Grey Book as someone who has worked in the NHS for the past twenty-five years, I was completely staggered. What I was staggered by was the extraordinary, prescriptive, complex, multi-layer organisation described, and alongside that you have this concept of consensus management, so those two things are never going to work together. The glue that holds this all together is planning. There is this extraordinary faith in planning which suffuses the whole document. I wanted to ask the panel to reflect on that. Maybe that explains how anybody could believe that the consensus management and the complexity of the structures was ever going to work. Did you really believe it? What do you think about it now?

Dr Eric Caines

In terms of management, the health service was held in low esteem, generally, around Whitehall and elsewhere. It did not know how to do things was the general feeling. Wherever you went it was done differently. It probably used the same sort of language – team-working and all that sort of stuff. It needed sorting, it needed a plan and it needed a methodology. It probably went overboard a bit in terms of the methodology but nevertheless it was understandable why we did that at the time.

Stephen Davies

Where did this faith in planning come from?

Nicholas Timmins

It was an era of faith in planning. Everything was planned.

Lord Warner

The Heath Government really believed in planning.69

Nicholas Timmins

The Heath Government was not far off a planned economy. I mean, it was a long way off a planned economy, but it was much more of a planned economy than we have seen. It fell out of fashion in about three years but it was the fashion at the time.

James Lee

It absolutely was. It was a fallacy, but the assumption, rather naively, was that it was possible to set achievable standards and goals, to specify the method, cost it and then allocate funds. It was completely the opposite of a market-driven system.

Nick Timmins

You have to remember the Soviet Union appeared to be really rather successful at this time. I'm not joking.

James Lee

After doing this at the NHS, I went on Victor Rothschild's Central Policy Review Staff under Heath.⁷⁰ There was an attempt to do something in a very troubled area of Liverpool where the same philosophy was applied. The idea was to combine education, health, and social services in a complex plan. Mrs Thatcher was the Education Secretary at the time.⁷¹ It was to overcome structural impediments through joint planning. As I say it now, I almost cannot believe that everybody believed this but it was almost a religious belief at the time.

Professor Martin Powell

Now you have reminded me of that phrase, 'maximum delegation downwards, maximum accountability upwards', I am reminded somewhere vaguely that that has been described as something like the most unintelligible phrase ever in the history of the English language, although clearly there have been a lot of candidates since then. Can somebody please tell me what the hell it means?

Dr Geoffrey Rivett

It means as Ara Darzi said, that with good District General Hospitals about the place, they should do everything within their capability, and that only things that needed specialist expertise should be

⁶⁹ See for example, Ball and Seldon, *Heath Government*.

⁷⁰ Lord Rothschild (1910-1990) was appointed by Edward Heath as first Director General of the Central Policy Review Staff, a Cabinet Office unit which aimed to co-ordinate government policy, in 1971.

⁷¹ Margaret Thatcher (1925-2013) was Conservative MP for Finchley from 1959 to 1992 and Secretary of State for Education from 1970 to 1974.

pushed up to tertiary hospitals, where the outcomes would be better for patients.⁷² That is a fairly common idea, and understandable?

Nicholas Timmins

Subsidiarity. Yvonne.

Dame Yvonne Moores

It is taking us back to the professional pressures and what had happened with nursing, and I think the impact that that had on the outcome and the Grey Book itself, because the Salmon Report gave us levels and levels of management, and detailed job descriptions. That is what then was reflected and used in the Grey Book. It also, of course, at that time created an enormous expectation in the nursing profession and although we were not fighting with the medics of the time, we were certainly wanting to talk about a collegiate relationship, not a subservient one, and that was a very powerful lobby.

Just while I am talking, I want to mention the terrible mismatch of what actually happened with Districts and Areas. I was in the North-West and we had nine single District Areas in Greater Manchester, two other multi-Districts, we mopped up the teaching patches in Districts which were greater than the size of the rest of the Areas put together. It was a complete leadership, management and planning error, and everyone had to work it through.

Terri Banks

One of the things that was required for this great planning system was that the Department [of Health and Social Security] started it off with national guidelines. One thing that did come out of that was the consultative document on priorities, which had a very big influence over the years and indeed made the first step towards linking across different professions to client groups and costing programmes.⁷³ It actually costed a lot of stuff and showed where the trends were now and where they might go in the future. That in turn led to the introduction of financial limits on planning, and linked with RAWP [Resource Allocation Working Party], it gave a financial structure within which Regions could operate.⁷⁴

Professor Nick Black

I have another question, coming back to consensus. To what extent, at this point in the early '70s, was the challenge of holding the medical profession to greater public accountability present in these discussions? To what extent was the ideal that politicians, and maybe the steering group, would have loved to have had was something much closer to what came later in terms of general hierarchical management and non-medical control of doctors, and that consensus was a middle

⁷² Lord Darzi, Professor of Surgery at Imperial College London since 1996, was Parliamentary Under-Secretary of State in the Department of Health from 2007 to 2009, and led the 'Next Stage Review' into the future of the NHS. The final report was *High Quality Care for All*, Cm.7432 (London, Department of Health, 1998).

⁷³ Department of Health and Social Security, *Priorities for Health and Personal Social Services in England: A Consultative Document* (London, HMSO, 1977).

⁷⁴ The Resource Working Allocation Party established by DHSS in 1975 designed a new NHS funding formula which took greater account of need. See *The Resource Allocation Working Party and the NHS: Origins, Implementation and Development, 1974-1990*, Witness Seminar held 21 November 2013 by the Centre for History in Public Health, London School of Hygiene and Tropical Medicine: <u>http://history.lshtm.ac.uk/2016/07/11/the-resource-allocation-working-party-and-the-nhs-origins-implementation-and-development-1974-1990/</u>

course to get some control and accountability of the medical profession while keeping them on board?

Dr John Marks

I was accountable in two ways. For my work in the NHS, I was accountable to the Executive Council who had a complaints procedure and that could go to appeal. That was one thing. I was also controlled by the GMC [General Medical Council]. That was, I believe, how we should be controlled, then.

Professor Nick Black

I was thinking of wider accountability.

Dr John Marks

There was none.

Dr Eric Caines

That only goes part of the way. It is right that we never got into defining accountability. What were we holding them accountable them for? For operating the process? There is no mention of outcomes and no mention of forms of medical improvements. Doctors were not being held to account for what they actually did in terms of patient care. None of that featured in this, so these words were relatively meaningless.

Dr John Marks

I do not think it was considered something that needed considering. We were accountable. If you worked in a hospital you were accountable to the hospital management.

Nicholas Timmins

We can have a long debate about how far consultants were accountable to hospital management. Let us have a coffee break.

[Adjournment]

Nicholas Timmins

Round two. We are going to do outcome and legacy. I want to read a quote from Celia Hall who was the medical reporter on the *Birmingham Mail* at the time all this took effect.⁷⁵ She said, 'Before 1974 all the good stories came out of the local authority's Health Committee and the local Medical Officer of Health; the Pill on the Rates and that sort of thing. Hospital Boards consisted of the odd Lord Lieutenant and ladies in big flower hats who never seemed to have anything to decide. After

⁷⁵ Celia Hall, who went on to be Medical Editor of the *Daily Telegraph* between 1995 and 1999, was then a reporter with the *Birmingham Post*.

1974, the council no longer had any stories. They all came from the Area Health Authority. But when you got there it consisted of dozens of administrators and appointees sitting around in great horse shoes so many rows deep that they scarcely fitted into the room – and they still were not clear about who was deciding what about whom'. But before we implement it in 1974, a Labour government is elected and has a matter of weeks to decide whether to go ahead with this. Lord Owen.

Lord Owen

It was not even a week. I had not been formally appointed as Minister, and I came to see Barbara Castle. I was appointed the next day and she said, 'David, stay and wait. There is a really important meeting,' and Philip Rogers, the Permanent Secretary, came in and he said, 'Secretary of State, I am sorry but we do have to make a decision today. It is three weeks away from vesting day'. This was March and it think the deadline was 1 April. She took it well and told him to present the case. He presented the case in considerable detail. The meeting must have been at least an hour and very forcefully but pretty fairly presented this machinery that was being built up and everything like that, and then he ended and said, 'Secretary of State, we are here to do what you want. It is possible to stop it. I have given you every form of argument why it would be very difficult but if you decide to do it we will loyally follow it through', and then Barbara said to me 'David, what do you think?' As I say, I had not been appointed but I had negotiated that I would be a Minister of State. I said 'I do not think we have got any alternative. I think it will be absolute chaos'. So she came in straight and said, 'I agree and I do not think we have any alternative'.

Barbara Castle was a very formidable person. When you get her on ideological issues, she was not the most rational or reasonable person but she had a razor sharp mind and huge courage. She was also already a very experienced and very good Minister as a Secretary of State for Labour. I believe if the trade union reform package that she had had gone got through she would have ended up being the first female Prime Minister.⁷⁶ You could have a hell of an argument with her and still respect each other in half an hour's time. I think she made absolutely the right decision. We then discovered how close to chaos it was in so many different respects. We discovered, for instance, that the Area Health Authority that was going to make the District team decision had been changed. The timetable was so behind and Keith Joseph had made decisions in many areas of the country which were very controversial. A whole raft of things had come out later but that is the history of it and it was all decided in that first meeting, and I have no doubt it was the right decision.

Nicholas Timmins

You did make a couple of changes. The number of local authority representatives [on Area Health Authorities] went up from a quarter to a third.

Lord Owen

We were tied with the party decisions. It was a bloody difficult decision for us politically. Most people believed that we would close down the regional option and make it just advisory and not have a Regional Health Authority, but the way Philip Rogers explained it and the way it was implemented meant that the Department were deeply involved in the implementation and they were guiding it, and he was guiding it and he was an old colonial civil servant and a man of great integrity, and he drove this through from the centre. The vehicle for driving it through was originally the Region. I have a memo here from about four months later when I am really taking

⁷⁶ See R. Tyler, "Victims of our History? Barbara Castle and *In Place of Strife*', *Contemporary British History*, Vol.20, No.3, 2006.

him to task because he gave us a commitment that the Region was not going to be built up in power and it was not being reduced. I challenged him over it and Barbara did too.

We were getting a lot of trouble, so our democracy in the NHS was quite honestly politics. It was the minimum we could do to keep the party onside and the minimum we could do without being too disruptive. I am not proud of it. It was not terribly necessary for the NHS reform. The toughest thing would have been to do nothing but then we would have had an impossible row on our hands and we were facing another election in six months. We had to show that we had done some changes. Philip was very good about that; having won on the substance he saw the political difficulty we were in but he could not shift from this centralised implementation and that was our real problem. I was fighting for him not to entrench the powers of the Regional Health Authority. A complicating factor was that the government as a whole were looking at regions, so it would have been quite difficult to close the regional health option as another study was going on. We were on quite a knife edge for five or six months with the reorganisation. It was not easy, but great fun. It was the best job I have ever done in my life; I thoroughly enjoyed it.

Nicholas Timmins

My other favourite quote about this is Patrick Nairne, who was Philip Roger's successor, and the whole thing became 'tears about tiers' over time.⁷⁷

Professor Brian Edwards

Going back to how we got into those jobs; in those days administrators, nurses, and treasurers had to apply for five jobs [in the reorganised NHS after 1974]. You ticked the five boxes and then you went off and had five interviews by five different parts of the new system, and then they all went into a hat and you got an offer. I was expected to be the District Administrator for Hull. In fact, I had been told that I had already got that but out of the blue came the offer to become the District Administrator for the General Infirmary at Leeds, which I accepted. So, that was going on right throughout the managerial system in the NHS and then of course that was replicated for our deputies, heads of service and everybody else, and so you did not complete your management structure until well into 1975. It was an unstable, thin organisation until 1975. I have been through the minutes of the District Management Team at Leeds for that period and I can tell you what the context was. It was pretty frightening.

Bob Nicholls

I was hinting before the break that where you stand depends on where you want to sit; distance lends an enchantment of the view, so beware, is what I say. Were you the victim or the beneficiary of these major changes? The answer, I suspect, for Brian, if he is honest, and me, is we were amazing beneficiaries. I had gone from St Thomas's [Hospital] with a wonderful boss to a boss with a good reputation at Southampton [University Hospital] as a Deputy Group Secretary, I think we were called. We had our own Hospital Management Committee. And then suddenly this process. It depended on the Region, so a small Region like Wessex - go-ahead - just about to open a new medical school – Dean, Donald Acheson – and suddenly, tick the boxes, fill in forms, and lo and behold, jackpot: my boss moves up to the Area and suddenly I am the District Administrator, so there is no immediate worry that we have got to prepare agendas for this Hospital Management

⁷⁷ Sir Patrick Nairne (1921-2013) was Permanent Secretary of the Department of Health and Social Security from 1975 to 1981.

Committee and be hauled over the coals.⁷⁸ This was great; we had a bit of freedom. Our team at District felt collectively accountable for the overall management of the district to the Area Health Authority based in Winchester (where the Regional Authority was also based) and individual members of the team would have occasional discussions with their professional counterparts. As I recall, we tried to avoid testing sapiential authority by resolving issues at District level and overall consensus management worked very well for us. This may have been, in part, because I saw my roles as Administrator largely as co-ordination, planning and supporting the clinicians. Interestingly, we did not choose each other. Wessex was good at preparation; we went on training courses and things before we filled in the boxes, but we had no say in the rest of the team. I had no input into the appointment of the nurse or the public health doctor, so whether we would get on was down to a bit of luck unless it was skilfully done by the Area; it might have been. Certainly consensus management was not the shock or disaster in Southampton that it was reported to be in other places. I was worried about that but it worked, consensus management, as we have said before, actually reflected the best places. That is how I was trained to work as an administrator. So, it was not the shock. In other places that clearly was not the case.

I think you have to be very careful of hearing from a few people for whom it worked very well personally and actually I found a note from Donald Acheson saying what a great job I had done; it was on a Christmas card. Donald was on the DMT [District Medical Team] because, as a teaching District with a new medical school, we were authorised to have the Dean as a member. I am not sure whether this was written into the Grey Book but although I had worked in the old teaching hospital set up with a Board of Governors with direct access to the Department of Health, this new arrangement certainly worked for Southampton. This was due in part to the fact that we were well supported by the go-ahead Wessex Region led by Professor Revans and John Hoare - a visionary Regional Administrator.⁷⁹ Luck plays a part in this and I was one of the lucky ones.

Nicholas Timmins

My impression of it was that where consensus management worked well it worked well but this was in a minority of places.

Dr Geoffrey Rivett

The downside was that we lost a very large number of skilled people. I am thinking very much of public health medicine. I went on a course for reorganisation and there were two Medical Officers of Health, both of high quality, one for the county and one for the county borough in its centre. Only one could become a Community Physician; the other one committed suicide. That was rather drastic but one should not underestimate the sadness and the horror of a lot of people who had been doing a pretty reasonable job and found themselves out.

Professor Brian Edwards

History will tell us that the loss of the Medical Officer of Health was a grave strategic error, because he was a person of importance, influence, with substantial independence in the local

⁷⁸ Professor Donald Acheson (1926-2010), was Dean of the Faculty of Medicine at the University of Southampton from 1968 to 1978, and later Chief Medical Officer in the Department of Health and Social Security from 1983 to 1991.

⁷⁹ Professor John Revans (1911-1988) was Senior Administrative Medical Officer for Wessex Regional Hospital Board from 1959 to 1973, and Regional Medical Officer for Wessex Regional Health Authority from 1973 to 1976. John Hoare was then Regional Administrator for Wessex Regional Health Authority, and later Regional General Manager during the 1980s.

authority and he was powerful. We lost that. The public health voice was weakened by this reorganisation.

Nicholas Timmins

The good Medical Officers of Health were great but they were not all good. That is true by definition. Coming back to a point someone made earlier, their relative power varied around the country quite a lot. Someone made the distinction between rural and metropolitan. It was a mixed bag. I am just about old enough to remember going to cover the annual conference of the Society of Medical Officers of Health, and I tell you: they are a very mixed bunch. John.

Professor John Wyn Owen

I was part of a group where consensus or working together worked. What were the challenges? One was certainly the financial challenge and commissioning a new hospital, and in the old days revenue consequences of capital schemes were something that would come with the new building. So we were confronted at the time of the oil crisis with a double whammy of both the cost of running the new building and the prospect of it not coming. Lights were already being turned off and there was this feeling that too much resource was concentrated in the South East or in London and resource reallocation was going to be a reality. So, we then had to look at how well we were performing and what we could do to actually live within our means. We came up with a project to close Lambeth Hospital and that put us immediately into conflict with the Community Health Council, which was extraordinary in terms of its articulateness, in terms of reflecting the sense and the politics of Lambeth around this rather exclusive institution doing its own thing in the way that it had always done things in the past, and was planning to build on the nine acre site in Lambeth, housing or accommodation for healthcare workers – in other words an elite compound in Lambeth.

Then the issue was that this was a new experience for us administrators to deal with locally elected people. Ken Livingstone and Ted Knight were a completely new experience.⁸⁰ One anecdote is that we had a policy of respecting previous organisations' policy. Suddenly in one of the Health Authority board meetings, Ken Livingstone asked whether it was true that Lambeth Health District was making Cow & Gate milk available, because Lambeth had a policy against it. I knew exactly what was behind it and Sir Kenneth Younger, the Chairman, said they can report to the next meeting, and it was a real experience of dealing with local councillors as opposed to the great and the good who had been Governors.⁸¹ Of course we were selling Cow & Gate milk in Lambeth clinics. Sir John Prideaux, who had been Chairman of the Board of Governors was about to speak, and then suddenly one of the councillors said 'Excuse me. You may not remember but you have to declare your interests, and to save you time here is a list of the organisations which you are associated with'.⁸² There was complete silence. It was then quite clear that somebody had changed the procurement rules and the headline in the Evening Standard was, 'Officers, not members, decide policy', and for me that was a real awakening, almost to the point David [Owen] was making, about how important in the new structure locally elected officials sitting on health boards were. That was an important dimension.

⁸⁰ Ken Livingstone was a Labour member of Lambeth Borough Council from 1971 to 1978, and later Mayor of London from 2000 to 2008. Ted Knight was leader of Lambeth Council from 1978 to 1986.

⁸¹ Sir Kenneth Younger (1908-1976) was Chairman of the Lambeth, Southwark and Lewisham Area Health Authority (Teaching) from 1974 to 1976.

⁸² Sir John Prideaux (1911-1993) was Treasurer and Chairman of the Board of Governors of St Thomas's Hospital from 1964 to 1974, Chairman of the Special Trustees from 1974 to 1988, and a member of Lambeth, Southwark and Lewisham Area Health Authority (Teaching) from 1974 to 1982.

The final thing that I want to say is that the St Thomas's team took the District concept. People have not been reminded that many of the Districts were based on the old civil defence concept of eight hundred beds to serve two hundred and fifty thousand people, which was the basic unit. We had taken our responsibilities for the health of the people in Lambeth seriously and our mental health services were provided in part by Tooting Bec Hospital which was in the South West Region. We asked, in order to provide a comprehensive service, for Tooting Bec to be transferred to the St Thomas's Health District. We were trying to make the concept work but we learned a lot of things. Particularly the most rude awakening was dealing with locally elected officials who had strong local allegiances and views, and were very different from the old fashioned Board of Governors of people who were the great and the good.

Dame Yvonne Moores

Whether it worked for us or not, it did not for me to begin with. Although the patch for which I was the overarching nurse was an Area, a single District Area, I then got a job in a District which was twice the size. I think the important point for me to make is that for the first time ever as a result of this change we began to manage patient pathways. It was not a hospital episode. It was a patient pathway across into their own homes and into community centres. We were able to use Health Visitors not just for kids but for elderly people. It was a major change and, in my view, of all the changes since, this is one of the few changes that actually made a difference to patient care and the delivery of clinical services.

Nicholas Timmins

That brings us partly to the aim of the integration bit. The hospital services and community services got much better integrated. The GPs still had their Family Health Practitioner Committees and their own direct line to the Department [of Health and Social Security], and Areas had some influence but no control. Fair?

Dr Geoffrey Rivett

Fair, and of course not all Boards of Governors disappeared in 1974. I had a very great pleasure of being part of the direct relationship between the Department of Health and specialist postgraduate hospitals, of which there were twelve. Somebody mentioned a 'cosy' relationship; cosy may possibly be too strong a term but it certainly was understanding and friendly and we felt like we were on the same side in the improvement of services. We were all proud of the postgraduates and we nurtured them. The relationships between the Department and the Regions varied and could be more confrontational; it was more about money and capital development, less about clinical care.

Nicholas Timmins

I remember someone saying to me that one of the beneficial effects of the teaching hospitals coming under the Area was that if you are a consultant at 'Bart's [St Bartholomew's Hospital, London] in 1974 and you drove out of the hospital, the consultants turned left to go to Harley Street, and after 1974 they occasionally turned right to go towards the Homerton.⁸³ It brought the teaching hospitals into a better relationship with the other hospitals.

⁸³ Harley Street in Marylebone, central London, was the preferred location for elite consultants to have their private consulting rooms. Homerton Hospital is in Hackney.

Dr Geoffrey Rivett

I have to come into that because it is reputed that the attitude in 'Bart's was that that 'Gentlemen do not go to Hackney'. The fact that Homerton has its own Foundation Trust and separated is partly because of the antipathy which sometimes existed between teaching hospitals and those 'below the salt' that had been managed by Regional Hospital Boards.⁸⁴

Professor Brian Edwards

It was true though, that when the Area Health Authorities were appointed, the Family Practitioner Committees came in and took over from the Executive Councils they were discernibly separate. They did not fully integrate. They remained in their separate organisation with their own Chief Officer and they did their business.

Bob Nicholls

Half of their members were elected by the professions and half were a mixture of local authority appointments and appointments by the Area Health Authority. So, certainly I would list it as one of the complete failures of the objectives of this, but that did not stop, as Yvonne [Moores] said, good places and good relationships doing far more across the piece than was done before, as happened in Southampton. Mental health, although not everywhere, got a boost as well. There were things that did work, but the leaving out of the GPs and the central contract arrangements, even if independence had been clear, was a big loss.

Lord Owen

The financial pressures were huge. Inflation was running at over twenty percent after the oil price rise. We were changing Area health budgets every month but we still gave a step-like increase to the NHS over these two years at one percent of GDP. It was totally irresponsible. The Chancellor was having to pay it out and one knew that it would come to a crisis and of course it came in 1976 with the IMF.⁸⁵ We had already introduced in 1975 a cost constriction, which actually was beginning to bite from the Treasury. There were no cost-savings; there was no £20m or whatever it was for the last reorganisation. I do not personally believe you can do any reorganisation of an organisation as large as the NHS without money to oil the system, so that was fortunate but the country was going broke while we were paying it out.

Lord Warner

We were almost certainly doing a reorganisation, although this never totally surfaced politically, where the cost of running the NHS went up at a point when the amount of money available for clinical services was either flat or going down.

Nicholas Timmins

It was certainly so for administrators and administrator numbers. I know that the way they are counted is not very reliable but it was a thirty percent increase.

⁸⁴ The first Foundation Trusts, semi-autonomous Hospital groups in the NHS in England, were announced in 2004, including the Homerton. See Klein, *New Politics*. 'Below the salt' is a reference to formal dinners, such as those at Oxbridge colleges, where the position of the salt cellar on the table indicated the status of those seated above and below it.

⁸⁵ See for example R. Roberts, When Britain Went Bust: The 1976 IMF Crisis (London, OMFIF, 2016).

Dr Geoffrey Rivett

The background of the planning system was that we were 'planning for negative growth'. One of the reasons why the planning system came to pieces was because thousands of bright people were constructing theoretical plans that would never be implemented because the money was getting less all the time.

Nicholas Timmins

Were there not also problems with the three tiers, given that everything was on typewriters? We did not have fax machines in 1974; it was all done by post, so some of the planning stuff took longer than a year to get up and down the tiers, so the plans were behind reality. There was no email; it was just telephones and post.

Terri Banks

Can I comment on that? The proposal that we were given on the planning system was literally that the plans would start with the document from the centre which was consultative, because it would eventually respond to plans coming up from the bottom. Planning goes right down to District and right back up through all the tiers, and that was going to take two years so there were going to be two planning systems on two-yearly cycles which never quite met. That was how the system was supposed to operate. In fact, of course, what happened was there was a first go at it during the 1970s which was a big learning process. One of the regional plans, for instance, did not have a single Pound sign in it, and the Department [of Health and Social Security] had a huge amount to learn. It was very difficult because Regions were thinking in quite different terms from the Department.

It was around, I remember, Brian [Edwards], in the early 1980s when we were really talking to each other, particularly about affordability, and then with the Griffiths Report, of course we got vastly simplified planning guidelines from the centre and it all started to make very much better sense.⁸⁶ That was an important legacy because planning enables you to think across different users and services which have got to be managed on the ground in a quite different way. You cannot manage a group of home nurses by client group. They do all sorts of jobs for different people but you plan how many you need. One of the problems that I kept hearing was that in order to think across services you have got to integrate them and you cannot put everything into one organisation; it is too big. There is the whole of Health and Social Services, and then you have a borderline with Education and all over the place. The basic point is that human beings will learn to manage borderlines if you have stability along those lines and adequately paid people and they will manage to get their contacts. But what we see is endlessly - 'We have a problem on this boundary so let us reorganise', and you simply create a problem on another boundary. I agree there are exceptions, including in hospitals and community health, but I think that is partly the story of the NHS: endless reorganisation. There are other reasons as well, but it is this idea that human beings cannot think across boundaries; you have to integrate and have an integrated management structure. The two are different. The planning system was a useful long-term legacy but it had an awful long way to go from how it was supposed to set out.

Nicholas Timmins

Let us have some more positive outcomes. Sally.

⁸⁶ National Health Service Management Inquiry (London, DHSS, 1983).

Professor Sally Sheard

Can I ask the McKinsey gentlemen in the room the point at which they signed off on the reorganisation? Was there any sense that McKinsey would maintain an interest or involvement after that vesting day of 1 April 1974?

James Lee

My memory of it is that our involvement ended with the publication of the Grey Book, because actually I am sitting here quite horrified. I had no idea that the positions were all up for grabs and people were moved from Hull to Dorset. That was never part of the thinking at all, which was a fault of ours because there should have been an implementation plan. The other thing is that, as there seems to be an opportunity for people to own up, is that I had no recollection at all that the new structure was costed at all. Eric, correct me if I am wrong but I do not remember a process where we even counted the number of positions and put a Pounds, Shillings and Pence sign on it. I do not think there was any costing at all.

Dr Eric Caines

James is right that the Grey Book was the end of their exercise. McKinsey disappeared, I disappeared, as did other people who went onto other things. It was not costed but the basic fact is that after 1974 the number of staff grew incredibly. It rocketed. The one percent increase that was delivered went on staff pay and settlements of staff disputes, payments and what have you. There were all sorts of disparities between what doctors got, what other people got, great disputes between the Whitley system and the review bodies system, and that is what was gobbling it up at the time.⁸⁷

Lord Owen

We did not have a majority [in Parliament]; we were busy financing the next election in October, and winning it.

Lord Warner

The people who stayed around were Brunel [Health Services Organization Research Unit], because my memory is I was there after the start in April, until I went to work for Barbara Castle in that June [1974]. I have a memory of people being brought in from Brunel to try to understand what the hell was meant in bits of the Grey Book and what the 'Bible' really meant, so that it could be communicated to the NHS. When Eric [Caines] went, this got settled back into the departmental structure with David Williams, and we were the residual people with 'expertise' on what all this meant. Partly because of some of the grading issues, there were still running disputes about what some of these grades actually meant, what they were supposed to do and how they related to other bits. All of that was still going on, as far as I am aware, after I disappeared into Barbara's private office. Certainly, there were still people coming backwards and forwards between Brunel and the Department.

⁸⁷ The long running system of Whitley Councils brought together representatives of employees and employees in public services to discuss pay, conditions and other issues. In the NHS see C. Webster, *Vol. 2*.

Professor Brian Edwards

It was worse than that. You had to submit your structure upwards, so the Area team had to submit their structure to the Regional team and the Regional team had to submit their structure to the Department of Health, who ticked boxes to see how far it fitted the Grey Book. I remember we were a bit uncomfortable with bits of it but we did exactly what we were asked for. We put it in so got a tick, and then we did a bit of finessing around the sides. The system looked at every bit of it, and if you left a nurse out – and one or two did – there was hell to pay because the whole system was being checked.

Dr Eric Caines

There was a period of shadow rolling out was there not, for a short time before 1974? Somebody would have got to grips with some of it.

Bob Nicholls

Positives – this will be very unpopular so I will have a go. The keeping of the Regions depended probably on your Region and I have already alluded to the Region I happened to be in, Wessex, which was go-ahead. It was small. I think Oxford has been mentioned as a Region which felt that this was a community. One of the Holy Grails is: how do we separate NHS management from politics? It is bloody nonsense if it is tax-funded but never mind; that is the Holy Grail, and actually Regions helped do that. They managed upwards, despite the hierarchy, and they protected and connected downwards. It is interesting that they survived until I came back, as some of you know, into London and Virginia [Bottomley], then my Secretary of State, was the only one left saying we still need Regional Authorities because it provided that buffer.⁸⁸

It is not all positive. The negative is that there were too many tiers, as had been mentioned before. John Hoare and I were in the October Club.⁸⁹ You need an old memory for this. Either Sir Keith Joseph or perhaps Permanent Secretary Rogers thought we were some revolutionary undermining group. John and I wrote a paper called 'Too Many Tiers' and we got to see - which must have been very unusual - Rogers and Joseph. We did not get anywhere and actually the 'Too Many Tiers' bit, which goes onto the negatives, moves on from the Region, Area, District. The outward flow is interesting. Where did I go after three years? I was really enjoying myself then, but I went to a single District Area, Newcastle, where the coterminosity worked. We even had a joint budget for what is now called learning disabilities with Newcastle local authority, so you could really do things if they were really coterminous. But what about the layers below and the drain of, certainly administrators? I had one Peter Griffiths in Southampton, and he was my sector unit manager for the main hospital that was becoming a prominent DGH, a teaching hospital, and if you had someone of that calibre, you could hang onto them, which we did for a couple of years.⁹⁰ There was a problem. That was not the bottom level either; if you really went to the frontline where the doctors and the nurses really worked...So, there were more administrators but not necessarily more management.

⁸⁸ Virginia Bottomley was Conservative MP for South West Surrey from 1984 to 2005, and Secretary of State for Health from 1992 to 1995. Regional Health Authorities were finally scrapped in 1996.

⁸⁹ The October Club was a group for former members of the National Administrative Training Scheme formed in 1964. See S. Snow, "I've Never Found Doctors to be a Difficult Bunch': Doctors, Managers and NHS Reorganisations in Manchester and Salford, 1948-2007', *Medical History*, Vol. 57, No.1, 2013.

⁹⁰ Peter Griffiths was Deputy District Administrator, Hospital Sector for Southampton and South West Hampshire Health District (Teaching) from 1971 to 1976.

Nicholas Timmins

That was one of the effects of the grading. If I remember rightly, when you look at all these beautiful diagrams in the Grey Book, it gets down to the District level and hospitals do not really get a mention anywhere. You are both examples of this: bright people who were running hospitals moved up a tier, so the quality of management in a hospital declined for a period, because the bright ones moved up one and, as you have just described, the District went to the Area, the Area went to the Region, so there was a sucking upwards of talent which gets further away from the frontline.

Lord Owen

I am not sure that we could have ever avoided it, but it was not helped by having this row about what I genuinely believed in at the time, of geographically full-time private practice and Ma Blackstone and the strike that went on and the refusals, and the endless meetings with the BMA, and the sun coming up over the horizon in Elephant and Castle and Barbara Castle saying, 'A comma here and we've got 'em'. It was very difficult, and Mr Grabham, who then was in charge of the hospital consultants...⁹¹

Nicholas Timmins

The BMA negotiators were 'Grab 'em and bolt'.92

Lord Owen

We did not add to the harmony; there was no doubt about that. It was not easy but we survived, just.

Professor Brian Edwards

Regarding the context in which these new teams were working; I have been through the DMT [District Management Team, for Leeds] minutes, which I am happy to pass on to colleagues. The team I was in had to shed two hundred jobs, which it did by vacancy review. Everybody docked a post; every nursing post had to go through the review process. In the event, no doctors were affected and the number of nurses [lost] was relatively low but the process of vacancy review was very hurtful to the professions who had never had anything like this before. So, there was cash. This is a quote from the DMT minutes; 'Think about headlines in the papers yesterday'. The organisation of the hospital was in a state of constant crisis, patients scattered throughout the hospital; few cold cases could be admitted which was having the disastrous effect on waiting lists.

It really was a challenging, difficult time. Forty of the beds at the Infirmary were filled with patients who should not have been there. We had the pay bed issue and we also had a capital squeeze, which brings me to David Owen. The Infirmary had spent twenty years designing its wonderful new teaching facility, and it really was wonderful. There it was, sitting on the shelf waiting for cash from the Department of Health. David came up, he flew in, he was in the hospital for twenty minutes,

⁹¹ Esther 'Ma' Blackstone was Medical Secretary and Chair of the National Union of Public Employees at Charing Cross Hospital during a 1974 dispute about a new private wing; see <u>http://www.nhsmanagers.net/guest-editorials/ma-blackstone-and-the-private-wing/</u>.

⁹² Reference to Dr Anthony Grabham (1930-2015), Chairman of the BMA Central Committee for Hospital Medical Services between 1975 and 1979, and Dr David Bolt (1921-2002), Deputy Chair between 1975 and 1979. Conflict with the medical profession about doctors' contracts and the provision of private 'pay beds' in NHS hospitals were defining features of health policy during the 1974-79 Labour government. See Klein, *New Politics*.

had a look at the model which we proudly showed him, and turned to me and said, 'Do you want this?' and we said, 'We do'. He said, 'Well, take the top floor off'. So we did.

Lord Owen

I gave them ten minutes to agree the cost saving. It was that or nothing. When I used to drive by the hospital I'd ask anyone in the car, 'Can you detect that there is one storey missing?' No one ever could!

Professor Brian Edwards

So, the capital squeeze was also quite important to those people who had spent a lot of time building their future, and that applied particularly to the teaching hospitals.

Nicholas Timmins

Another bit of context is that as this was happening there was a junior doctors' strike because of pay. They went on strike for the first time.⁹³

Lord Owen

That was a good moment when I said to Barbara Castle, Aneurin Bevan, who was her hero, had a majority of two hundred [in Parliament], we had the hospital doctors out, GPs threatening a strike and the junior hospital doctors out, and we paid the GPs £3 for family planning advice, and suddenly they stayed on. So, we stuffed them with gold even in those days.⁹⁴

Lord Warner

It was even better, because then we even had the admin and clerical staff out on strike for more pay, to pay the pay award that had been given to the doctors.

Nicholas Timmins

Coming back to the local authority involvement, I have very mixed views about it because I am not sure it was entirely successful. This was a bit later on, in the early 1980s when the money was again being incredibly squeezed. I remember going to a meeting with Brent Health Authority, which had to make £250,000 of cuts, and there was an incredibly charismatic, completely Maoist, Methodist minister there, and the local authority people who organised a demonstration against these cuts at the local authority meeting, to the point where the chairperson had to retreat through the French windows and call the meeting to a halt, because it was just complete chaos.

One of the effects of the 1974 reorganisation was that it created Community Health Councils who again were very mixed in their results and some of them just set themselves up as critics against any form of change whatsoever. And then you had the local authority people, particularly where in the early '80s there were some very left-wing councils who fought every cut going. So, the reorganisation handed all these people a megaphone, so the NHS actually became much more politicised as a result of that. It is almost telling that when we were debating the run up to this and

⁹³ See Webster, *Vol.* 2.

⁹⁴ Reference to Bevan's famous remark that consultants supported the introduction of NHS in 1948 only after he had 'stuffed their mouths with gold'. See S. Sheard, 'A Creature of its Time: The Critical History of the Creation of the British NHS', *Michael Quarterly*, Vol.8, No.4, 2011.

people said, 'Was there any national debate about this? Was there a patient voice?' – it all just went on in what you might see as a paternalistic fashion, but there was not any of that in the run up. The effects of the reorganisation was handing these people a megaphone. There was a lot more criticism.

John Wyn Owen

Just a comment on Lambeth, Southwark, Lewisham, because literally the day I left to go to work for the Government on its export side was the day the special commissioners were appointed, because the local authority members had decided that managing within the budget was not what they were intending to do.⁹⁵ I think that that was a major shift in terms of the way in which a governing body actually responded. You may say that was politically driven and was a reflection of the politics, particularly in Lambeth.

Can I just flag something else which you might want to come back to? Much of our conversation tends to be focused on London, though we have been reminded of different areas. In my own experience, in St Thomas' [Hospital] history, we did move Regions and were uncomfortable bedfellows for established players like Guy's and King's [Hospitals], and a lot of people wanted to go back but we made a strategic decision that we would make our bed in the South East region. That was important. We also decided that we would work with the most deprived District, Medway, to make joint appointments. In other words, we would demonstrate we were active in the Region.

We have not touched on the medical schools in London in terms of their reorganisation and the numbers. There is also Cambridge with its own clinical school, which was going to reduce the intake into places like St Thomas's and it did spur us, with help from Brian Abel-Smith and a workshop, and contributions by Robert [Maxwell] and others, to actually seek to recreate a united medical at Guy's and St Thomas' – not top-down, but certainly a movement from within St Thomas'.⁹⁶ The interface with the University of London and medical school education and medical education in general is quite an important part of the discussion which we have not actually touched on.

Nicholas Timmins

But was that a direct element of the'74 reorganisation?

John Wyn Owen

No, it was alongside it.

Sir David Nicholson

Were Joint Consultative Committees part of this reorganisation?

Nicholas Timmins

Yes.

⁹⁵ See Rivett, Cradle to Grave.

⁹⁶ See *The Recent History of Guy's and St Thomas', 1970s to 2000s*, Witness Seminar held 16 June by the Centre for the History of Science, Technology and Medicine, University of Manchester: <u>http://www.chstm.manchester.ac.uk/downloads/guys-thomas-witness-seminar-2011-06.pdf</u>

Sir David Nicholson

Thinking forward, they were an enormously positive thing. In my career, I worked in learning disabilities and that protected funding, which essentially was there to bring together local government. It was enormously powerful and made really big changes to learning disabilities at that time.

Professor Brian Edwards

They were the precursor to the shadow health authorities and then the health authorities.

Professor Walter Holland

One of the really positive outcomes of the reorganisation was that the appointment of Community Physicians, as they were called, became dominated by their professional competence rather than by their political affiliations. I have examples of where councillors who took part in the appointment procedures in the reorganisation were appalled to find that they were outvoted on individuals who applied.

Nicholas Timmins

This is where the transfer of Medical Officers of Health across to...

Professor Walter Holland

Yes, because they all had to reapply.⁹⁷ For example, the Medical Officer for Health of Lambeth had to reapply, and there were some very strange appointments because of collusion between consultants who did not want a particular Medical Officer of Health and councillors who wanted a 'yes' man rather than somebody who would stand up.

Lord Warner

Joint finance [with local authorities] came shortly after this, fought tooth and nail by the Department of Health and civil servants, particularly the finance people. Barbara [Castle] announced it. We had to cook this up slightly surreptitiously and she announced it and committed, so that all came in 1975. That came out of a pressure from local government and some people in the NHS, who were trying to find a mechanism that would facilitate on some of these joint projects, particularly in the non-hospital projects. That came out as a response to some of these continuing silos. Even at a time of considerable financial difficulty, there was some creativity.⁹⁸

The lasting impact of this is that I do not think anybody learned from this example about the disruptive effects of reorganisations, because Ministers of all persuasions have gone on reaching for the reorganisation lever. We probably never costed it or noted what the disruption was, and we have gone on making the same mistake time after time.

⁹⁷ The longstanding position of Medical Officer of Health was replaced by that of Community Physician inside the NHS in 1974. See M. Gorsky, 'Local Leadership in Public Health: The Role of the Medial Officer of Health in Britain, 1872-1974', *Journal of Epidemiology and Community Health*, Vol. 6, No. 6, 2007.

⁹⁸ See G. Rivett, *Cradle to Grave*.

Nicholas Timmins

You cannot look at the reorganisation in isolation, because there are all these other things going on at the same time like Joseph's emphasis on 'the afflictions' – chronic conditions that could not be cured – and on the Cinderella services for the elderly and mentally ill, plus joint finance and the Flowers Report on medical education.⁹⁹ You can sort of separate them out, but it would be a mistake to separate them out too much, because it was all in the context of what was going on. Frank.

Frank Dobson

Listening to the examples of success, it strikes me that they are all dependent on the good will and talent of a limited number of individuals. For example, because of Yvonne [Moores] exploiting the opportunity to do something she wanted to do for years, and having the talent to get people to accept it, it worked. It worked at Leeds General Infirmary because Brian [Edwards] was getting together with, no doubt, the Chief Medical Officer and the Chief Nursing Officer, and they were a united team. It seems to me therefore that if you try to identify any improvements, the improvements could probably have been brought about whatever the organisation. The idea, certainly in London, that it got people working together was a proposal in the area I represented that there should be an amalgamation between University College Hospital and the Royal Free Hospital, which were a long way apart in terms of getting around London. I therefore asked if there should be an amalgamation with the Middlesex [Hospital], to which the answer was, 'It is not in the same District' and then played, as the ace of spades, 'It is not even in the same Region', to which my response was, 'It is two hundred effing yards apart'. So, I am an anti-reorganiser to the bottom of my socks, quite frankly. The main lesson to learn is to just try to help the folks who are doing their job do their job as well as they can.

I have a totally iconoclastic theory about this general theory that seems to be if you have got some separate functions and you bring them all together in one organisation, they will all start liaising with one another by osmosis. I believe in many cases that if you keep them separate and they know they have got to liaise with one another, they will put in place machinery to liaise. One of the jobs of Ministers and more senior people in any hierarchy is to make them liaise. That is better than trying to put them all in one great big ship.

Nicholas Timmins

Your point is well taken, Frank. You did create Primary Care Groups and then Primary Care Trusts. Which was a reorganisation.

Frank Dobson

Let it be said that it was done with a two-thirds majority of the BMA in favour of it.

Sir Cyril Chantler

If we're talking about legacy, I completely agree with Frank. He was talking about the Royal Free and University College Hospital. When I became chairman of UCL [University College London] Partners it was quite clear that one group absolutely wanted to take over the other. It was also clear to me that if I even dreamed that as a possibility, I would have to find another job. Someone said to

⁹⁹ London Medical Education. A New Framework: Report of a Working Party on Medical and Dental Teaching Resources (London, University of London, 1980).

me, 'What do you think your job as chairman of UCL Partners is?' and I said, 'I am a cross between an academic dating agency and ACAS [Advisory, Conciliation and Arbitration Service]', and it works. You do not have to make people merge; they can find ways of working together.

I wanted to ask you something else in relation to legacy. This has been fascinating, interesting and rather depressing, but all that time I was busy trying to find ways of looking after children with kidney disease, so I only really got involved in the early 1980s when the whole thing, certainly at Guy's [Hospital], was beginning to fall apart quite seriously. Then I was on the NHS Policy Board and then I got interested in policy. I came across something which Aneurin Bevan wrote in 1950: 'The NHS is a novel experiment. It is an attempt on the part of British society to reconcile two normally conflicting interests: centralised financial responsibility and decentralised administration at the periphery,' and it seems to me that we have been on a journey, both parties, government after government, reorganisation after reorganisation, trying to solve that problem.¹⁰⁰

I always found Enoch Powell's monograph on medicine and politics, written in 1966, very interesting.¹⁰¹ It is also very well written, amusing, and profoundly disappointing, because he says that the thing is impossible. Because it is tax-funded, a Minister in Parliament has to be accountable for it and therefore it has to be centrally administered. In other words, the solution to Aneurin Bevan's conundrum has not yet been found. But it may be that, listening to you today, we are now where we were starting then, with the need to involve the local authorities, and get social services and the health service at a local level to work closer together. We are still on that journey. Certainly where I work now, in Newham, we are near to getting a joint investment between the Federation of General Practitioners, individual practices, working with the Mayor to invest in primary care and bringing nursing, the social services and the health service at a local level to be kept away from hospitals.

Dr John Marks

If we are moving onto legacy, what lessons could be learned? I met Keith Joseph in Hertfordshire when he came to open a health centre. When we had a party after the reorganisation, he said to me, 'I think we have done a charter for bad doctoring' and I said, 'No, what we need is a pilot study', and at least three or four other people also asked him for it. The answer was, 'You cannot have it because they have got to have it in time for the reorganisation of local authorities'. We have had twenty reorganisations; not one of them has had a pilot study beforehand to see if it will work. I found a marvellous quotation in Kenneth Clarke's autobiography *Kind of Blue*.¹⁰² At the time he was a junior Whip and he said he put pressure on MPs and ensured 'a favourable vote for a ridiculous proposal'. He continued that, 'The substantial reforms in the NHS' – well I could give a different description – 'which I would eventually enact in the late 1980s' – that is one way of describing them – 'had as a starting point the complete abolition of Keith's ill-fated management system.' It goes on that, 'There will be another reorganisation and no one will look at it beforehand'.¹⁰³

¹⁰² K. Clarke, *Kind of Blue: A Political Memoir* (London, Macmillan, 2016). Kenneth Clarke has been Conservative MP for Rushcliffe since 1970 and was Secretary of State for Health from 1988 to 1990.

¹⁰⁰ From a speech given by Bevan to the annual conference of the Institute of Hospital Administrators in May 1950. See <u>https://www.sochealth.co.uk/national-health-service/the-sma-and-the-foundation-of-the-national-health-service-dr-leslie-hilliard-1980/aneurin-bevan-and-the-foundation-of-the-nhs/bevans-speech-to-the-institute-of-hospital-administrators-5-may-1950/.</u>

¹⁰¹ J.E. Powell, A New Look at Medicine and Politics (London, Pitman Medical, 1966).

¹⁰³ Ibid. p.71.

Nicholas Timmins

Pilot these things.

Dr Geoffrey Rivett

To some extent we are getting a pilot in Manchester.

Nick Timmins

Devo Manc is a pilot.

Sir David Nicholson

Theoretically we are, but what tends to happen in those situations, a bit like with the Foundation Trusts, which started off as a pilot, and the original view was that not everyone would be a Foundation Trust, but the pressure for consistency across the whole system becomes very great, hence Manchester. What is happening in Manchester will be a great pilot to see whether it works. What is happening in the rest of the system now is that it is gearing itself up, in one way or another to go down that road. Very quickly you get that herd mentality that takes it on, which has always been a danger. Enormous courage is needed from the centre and politicians to stop people going to do things in that way.

Nicholas Timmins

I remember when the BMA was urging Ken Clarke to pilot the original internal market and said, 'Why not do it in a region like East Anglia?' to which he said, 'If we run that as a pilot in East Anglia, you lot will bugger it up'.

Dr John Marks

He said 'You buggers will destroy it'. That was at the Carlton Club, where he took me to a dinner. We sat down to dinner, and then we came down to business and I said, 'Ken, this may be the best thing since sliced bread. Let's try a pilot,' and he turned to me and said 'You buggers would destroy it', and I walked out.

Sir David Nicholson

And he was right.

Nicholas Timmins

He was right.

Dr John Marks

He was not right.

Sir David Nicholson

When you look back, who has ever been in favour of any reorganisation? It was very interesting that our colleagues from McKinsey, who presumably were paid for it, concluded that really it was nothing to do with that; it was all badly implemented. Similarly, almost every reorganisation that you do, people stand back and say, 'It has been badly implemented and it was never meant to work like that'. Almost as soon as you do one, the next one is being developed.

Nigel Edwards

That is the thing about this. Looking back on it, this seems to me to be the trigger for many of the reorganisations subsequently.

Nicholas Timmins

It absolutely was for the 1981 one.

Nigel Edwards

Yes, but it also seems to have legitimised the view that you can do this by design from the centre, and it just takes one clever person to do it. I actually slightly disagree with David [Nicholson]; I think NHS management has got a bit of a dishonourable record for leaping on the next reorganisation; with the exception of the last one, I have to say, which no one leapt on as an exemplar of good practice.¹⁰⁴

Sir David Nicholson

I agree with you that the service almost becomes pregnant with the next one, and I remember very well the PCT [Primary Care Trust] issue; everyone wanted to merge PCTs and they were taking it all forward. That in a sense reinforces the issue that no one is in favour of the current arrangement, so no one defends them. When people come up with ideas, they get traction and that is what happens. My conclusion with all of this is that if the answer to the question is a restructuring, you are asking the wrong question.

Nigel Edwards

The other thing I think it sets up is the idea that you can design an ideal structure. We have seen in subsequent reorganisations the attempt to find the correct size and the correct design of the geography.

Nicholas Timmins

Which history demonstrates is impossible.

Nigel Edwards

Absolutely; anything that is big enough to deal with a teaching hospital is too big to deal with general practice.

¹⁰⁴ Health and Social Care Act 2012 (London, HMSO, 2012).

Dr Geoffrey Rivett

We had the challenge just now about who was ever in favour of reorganisation; well, the *Lancet* was: 'This week's White Paper on the reorganisation of the NHS (in England) is welcome and wise...the picture is emerging and it looks none too bad...The future looks brighter.'¹⁰⁵

Nicholas Timmins

One of my favourite quotes from Roy Griffiths was 'Reorganisation is the thing you absolutely should do but only when everything else has failed'.

Dr Eric Caines

John [Marks] raised the point about pilot studies and this seems like something you ought to do. I had a fierce argument with Margaret Hodge in Oxford recently about this, who was disposed to blame every government failure on civil servants and consultants.¹⁰⁶ I just asked her to consider the nature of the electoral cycle. A party comes into government; it comes up with a scheme; it then consults; it then legislates, by which time you are at least halfway through the electoral cycle. You then start to implement. By that time, the opposition is saying 'We would not do this; we should scrap this when we come in'. When do you have time for a pilot? You are lucky if you get to the starting point. These are huge schemes and they just do not fit into our mould of politics and our electoral cycle.

Dr Robert Maxwell

I completely agree with the point, 'Do not reorganise to solve problems you can solve in any other way'. Reorganisation is seldom, if ever, a must. Before getting involved in the Department of Health study, I spent nine months or so on a reorganisation of health and social care in southern Ireland [with McKinsey & Co]. That organisation, as far as I know, has never been changed since, but retaining and adapting existing institutions does require a different attitude to what has become the English one. In England it's partly the fact that the whole NHS is under direct central government control, which has both good things to be said for it, and less good things, and this is one of the less good things, because of the electoral cycle and because of the increasingly partisan and confrontational temperature of British politics. It is also the sheer size of the organisation which makes it such an awful task to undertake. For each reorganisation that has come along there has been a certain argument for it, except the last one; I could not understand that one.¹⁰⁷ If you reorganise something as big as the NHS as often as it has been reorganised, you damage an awful lot of the people involved in making the service run - not only those who lose their jobs but morale of the whole organisation suffers and public confidence in it. When I first got involved with the NHS in 1968 at Oxford [with McKinsey & Co], the morale of both doctors and nurses was very high. It is much lower now. That is not only a British problem; in other systems too there are many ways in which the professionals are less happy about their work. Some of those are just changes in society; some are good, such as doctors and nurses being held more firmly to account than they were then, but it is also an overreliance on contract as opposed to trust. I do think that there are a lot of lessons to learn, but not easy ones.

¹⁰⁵ Quoted in Rivett, *Cradle to Grave*, p.265.

¹⁰⁶ Dame Margaret Hodge has been Labour MP for Barking since 1994, and was Chair of the Public Accounts Committee from 2010 to 2015.

¹⁰⁷ Health and Social Care Act 2012 (London, HMSO, 2012).

Dr Gillian Ford

This is a rather flippant comment but I did feel that some politicians – sorry David [Owen], not you of course – were very glad that there were so many tiers between what was happening in the periphery and Parliament that they no longer had to answer questions about why Mrs Smith had to wait three years for her hip replacement. They used to have those sorts of questions.

Dr Geoffrey Rivett

Tiers are a difficult problem. When I left the Department [of Health] on retirement, I had a farewell chat to Virginia Bottomley, and she said 'Any last words?' and I said 'Yes, no one tells you the truth that the Districts lie to the Area, the Areas lie to the Region, the Regions lie to the Department officers and they lie to you. By the time things have gone through five tiers, even with people who are trying to produce a reasonable pattern, your picture is not going to be right: Send three and fourpence. We're going to a dance.' 'Is it as bad as that?' she said. I said 'Yes it is, it is probably worse'.

James Lee

My book ending of this is that I stopped being a [management] consultant in '78. I was in the media for the rest of my career, except that at the age of 65 I agreed to become the Chairman of an NHS Trust. I make a very serious point about change. Remember, I should have but I thought hardly anything about the NHS for the whole of the intervening period. I had actually been healthy during that period too, so I was not even a patient. So, when I discovered that precisely the same fundamental problems existed: the balance between what is done in the hospital and in the community, the development of general practice, getting diagnostic equipment into health services, the more I discovered the more depressed I became that, for all these reorganisations and all these systems, the essential problems remained and, similarly with mental health, although I remember during the study I was taken around – I think it was in the Birmingham area – a massive mental institution, which felt like a prison, but nowadays of course we have not got enough mental facilities. Again, the balance between acute care and mental has not improved, so my question is this: why is it that the fundamental things that are at the heart of the problems cannot change? I am afraid it goes right back to the tripartite nature. I am sorry to the GPs here but I think the notion of general practice as private business is a big part of the problem. The way in which social care is defined and funded is absolutely terrible. Frank [Dobson], I accept your point that good men can overcome difficulties but my chairmanship was in Maidstone and Tunbridge Wells, and Kent County Council was driving down the budget for care homes, social care and social services. Our general medical wards were stuffed full of elderly patients who our general medical consultants would say should not be there. There was no way that good will or talent or anything could overcome this. It was a question of money.

We built the last PFI [Private Finance Initiative] hospital for £300m.¹⁰⁸ At the time, our Chief Executive asked the Department [of Health] if we could include in the physical design what in an American hospital we would call a rehabilitation or intermediate care centre. The old people do not stay in the general medical ward; they move into another building. I thought, as a problem solver, that this was such an obvious solution. It was not possible; it was not allowed; PFI could not include that. When we were cutting back on community nurses and local health visitors, I asked our Chief Executive why we could not employ these people on our budget. There were simple solutions that you thought anybody with a bit of common sense could see were obvious. They were blocked.

¹⁰⁸ On PFI see Klein, New Politics.

So what is wrong with this system? There is something fundamentally wrong that changes, which are so obvious and so common sense and essentially quite simple to implement, have been going on since 1974 -forty-two years.

Nicholas Timmins

Does anyone have a succinct answer to that question?

Nigel Edwards

Because the customer of the NHS is the Secretary of State, not the patient.

Professor Nick Black

I agree with all of the comments that have been made, and much of what we heard in 1974 has been echoed today in exactly the same way, but despite all of that, over the intervening forty years, there have been notable improvements in the quality of care. Of course there are lots of shortcomings; I am not suggesting everything is fine – far from it – but there has been an improvement in quality of care, in outcomes, the sorts of services which were unthinkable forty years ago. We should not lose heart or lose sight of the fact. I would say the answer is because these are underlying tensions between politicians and the professions, and between different parts of the professions and even within professions such as general practice and specialists. These will never go away; these are features of all healthcare systems. There are intractable problems which we have to keep trying to manage better. That is why we keep trying different things.

Nicholas Timmins

We have five minutes to go. [To Sally Sheard] Is there anything we have not covered that you want covered?

Bob Nicholls

You have raised, but no one has picked up, that there was no public interest in the '74 reorganisation. You quoted Shirley Williams about the CHCs [Community Health Councils]. I had good ones in both Southampton and Newcastle. You had to work at it but they began to give root to the patients' viewpoint.

Dr John Marks

I have worked as a family General Practitioner for two years in a salaried service. It was called the Royal Army Medical Corps. I did the same job there as I did at home. This is the answer. The ultimate responsibility of the GP in the NHS who was salaried is the Secretary of State and in the Army it was your commanding officer. I believe the ultimate responsibility is to the patient.

Nigel Edwards

Can I ask one question? I remember talking to someone who had been talking to the nurses from his hospital bed about the 1989/90 reorganisation and they completely failed to notice anything. A common thing that is often said by people who work in hospitals is that the motto is, 'This too shall pass'. I wonder whether anyone actually in a hospital ward noticed. Did it change clinical practice or key decision makers for clinicians at the front line in any way that was meaningful?

Nicholas Timmins

I think that is a really good question which you can ask about all the reorganisations. We have not got time now. You can point to one or two of them where it did make a difference to what happened to the patient, but for quite a few of them, I do not think it made much difference at all. Doctors carried on doctoring. Nurses carried on nursing. Porters carried on portering.

Dr Geoffrey Rivett

And they have improved their doctoring and nursing.

Nicholas Timmins

They have. The quality of clinical care has clearly gone up enormously, but whether it has gone up as a result of any of these reorganisations is highly dubious.

Professor Nick Black

There are parallel realities between organisation, management and things that we are all obsessed with and find fascinating and the world of clinical practice of doctors, nurses and patients. The two are hard to navigate.

Nicholas Timmins

Is there anything we have not done that we should have done?

Professor Sally Sheard

We have covered an enormous amount; are you going to do a summary?

Nicholas Timmins

You must be joking!

Professor Sally Sheard

I did not seriously expect you to do a summary. I think what we have proved this afternoon is the value of history and of histories in plural, because we have managed to sit here and have some very informed debate. We have not had major disagreements; I was concerned at some points that we might have those but we have been very civilised in how we have approached this exercise. I do think that we have lost that institutional memory and that, for me as a historian, is very sad. We have a huge capacity for putting the history back into the Department of Health in various forms. One thing we will do with this event is transcribe the audio tapes, produce some summaries and then we will be sending them to Simon Stevens and Jeremy Hunt and saying, 'Look, this is what you need to know about what went wrong and what went right with different reorganisations'.¹⁰⁹

I would like to end by thanking everybody for their contributions and thanking Nick [Timmins] so much for chairing. He is an expert at doing these things now; we will be calling on him again, I

¹⁰⁹ Simon Stevens has been Chief Executive of NHS England since 2014. Jeremy Hunt has been Conservative MP for South West Surrey since 2005, and Secretary of State for Health since 2012.

hope, next year. We will send you the raw transcript, so that you have an opportunity to make some comments and reflect on what has been said. I would like to thank Phil Begley, in particular, who has co-convened this with me. Phil is the one who found lots of you - I am not quite sure how - through Googling and Wikipedia. I think it was James [Lee] who wrote to me and said, 'How did you find me? From 1972? And now you've rediscovered what I did for McKinsey'. If you have any further comments, if you go home and think there are things that have not been said, can you please email me? Thank you all very much.

[Ends]

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Source: Management Arrangements for the Reorganised National Health Service (London, HMSO, 1972).

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