



NHS

SIXTY YEARS OF THE NATIONAL HEALTH SERVICE



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EDITOR

Six decades that have transformed the NHS

'Managers have metamorphosed from clerks into strategic leaders; clinicians have moved from hierarchies into teams and the focus on healing is giving ground to prevention'



HSJ is delighted to bring you this celebration of the extraordinary journey the NHS and its staff have taken since the service was launched six decades ago on 5 July, 1948.

It charts the currents that have shaped the modern NHS, from management, politics, clinical practice, campaigns and public expectations to architecture, the media and popular culture.

Reminiscences of those who were in post on the first day vie for your attention with stories from three managers who were born in those first hours, and frank recollections from former secretaries of state.

We discuss five days that shook the NHS, and see what the service has to learn from the only two institutions on earth with more staff: Indian Railways and the People's Liberation Army of China.

We also reveal the 60 people identified by our panel of judges who have had the greatest influence on the NHS.

The stories and analysis reveal a service that has been transformed. Managers have metamorphosed from clerks into strategic leaders; clinicians have moved from rigid hierarchies into multidisciplinary teams; mental health has moved from the asylum to the community; the focus on healing the sick is giving ground to prevention.

The area that has changed least is the power accorded to the patient. But progress is finally being made; perhaps by the time the NHS marks its 75th anniversary it will be able to celebrate the arrival of a truly patient-centred health service.

I am delighted to thank our partners in these NHS 60th celebrations – BT, Tribal, Lloydspharmacy, Humana and Airwave – for their support, which has made this publication possible.

We hope you agree it is a fitting tribute to 60 extraordinary years.

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In 1948 the UK population was 50.065 million. Life expectancy was 65.9 for men and 70.3 for women. Many children were affected by rickets (below right), and heart disease and cancer were the most common causes of death. An advertising poster urged ex-nurses to join the National Hospital Service Reserve, and child welfare became a priority (below left).



LIFE I



The average house price was £1,751, but thousands of families were living in prefabricated homes after one million houses were destroyed in bombing raids during the war.





While a male teacher could expect to earn £615 a year, a male manufacturing worker aged over 21 earned on average the equivalent of £6.86 a week; for a female manufacturing worker aged over 18, the figure was just £3.70p a week on average. The Attlee government nationalised the coal industry in 1948 (below left) and the first babies to be born in the NHS arrived that year. On 22 June, the Empire Windrush docked at Tilbury with 492 immigrants from Jamaica, of whom 192 made the voyage on the decks as the cabins were full.



N 1948



Bread rationing, which had begun in 1946, came to an end in July 1948. Jam was no longer rationed from December. Clothes had been de-rationed from March. A pint of milk cost the equivalent of 2p, a dozen eggs 9p, a pint of beer 7p, a litre of petrol 3p and a cinema ticket 7.5p.



The "new look", introduced by Paris fashion house Dior the previous year, was in vogue in 1948 (left) and the Olympic flame arrived at Wembley for the 14th modern Olympiad (above).



FIVE DAYS THAT

The NHS has weathered countless scandals, speeches, policy launches and inquiries. Peter Davies and Daloni Carlisle discuss five landmark events and talk to those involved

1961: ENOCH POWELL'S WATER TOWER SPEECH

In March 1961 then health minister Enoch Powell made what became known as his "water tower" speech to the annual conference of the National Association for Mental Health, later known as Mind. Mr Powell, of course, is now better remembered for a rather different speech. But his description of asylums as "isolated, majestic, imperious, brooded over by the giant water tower and chimney combined" heralded a shift in mental health policy.

Mr Powell envisaged the closure of at least half of Britain's psychiatric beds, some 75,000 of

them, with services to be replaced by care in the community. What psychiatric beds there were would be relocated in general hospitals.

The move to close old psychiatric institutions was already underway, he told his audience. "There is not a person present whose ambition is not to speed up those present trends. So if we are to have the courage of our ambitions, we ought to pitch the estimate lower still, as low as we dare, perhaps lower."

How wrong he was. A gladiatorial battle ensued, fought largely in the pages of medical journals the *BMJ* and *The Lancet*, as doctors slugged out the rights and wrongs of the policy. Dr Henry Rollin, then a

psychiatrist at Horton Hospital in Surrey, was among them. "I sided not with the angels," he says of his decision to fight the bed closures.

He did not recognise the picture Mr Powell painted of the horrors of the institutions, described in the 1962 Hospital Plan as "majestic, brooding structures, dominated by the twin ideas of isolation and custodialism, housed in depressing and decaying buildings, suffering from acute staff shortages".

Nor did he recognise the running down of status of the hospital; he saw bed numbers at Horton rising.

Dr Rollin was sceptical about whether local authorities would be capable of setting up facilities in the

community. "The trouble was, nobody had asked the community if they did care," he says. "They didn't give a damn."

History shows the angels won the battle. "Hospitals began to close incredibly rapidly," says Dr Rollin, who retired from the NHS in 1975. By 1969, 24,000 beds had gone.

"The situation when I retired was heartbreaking. All the work we had done was destroyed. The community services were not there and the patients have simply ended up in prison. It is very, very sad."

Dr Rollin's view is not popular today. "Of course closing the institutions was the right thing to do," says chief executive of the Mental Health Foundation Andrew McCulloch. "It was the clear result of evidence-based medicine and evidence-based health policy."

He points out that Mr Powell's speech was preceded by the 1959 Mental Health Act, which he



SHOOK THE NHS

describes as “a benchmark piece of legislation that put its mark on legislation around the world”.

“The water tower speech was key in that it made the deinstitutionalisation into policy. My personal belief is [Powell] was expressing his own view.”

Care in the community has not been an unqualified success and yes, Mr McCulloch adds, the prisons have taken up part of the population that used to be in the asylums.

“But that’s not a criticism of deinstitutionalisation. Some people are achieving world-class mental health services. The trouble is, we have a complex, evidence-based approach to care but have not sorted out the whole system.

“If there is a perception that care in the community is not working, it is because we have not grasped the bigger picture. Mental health services get tarred with the brush of failures in social policy.”

‘Enoch Powell described asylums as “isolated, majestic, imperious, brooded over by the giant water tower and chimney”’

1967: THE PUBLICATION OF *SANS EVERYTHING*

In 1967, campaigner Barbara Robb published *Sans Everything: a case to answer*. A critical look at the care of elderly, mentally ill people in long-stay institutions, it sparked major disquiet over the quality of care.

Barbara Robb had founded Aid for the Elderly in Government Institutions in 1965, following her involvement in the care of patient Amy Gibbs at Friern Barnet Hospital in London. Her book was a passionate cry of distress at the undignified suffering of elderly people in hospitals, along with discussions about solutions.

Although the book did not name hospitals or patients, after receiving wide publicity Ms Robb passed on details to the health minister, who instigated “enquiries by special committees” into several institutions. But the results did not please the system’s critics.

Dr Michael Denham, past president of the British Geriatric Society, has written about the book and its impact. Drawing on the work of Professor John Martin, who in 1984 delivered a scholarly report about hospital scandals, he says: “The committees considered the majority of allegations of cruelty were unfounded or were based on unreliable evidence. The complaints were considered inaccurate, vague, lacking in substance, misinterpretations or over-emotional.”

The committees were instead often impressed by the quality of care. The answer lay in greater numbers of better trained nurses, they said. Ms Robb was indignant and complained to supervisory body the Council of Tribunals, which rebuked the minister.

But that was not the end of the story. Dr Denham says: “In 1967 a further scandal occurred ➔ 6

TOP PHOTO, MARY EVANS

5 ← at the Ely Hospital in Cardiff in a unit for the mentally subnormal. A nursing assistant made allegations [in the *News of the World*] of cruelty to patients and pilfering of their food and property. Geoffrey Howe QC chaired an inquiry in 1969, which confirmed the allegations and reported that the whistle blower had been victimised.”

When the Ely scandal broke, then health secretary Richard Crossman felt he had been caught on the hop because he had no inspectorate to warn him of bad performance.

Dr Denham says it turned out “that the Department of Health and Social Services had known – but did nothing. This led Crossman to create the Hospital Advisory Service in 1969, to act as his ‘eyes and ears’, but [it] would not investigate individual complaints”. The service started work in 1970 and visits were

carried out by teams of professionals: consultant geriatricians or psychiatrists, senior nurses, paramedics, administrators and later social workers.

“It is best considered as a form of peer review,” says Dr Denham. “The hospital visits lasted one to three weeks and reports remained confidential to the unit concerned, although many years later reports were made public.”

Later the service was renamed the Health Advisory Service when it took on a social/community component and is now the Health and Social Care Advisory Service, run as an independent charity.

Meanwhile debates in Parliament prompted by *Sans Everything* led to the 1972 NHS Reorganisation Bill that set up the health ombudsman system.

“What is sad to report is that the

problem of abuse continues,” adds Dr Denham. “As late as 2000, episodes of abuse of older people in hospital were still being recorded and pejorative terms like demented, crinklies or crumbles continue to be used.

“In 2007 the Healthcare Commission still felt it necessary to reiterate the need to improve dignity, nutrition, privacy and training in the care of older people. It is enough to make one weep.”

1983: THE GRIFFITHS REPORT

On 25 October 1983, the day the US invaded Grenada and a 41-year-old Neil Kinnock made his Commons debut as leader of the opposition, life changed in the NHS for rather different reasons.

The foundations were laid for a decade of radical change in the NHS

when supermarket chief Roy Griffiths’ long-awaited report on health service management was published.

The next day’s papers scarcely reflected the report’s significance, with coverage restricted to the inside pages. But that did not alter the effect it had on health professions. Griffiths’ recommendation that general managers be appointed at every level of the service was to reverberate far and wide.

“I don’t think you could have done the internal market without the Griffiths report and management reform. It was absolutely crucial,” says Norman (now Lord) Fowler, then health and social services secretary.

Roy Griffiths, managing director of Sainsbury’s supermarket, had been appointed the previous year as

‘I felt quite resentful that this bloke from a supermarket had been brought in’

prime minister Margaret Thatcher’s adviser on health policy. Frustrated at perceived inefficiency, she instructed him to investigate “consensus management”, under which responsibility for decision making in NHS organisations was shared – or shunned – by senior officers from the main professions.

“As a long-serving public servant, I felt quite resentful that this bloke from a supermarket had been brought in,” says Ken Jarrold, then district administrator of Gloucester health authority. “I was not alone in feeling that. But once people met him and saw what an able guy and experienced manager he was – and how deeply committed to the NHS – that feeling dissipated.”

Originally from a mining family, Mr Griffiths tended to confound expectations. “He was a good man though he wasn’t everyone’s cup of tea. But he did a great service for the NHS and produced a very good, succinct report,” says Lord Fowler.

In a dozen pages, couched as a letter of advice to the secretary of state, Griffiths diagnosed the problem and proposed the solution, famously remarking: “If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge.”

Reaction ranged from the skittish to the downright hostile. Trade union COHSE dubbed it the “Sainsbury report”. The British Medical Association declared it a threat to clinical freedom, unless



doctors only were eligible to be general managers. The Royal College of Nursing feared nurses would lose influence on boards.

"I was doing meetings around the country with 300 nurses turning up," says Ray Rowden, then the RCN's national management officer in charge of campaigning against general management. Ironically, Mr Rowden later became a general manager himself. "With hindsight Griffiths was absolutely right and remains right to this day," he says.

1991: LAUNCH OF THE INTERNAL MARKET

Would the government suffer a pratfall on April Fool's Day 1991, when, as if with the flick of a switch, the NHS became an internal market? In the two years since the initial proposal to divide the service into "purchasers" and "providers", preparation had proceeded apace but without proper trials, although a simulation exercise had predicted rapid collapse into chaos.

Nervousness in Downing Street had set in months before. "You could see why [then prime minister] Margaret Thatcher was concerned," says Peter Griffiths, then NHS deputy chief executive. "It was so sketchy. How it would work in practice was very much left to senior NHS managers."

But managers were excited. "For the first time in people's living memory – probably since 1948 – there was a reorganisation not planned by civil servants in Whitehall," says Mr Griffiths. But in the Department of Health those same civil servants "sat on their hands and waited for disaster to happen", he adds.

The reforms had been masterminded by then health secretary Kenneth Clarke. Health workers suspected they were a preliminary step to privatisation.

"With hindsight I'd concede it would be perfectly sensible to pilot a major change to any system of this kind but the politics were just against it," says Mr Clarke. "I ran a kind of debating society with my little team, arguing it through and refining it. I was always prepared to listen to why a particular part wouldn't work, but 99 per cent of the argument was politics, vested interest and fear of change."

By April 1991 Mrs Thatcher had left office and Mr Clarke was no longer health secretary. But anxiety that some managers might take competition too far too quickly had prompted the NHS management executive to order a smooth take-off and soft landing for the policy.

Two months earlier Mr Griffiths had become chief executive of London's Guy's Hospital, seen as a



flagship trust for the reforms. Discovering its finances had gone awry he announced a staff freeze, translated in the press as 600 redundancies.

"This was... just before local elections. The Conservatives did very badly and one reason was the Guy's announcement – proof positive of what would happen if you let the Tories privatise the NHS. And I'd been a proponent of the smooth take-off message for months."

In the event Guy's (albeit merged with its neighbour St Thomas') and the internal market survived. "Those reforms are still a huge influence. Their principles changed the NHS for ever."

2001: THE BRISTOL INQUIRY REPORT

The Bristol inquiry – *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*, to give its proper title – is one of the most influential reports in NHS history.

Chaired by Sir Ian Kennedy, now chair of the Healthcare Commission, it looked into the

systemic failures that led to the death and disablement of children who underwent heart surgery at the infirmary over 10 years. Reporting in 2001, it changed everything.

Sir Ian recalls the mindset at the time. Doctors were disenfranchised after the Thatcher years of penny pinching, he says.

The General Medical Council's treatment of doctors involved in the scandal was viewed as picking on the profession. Managers, meanwhile, just wanted to be allowed to get on and meet their new targets.

"There was before Alan Milburn and after Alan Milburn," says Sir Ian, referring to the then secretary of state for health. "Before, there was a kind of sense in which politicians do not get involved in the details of quality or safety and left it to professional management."

The Bristol inquiry changed all that. Mr Milburn introduced the 2000 NHS Plan, which sowed seeds for the debate on quality and safety that the report would spark.

Coming after inquests into the deaths of children and the GMC striking off the doctors involved, Sir Ian had several objectives "and only

some of them were about finding out what had happened". He also saw a need for catharsis and for those involved to understand what had taken place.

Sir Ian designed the inquiry chamber himself with the help of an architect. "I created a theatre in the round. Centre stage was the witness." He chose soft furnishings and blinds to create a calm atmosphere and installed television sets that showed not just who was speaking but also which document they were speaking about – and there were 980,000 of these.

The images were relayed to family rooms and locations in the West Country for families who could not travel to London for 90 days of hearings.

When the inquiry started there were two factions among the parents. By the time the report was published, they approached Sir Ian jointly, asking him to lay a wreath at the hospital in memory of the children who had died. "I said it would not be appropriate but I was delighted," he recalls.

The report made 196 recommendations and was, says Sir

'The central thesis was that care should be centred on patients and not on those looking after them'

Ian, "a blueprint for modern 21st century healthcare based on the lessons of what had happened".

"We were commenting on the whole way in which you perceived or delivered healthcare. It came as a surprise to everybody except government," he says.

The government immediately accepted all but eight of the recommendations and since 2001 these have been slowly implemented. Some – such as the Healthcare Commission and the emphasis on safety – are now part of the fabric of the NHS. Others are still in the pipeline, for example revalidation of doctors and the debate over recognised qualifications for managers.

Sir Ian says it is hard to disentangle his legacy from that of other changes in the NHS and society as a whole. And there is still some way to go. "The central thesis of the report was that care should be centred on patients and not on those looking after them," he says. "We are still trying to work out how best to listen to and engage with and involve patients." ●



A DRAMATIC EVOLUTION

In 1948 the most senior managers in the National Health Service were men who wore suits and ties and had large offices with big desks.

In 2008, the most senior managers in the NHS are still mostly men in suits in large offices with big desks. But beyond that superficial similarity, the two are worlds apart. The roles performed by managers today have evolved dramatically from those seen 60 years ago.

The language used to describe them is just one way of tracking such changes. In 1948 the top dogs were called hospital secretaries; today they are chief executives and directors.

In 1948 the lower ranks were clerks and their roles could include tasks as mundane as weighing out slabs of Genoa cake for patients. Today there is a welter of titles and jobs to go with lower-ranking managers, from communications to human resources to commissioner.

The job of a junior manager in those early days was very mundane, says Anthony Dalton, who joined the NHS in 1955 as a junior clerk.

"The work was about as boring as it could be," he affirms. "It was supposed to be a training programme where you spent six months working with the chief and then six months in the office, manually recording all the patient admissions and discharges and deaths and cremations. It was basically cheap labour. As a graduate who had been to Cambridge University, it was a hell of a shock."

But if the lowly tasks were boring and mundane, the chaps in the top jobs wielded significant power and influence.

Daloni Carlisle charts 60 years of the developing role of the NHS manager

Eric Smith, who joined the National Administrative Training Scheme in its first intake in 1956, recalls where power lay in the early days.

"At the outset of the NHS in 1948, two hospital management systems existed as a legacy of the past: those hospitals run by local authorities and those run as voluntary hospitals," he says.

Although they were quite different and had distinct roles, in 1948 the two had to come together to adopt a single approach under one management structure: the hospital management committee.

"They were welcomed by some with great anticipation and loathed by others with some foreboding," says Mr Smith.

Group secretaries were at the top of the ladder, with hospital secretaries on the next rung. Their roles were wide-ranging, with a general responsibility for the welfare and running of their hospitals. "They were very much a partner with nursing and medical colleagues," adds Mr Smith.

Secretaries no longer

Then, for two-and-a-half decades, NHS structures stayed remarkably unchanged. "It is something today's managers will find hard to believe, but there was no national reorganisation from 1948 until 1974," says Ken Jarrold, who joined the NHS in 1969, going on to be a senior manager.

The restructuring in 1974 created four layers of management: hospitals, districts, areas and regions. The advent of district management teams in that year finally saw the title of secretary dropped in favour of administrator – a much more suitable title in Mr Smith's view.

"At that time, of course, the district administrator became the chief executive of the district health authority, with a much wider range of health services, including child and public health," he says.

The area health authorities were supposed to be aligned with local government and therefore to generate what would now be called "joined-up thinking".

In practice, something quite different played out. "What happened was that people fought over territory," explains Mr Jarrold. "There was crowding and confusion and it was very rapidly realised that the wrong thing had been done."

Although there was a "grey book" available with a very clear diagram of accountability, in practice people were not clear about where their accountability lay because there were too many layers, he adds.

Jan Filochowski, who joined the NHS in 1978 and has worked in numerous senior NHS management jobs, most recently as chief executive of West Hertfordshire Hospitals trust, also remembers those days. There was almost no national interference in hospitals and power was concentrated in the regions.

"Richard Crossman [Labour health secretary from 1968 to 1970] referred to regional health authorities as 'semi-autonomous governors in the Persian Empire' → 10

'Management was welcomed by some with great anticipation and loathed by others with some foreboding'

9◀ – they do what they damn well like,” he recalls. Power moved away from hospitals. “The people managing hospitals were quite low grade and all the important jobs were sector administrators in the districts and areas. The further away from the hospital you were, the more important you were,” says Mr Filochowski.

At the time, consensus or team management was in vogue, with the notion that every staff group should have a say in running the NHS, not just doctors. Mr Dalton remembers it well.

“It became very discredited,” he says. “When you have a team with difficult people, it can be tremendously hard to get agreement. And if you don’t get agreement, there is no team decision.”

Mike Brown, another retired NHS manager, who is now director of the NHS Retirement Fellowship, also remembers this era.

“There were lots of meetings,” he says. “Often you got the lowest common denominator decisions made just so that you were not offending anybody on the team.”

But the NHS does not exist in a vacuum and this was the 1970s. The country was in financial crisis, with the Labour government taking a loan from the International Monetary Fund and the conditions that went with it: workers took to the streets during the 1978-79 “winter of discontent”.

“This was a defining moment for public services,” recalls Mr Jarrold. “It was the moment when financial restrictions and accountability became a reality for the first time.”

When in 1979 Margaret Thatcher’s Conservative government came to power, “the Tories said it was much more important what goes on near the patient,” says Mr Filochowski. “Their view was that we needed strong and powerful managers managing what goes on in our hospitals and wider facilities.”

In 1982 the area health

authorities were abolished and in 1983 leading businessman Sir Roy Griffiths reported his findings, leading to the introduction of general management in 1984.

Mr Smith recalls: “It wasn’t until Griffiths that management responsibility was focused more at hospital level, when so-called administrators were designated managers; and, with the demise of district management teams, senior managers of hospital units were properly given a wider range of authority.”

The Griffiths revolution

For Karen Lynas, director of leadership at the King’s Fund, Griffiths was the trigger for radical changes that saw managers become involved in strategic and system management. He shook up a health service that had been in the grip of consensus management – a service, he famously found, where there was no one in charge.

Griffiths recommended the NHS should do away with some layers of administration and reform the remaining staff into managers at hospital level.

“I think this is where everyone will draw the line,” says Ms Lynas. “From this point forward, there was much more management and leadership – although that was not a word used at the time. That’s where managers became professional and autonomous.”

The introduction in 1984 of general management wrought momentous changes, so Mr Filochowski also sees Griffiths as a turning point.

“The big step for Griffiths was the introduction of managerial accountability: the ability to identify a manager who could be called to account.”

Mr Brown agrees. “Suddenly the chief executive carried the can and you could override the consensus management.

“That was good, although of

‘I remember one of the medical journals saying that giving power to administrators was like giving whisky to red Indians’

course it didn’t mean you could do as you liked.

“As chief executive, you could not do anything that would not be carried in the organisation and as the chief executive you had to have antennae to know what would work.”

Nor was it a popular move among medics. Mr Dalton recalls: “I remember one of the medical journals saying that giving power to administrators was like giving whisky to red Indians.”

The other notion that gained currency at this time was that somehow managers from outside the NHS could do a better job. They were duly wheeled in from the army and industry, but generally did not last long. Mr Dalton explains why. “The big challenge of the health service – and one that does not change – is how to manage doctors.

“That’s what makes NHS management different from education or retail management. At the heart of it is a relationship between a doctor and a patient.”

Mr Dalton and an entire cadre of NHS managers who had come up through the National Management Training Scheme were well schooled in this and had learnt how to marshal arguments, negotiate and persuade, use peer pressure and frankly, how to sit it out, knowing that change takes time in the NHS.

Outsiders were not savvy on this and in one senior manager’s words: “The consultants just ganged up on them and forced them out.”

In the early 1990s the Conservative health secretary Kenneth Clarke began to hold the NHS to account not just for spending but also for the service’s horrendous waiting lists. This was done through the mechanism of the internal market.

Mr Jarrold says: “[Clarke] created the hospital trusts, which in turn created clear accountability on the provider side. The national agenda



1948-2008: MAJOR MOVES AND CHANGES

1948-1960

A small band of administrators support doctors in delivering care and treatments. Power is vested in the hospital medical board, with the most senior manager, the hospital secretary, running the hospital management board. In 1956, the NHS launches the National Administrative Training

Scheme, later to become the National Management Training Scheme.

1960s

The 1967 Salmon report on senior nursing structures brings senior nurses more overtly into management.

1970s

The 1974 NHS reorganisation

introduces the area health authority to sit between the districts and regions and new tiers of management take power outside the hospital. Consensus management is the flavour of the decade, allowing all groups of staff a say in how the NHS will be run. Financial crises force



all public services to focus on finances and for the first time

management gains some control in this area but little influence over clinical matters. In 1979 prime minister Margaret Thatcher receives the report of a Royal Commission on the NHS, which concludes that the

service is too complicated and consensus management too slow.

1980s

Sir Roy Griffiths, a senior manager with Sainsbury’s, examines NHS management and finds that “no one is





Daily dialogue: managers can now be found away from their desks and communicating across the service.



was for the purchasing side to hold the provider to account.”

Trusts reintroduced the hospital board, with non-executives drawn from a wide range of backgrounds. They also reintroduced the old triumvirate of manager, nurse and doctor, with each trust having a medical director and a nursing director among its executives.

Mr Brown, who at the time was chief executive of a large Manchester trust, says: “You had to carry your

board with you and these were knowledgeable and competent individuals from different fields. I think it was a good thing because you were spending large amounts of taxpayers’ money and it was not fair for a single person to be accountable for that. It was good too to take a complex issue, kick it around with your board and come up with some good answers.”

However, targets meant managers suddenly found themselves being accused of interfering with clinical matters as they tried to push through changes that would allow them to meet central targets.

Mr Dalton recalls the debate on day surgery. Sir Brendan Devlin, who then led the Royal College of Surgeons, produced a report endorsing day surgery in the early 1990s. “I sat across the desk from one of the consultant surgeons in my office in Carlisle [where he was then district general manager] and he threw the report down,

saying it was second-class surgery,” says Mr Dalton.

As a manager, he was also responsible for seeing through a national programme for greater specialism in medicine and had to persuade his resolutely generalist consultant workforce that introducing urology as a specialism was a good thing.

It was also a time of industrial unrest, with protests about low wages from nurses and contracting out from cleaners – with managers caught in the middle. In acute trusts, chief executives saw their pay rise and with it public resentment over NHS fat cats.

Blair’s targets culture

Then, in 1997, everything changed again. New Labour won a landslide in the general election, partly on a pledge to get rid of the internal market and to put more money into the NHS. On the 50th anniversary of the NHS, the then prime minister Tony Blair attended the main celebratory event – a joint conference by the NHS Confederation and the Institute of Health Management.

“Blair had this Messianic belief in his ability to reform public services through a huge edifice of targets and performance management,” says Mr Jarrold. With this came not just personal performance management but also star ratings.

After a few false starts, Alan Milburn, appointed health secretary in 1999, introduced a tranche of reforms.

Then in 2001 the report of the inquiry into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 saw the whole arena change in terms of clinical governance.

“It was a revolution,” says Mr Filochowski. “It basically said that there cannot be any no-go areas for managers, and doctors realised they could no longer say ‘hands off’”

Managers were sacked for failing to meet targets. They were sacked for fiddling the figures. They were penalised if their organisation was deemed to be failing. A new code of

‘The Bristol inquiry was a revolution. It basically said there cannot be any no-go areas for managers’

conduct was introduced to counter the notion that managers were somehow, despite the insecurity of their tenure, not accountable.

It is at this point that we tip from history into current affairs and speculation over where foundation trusts will lead NHS management roles and how the commissioner’s role in primary care trusts will develop. But that is for another day. On the 60th anniversary of the NHS, it is fair to say the man in the suit in 1948 would not recognise his counterpart in 2008. ●

in charge”. In 1983 he recommends the NHS should introduce general management to encourage clear authority and accountability for planning and decision making, more flexible team structures and greater emphasis on leadership. General management is introduced in 1984,

along with a cadre of non-NHS managers from the private sector; most of them do not last long.

1990s

The 1989 white paper, *Working for Patients*, creates the internal market, in which the NHS is managed according to market principles. The first waiting list targets see managers beginning

to impinge on clinical territory. In 1997 New Labour comes to power on

a promise to invest in the NHS and make it a more responsive service. New

targets begin to bite, with claims management is distorting clinical priorities. Investment is poured into the NHS.

2000s

The NHS Plan sets out a wide range of targets, and managers become accountable for delivering these. Performance

management adds to accountability. The Bristol inquiry report in 2001 radically changes the landscape for doctor/manager relationships.



PHOTO: LUSION, REPORT DIGITAL, GETTY, TOPFOTO, PA

ICING ON THE CAKE



For Chris Pelloe, Jenny Brown and Sue Hood, their birthdays this year are especially unforgettable events. Not only does the NHS turn 60 on 5 July, 2008, they do too. All three entered the world on the same day as the service and went on to enjoy lengthy careers in the service.

All three were also working at Addenbrooke's Hospital in Cambridge when they and the NHS celebrated their 40th birthday in 1988, a day marked by the three being pictured on the front of the local paper. Twenty years on, they reflect on lives shaped by the NHS.

JENNY BROWN

In Jenny Brown's office at Cambridgeshire primary care trust is a certificate marking her 35 years of service in the NHS, awarded to her when she was with her previous employer, South Cambridgeshire PCT. With 14 jobs in 40 years, her lengthy CV is a track record of the reorganisation of the health service.

Although she was the first baby born in Crawley under the NHS, Ms Brown did not intentionally set out to have a long career in the service.

She first started work as a nursing auxiliary at a psychiatric hospital in Colchester. "That was an amazingly useful experience in learning how to deal with people. The hospital was a big institution, full of people committed for reasons that we would never allow now. But I would never have thought I would still be in the NHS 40 years later. I was only 20 and just needed a job."

Ms Brown moved to London and took a job as receptionist at the old Westminster Hospital, later becoming supervisor. After qualifying in medical records, she became an assistant medical records officer at St James' Hospital in Balham.

"Once the shelves in the x-ray library went down like a deck of cards and all the records got mixed up. There was such a mess, I could not open the door and had to climb in through the window. I had to take over an empty ward to work out which x-ray belonged to who. There were thousands and it took days to sort out."

Returning to East Anglia, Ms Brown joined Addenbrooke's in 1978, becoming medical records officer in outpatients and then patient services officer. The role meant overseeing 300 reception, filing and ward management staff.

"There was strong union activity. At one point they occupied the

Three managers who share their 60th birthday with the NHS talk to Emma Dent about their long careers in the service

medical records library and only allowed cancer patients and children's notes to be taken away. It was all so much more about staff needs and not those of the patients. I don't know how much energy was expended on issues such as the porters' bonus schemes. But I was impressed with the quality of staff and we were at the leading edge of outpatient appointment booking."

Ms Brown worked at Addenbrooke's for 11 years and gained a diploma in management – "a real eye opener" – before she was offered the role of screening services manager at Cambridge health authority, working with the director of public health to implement a breast screening programme.

"Then the internal market came in and I moved into the East Anglia internal market programme as a healthcare purchasing manager. We were designing contracts but there

was no written guidance or rules. My medical records experience held me in good stead when it came to understanding the data."

Ms Brown then moved again to a more senior role in purchasing at the Cambridge and Huntingdon Health Commission.

"You have to be able to adapt to change in the NHS," she says wryly, looking at her lengthy CV. "I had to apply for my job again as recently as 15 months ago."

After four years, during which time Ms Brown did a certificate in health economics, she joined Cambridge and Huntingdon health authority as assistant director of acute services. "It was working on performance management and with fundholders – my bread and butter."

The launch of primary care groups in 1999 saw Ms Brown make yet another move, to South Cambridgeshire primary care group

and some of the "most enjoyable times" of her career in developing community services. When PCGs became primary care trusts three years later, Ms Brown changed jobs again, to become assistant director of service and capacity management, only to face more change when PCTs merged and Cambridgeshire PCT was formed.

Now deputy director of practice-based commissioning business planning since December 2006, Ms Brown remains enthusiastic.

"Cambridge is a place where things happen; we have made great strides here."

She is looking forward to retirement, though, albeit with plans to continue local voluntary work.

"It is time I had a bit of time to myself – I need a work-life balance," she says. "The whole tempo of life has speeded up – managers work much harder and for much longer hours now."

SUE HOOD

Sue Hood's parents never forgot she had been born on the same day as the NHS. "They remembered standing on the steps of the hospital as the town hall clock chimed midnight and realising they would not have to pay for the hospital care," she says.

After working as a junior reporter on a local newspaper, Ms Hood was a civil servant before joining the NHS in 1982 when she got a job as a secretary at the Cambridge health authority.

"Day-to-day life was not very different from in the civil service. It was all fairly formal; we weren't allowed to use first names at work and always had to wear a smart suit. Women were not supposed to wear trousers," she recalls.

Five years later Ms Hood was managing all medical secretaries at Addenbrooke's. "They were scattered all over the hospital; sometimes I had to walk half a mile to find someone."

Shortly afterwards, computers took over from electric typewriters and all medical secretaries were transferred into clinical directorates. Ms Hood went on to be a manager in general medicine and after a move to Broomfield Hospital in Chelmsford, Essex, managed its new clinical audit department.

"We had no office, no carpet and did not really know what we were doing. A lot of work had to be done to get the consultants on board. We worked with the local authority on what was causing people to be admitted."

In 1998 she won the *HSJ* Roy Griffiths award for innovative management. As a result, she went on a management programme run by the King's Fund which included



Jenny Brown, left, was Crawley's first NHS baby and has worked in many roles. Sue Hood, right, looks forward to her well-earned retirement later this month.

a placement at a rural ambulance service.

Ms Hood stayed in the audit department until 2002, when she was made redundant. A move to a community health council proved short-lived when they were abolished three months later.

Another move to a primary care trust was also short, as it was subsumed into a larger one in the recent reorganisation.

Ms Hood now works as a temporary medical secretary, mainly at Broomfield Hospital. She is due to retire this month and is looking forward to having more leisure.

"I have enjoyed nearly everything I've done but especially when it has really helped patients, particularly some work with local GPs on living with the aftermath of a stroke. And once, a few days after I had started working at the medical secretaries' unit, where my office was on the edge of a ward, I found two people in tears. I put my arm around them. I found out later they had just turned off their son's life support machine. I was in the right place at the right time and I think it helped that I wasn't wearing a white coat."

CHRIS PELLOE

Chris Pelloe's father also never forgot that his baby shared his birth date with the NHS. An administrative oversight meant he was still charged for the birth at the London Hospital, although Mr Pelloe has brought his birth certificate along to his meeting with *HSJ* to prove he was entitled to free care.

He joined the NHS in 1967 because his mother decided he should. "You did what your parents told you to then," he says.

After he had spent nine months as a hospital porter at the Royal Berkshire Hospital in Reading, the family moved back to London and Mr Pelloe began work in the accounts department of Guy's Hospital. This involved marking all payments in huge ledgers.

"I didn't think about working in the health service, it was just a job, although I did make a great friend while working there; we are still friends to this day."

His next move, initially to become a clerical officer, also at Guy's, began a career in hospital supplies.

Mr Pelloe's subsequent position involved helping supply all capital equipment for the new Charing Cross Hospital in Fulham. When the site was opened by the Queen in 1973, he acted as a steward on the day.

A move in 1975 to Cambridge was supposed to be temporary but he found he loved the city and working at Addenbrooke's, with its social

'I took redundancy. I had worked in the NHS for 28 years. I loved my work and I was gutted'

club, swimming pool, squash court and cricket club.

When Mr Pelloe's job in supplies was moved to Cambridge's Fulbourn Hospital in 1978 he was promoted to senior purchasing officer, a job he did until 1986, when supplies was transferred to the regional health authority.

Mr Pelloe later became team leader, setting up a contracts database, and then contracts manager in medical and surgical supplies. When NHS Supplies was formed in 1992, with all equipment shipped across the service from regional warehouses, Mr Pelloe was responsible for negotiating prices for the Suffolk site.

"We had to renegotiate all the prices every six months, on about 2,500 lines. It was enjoyable but also high pressure as we were also doing specific contracts for individual hospital departments. The most difficult thing I did was being charged with saving £500,000 one year and we achieved a saving of £750,000. But a real highlight was procuring products

for Papworth Hospital for heart and lung machines. They had never been on contract before and I achieved a saving of £47,000 plus VAT; money that went back into the health service."

NHS Supplies saw a wave of redundancies in 1996. Mr Pelloe was one of those who took redundancy. "I had worked in the NHS for 28 years. I loved my work and I was gutted."

Mr Pelloe started a consultancy talking to equipment and supplies companies about how the NHS works, but this came to an end as "the NHS kept changing". He now works in the wine and spirits department of his local Waitrose.

"The change of work did me good. Getting more exercise and not socialising with clients meant I lost four stone in weight."

He misses former NHS colleagues and helping patients. But his greatest regret is having to leave the NHS two years short of being entitled to a full pension. Future plans include travelling with his wife to see relatives in the US and Philippines. ●



Chris Pelloe found his career in hospital supplies "enjoyable but also high pressure".

ALL ROADS LEAD TO IT

BT is dedicated to a future where information technology works for healthcare on all fronts, says Lyn Whitfield

As the NHS approached its 50th anniversary, it launched a major public consultation that led to the creation of the NHS plan, a 10-year blueprint for reform.

Yet since that plan emerged, the health service has been the subject of at least two further inquiries: one conducted for the Treasury by former NatWest chief executive Sir Derek Wanless and, most recently, by junior health minister Lord Darzi.

All have grappled with deep-seated issues and all have concluded that more investment in better IT will be key to addressing these points.

"The first New Labour government arrived in office with an election promise of bringing radical NHS reform," says client engagement director for BT's London NHS Programme Brendan Major. "The first rational step was to review it – to find out whether it

really was a good way to pay for and to organise care. One of the things Wanless concluded was that the service should be spending much more on IT, because IT spend is a reliable proxy for whether you are doing things in a manual, cumbersome or, in the case of the NHS, potentially dangerous way. Effectively, he concluded that you cannot be doing things well if you are only spending about one per cent of your budget on IT [as the NHS was doing in 2002]."

New demands

BT London chief executive Paul White lists some other underlying pressures on the NHS from an ageing population and increasing prevalence of conditions such as obesity.

At the same time, medical advances continue to be made and the NHS is facing new kinds of demands from its patients.

"More of the population now expects access to the highest quality and the safest care," notes Mr White. "Scandals from a decade or so ago – the Bristol heart surgery inquiry in particular – really raised awareness of the fact that not all hospitals are equal. Since then, we have seen the development of pathways of care for patients, new regulators and new emphasis on patient choice."

Such moves "bring us back to IT" because all depend on information – for policy makers to plan, for commissioners to buy care pathways, for frontline staff to operate them, for auditors to monitor their effectiveness and safety and, increasingly, for patients themselves.

"There is a real need to get the right information in the right format to the right people at the right time – starting with the fundamental fact that you've got the right patient, who, increasingly, may be dealt with remotely," says Mr White.

The Wanless report helped to pave the way for the National Programme for IT in the NHS. BT's involvement with the programme includes winning the contract to replace NHSNet with broadband network N3 and to create the NHS data "spine" that will eventually hold the summary care record of every person in England.

Meanwhile, BT became the local service provider for London, tasked with standardising administrative and clinical systems into NHS trusts (which will continue to hold their own, "detailed" care records) – and getting them to interact with each other. BT adopted a "best of breed" strategy, using different suppliers for GP, mental health and hospital departmental systems.

"We have successful deployments at many sites. The next step is to join things up and get that proper, coherent record, with role-based access for staff," says Mr White.

The need for truly joined-up IT continues to grow.

The Darzi report on London's health services recommended creating new community service

while concentrating specialised acute and tertiary services on fewer sites. This will only work if people can move easily between different services and teams, wherever they are based.

"The Darzi model challenges the estate-based model of healthcare that we are all used to," says Mr Major. "It will only work if IT is there to glue it together, to tell people who you are and how they need to treat you."

This kind of change is difficult. Clinical practice, in particular, will need to change as policy and IT asks frontline staff to do things differently. "A lot of this comes down to trust," adds Mr Major.

"Many doctors still only trust themselves and those they work with to do things [such as] take a case history. They need to start working with the information in front of them – to accept that the record is the case history."

He adds that the "prize" of this change will not just be doing things faster or even more safely, but also doing them more efficiently.

For example, by making effective use of an electronic patient record, "a GP might be able to directly book a patient into a hospital bed, and the consultant's 'grand round' could be replaced with a remotely delivered, clinically targeted and less intrusive process. Or a GP might be able to prescribe electronically."

Force for change

Both Mr Major and Mr White feel the future of IT in the NHS lies in making good use of technology that is on the verge of widespread adoption.

"What chief executives are interested in – or should be interested in – is not IT as such, but in how they can use it to change their organisations," says Mr White.

"That means really investing in the change process. Big corporations might [invest] three or four times what they are spending on IT on deployment and change management – something not many NHS organisations are doing."

But Mr Major adds: "There are





‘It is the coalescence of existing technologies that will be most interesting – virtual consultations, for instance’

chief executives who want their organisations to be early adopters and to get things working for them.”

This makes them demanding clients. “But we say, bring it on. BT has a history of handling big projects. Where programme management stuff can look dull on paper and suicidal to apply is where we can really add value.”

Meanwhile, trusts that cannot cost and effectively provide their services and show they are delivering excellence may find they are no longer in the game.

Both men are keenly aware of the arrival of consumer-centred healthcare IT, such as Google Health and Microsoft’s HealthVault, which presage a more consumer-minded health service user.

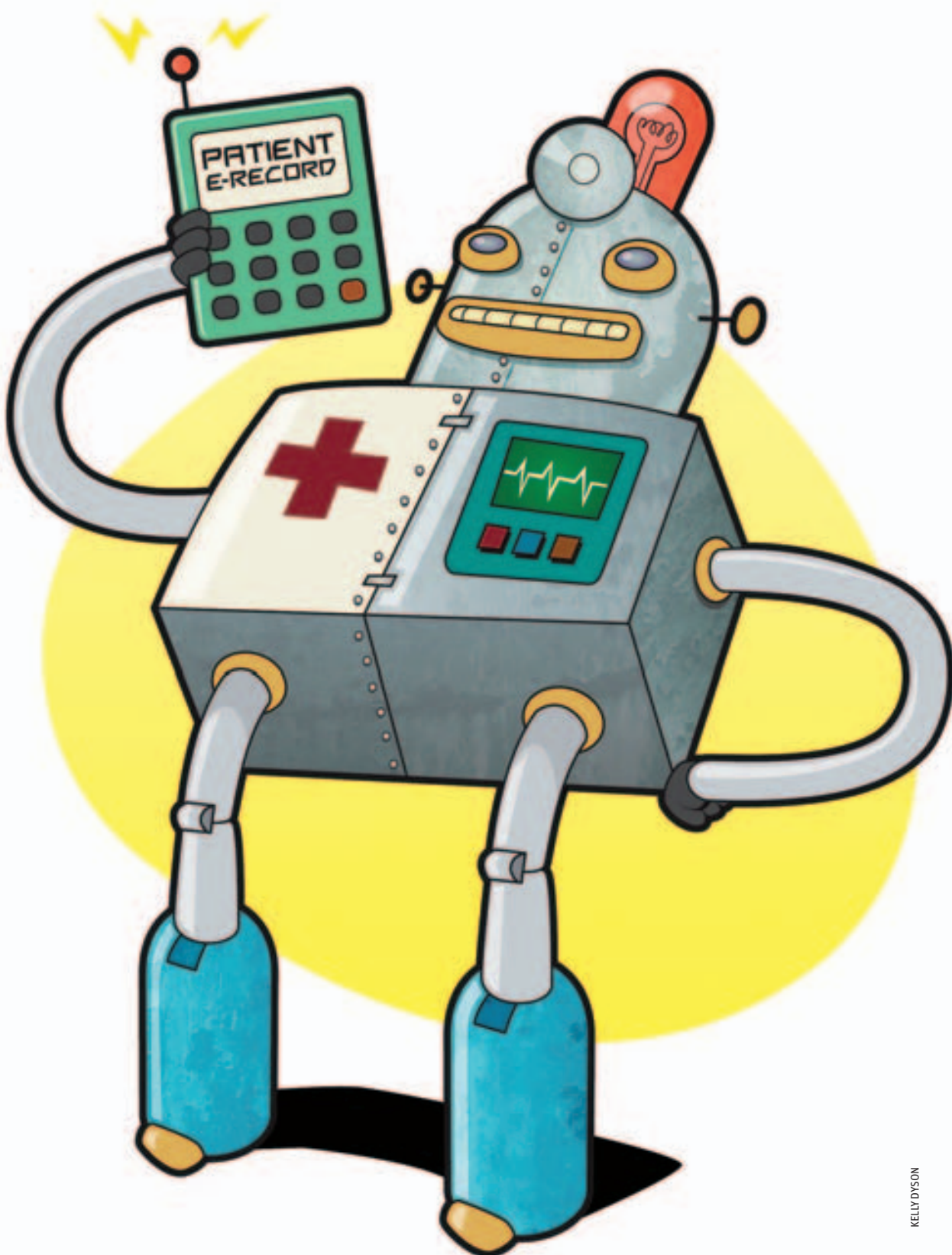
“Dealing with a better informed population is one of the challenges faced by the health service,” says Mr White. “The effects are unpredictable, particularly if the government is successful in its drive to get people to take more responsibility for their health.

“If they do, I think they are going to start saying, ‘I have done my bit, now what is the service going to do for me?’ And that will drive even more interest in access to efficient and safe services, although the danger is that it could also lead people to say, ‘Why should I pay for people who have not taken care of themselves as I have?’”

Mr White adds that emerging technologies will produce some exciting IT. “If Lord Darzi was here, he would be talking about robotics and how it will allow surgeons in New York to perform operations here in London. But I think it is the coalescence of existing technologies that will be most interesting – virtual consultations, for example.”

And he suggests that more self-diagnosis will be carried out, supported by computer models.

“There will be more self-care, again supported by IT-enabled services. People will not rely on the NHS to try and do everything it does now.” ●



PATIENTS FIRST



The history of patients in the NHS is one of tremendous satisfaction, loyalty and trust, but also of paternalism, exclusion, frustrated communication and lack of power.

While a rhetoric of “patients first” has existed since at least 1979 and the strength of the patient voice has grown, the potential for patients truly to influence their consultations, care pathways and the shape of services remains largely unrealised. But a real change may be at hand.

At the founding of the NHS, patients were not in the picture. Nye Bevan painted them in at the very margin, their voice drowned by the obstreperous medical profession. He told the Commons he hoped “what will reach our ears will not be the declamations of partisans, but the whispers and piteous appeals of sick people all over the country, who are reaching out their hands to this House of Commons to give them succour”.

A study of pressure group politics of the time found “no organised group representing the user or potential user of the service” and concluded that the only person not represented around the health minister’s table was the patient. Dropping a bedpan, it seemed, had more resonance than dropping a patient.

Within two months 93 per cent of the population was signed up to the service. But they did not make the choice, their doctors did, bringing their patient lists with them.

However, by 1951 public demand was too much and the great effort to control NHS expenditure began in earnest. The service consolidated, but consolidation meant whole categories of need remained outside the service. “Need” had not been defined at the foundation of the service and remained determined by what ministers felt was affordable and

The views of the most important person in the health service were scarcely considered in the early days. Don Redding looks at how patient power has evolved

doctors considered properly “medical”. Patients could not force their issues onto the agenda, so slowly the rise of patient pressure groups began.

Family planning was an early example. Doctors saw this as a “social”, not a medical, question but that changed when the pill arrived. As Audrey Leathard noted in her history of family planning: “Oral contraception required professional advice. This decisive factor brought the medical profession into family planning.”

Pressure groups

This prefigured the later rise of patient-oriented associations focused on a specific condition, providing support for sufferers and working to place it higher on the list of political and medical priorities. Such groups grew from 230 in 1979 to around 500 by 2000.

Social historian Rudolf Klein notes that these organisations gave increasing visibility to patients’ demands. They certainly represented a challenge to previously dominant pressure groups, such as doctors, managers, politicians and the health technology industry. But their threat has often been diffused or defused.

However, patients’ associations are now more integrated into health policy development and are even overcoming the turfism that has previously bedevilled co-operation – witness the joint work of cancer charities on the new cancer strategy.

Another thread is patients’ ability to participate in and influence

decisions. With few early studies about the first 15 years of the NHS, the assumption is and was that patients were grateful and deferential about their new access to free care. But sociologist Ann Cartwright’s 1960s studies suggested that high levels of reported satisfaction hid underlying problems, which remains the case today.

Her 1964 survey of hospital inpatients, *Human Relations and Hospital Care*, showed that three-fifths of the sample reported difficulties in obtaining information. One-fifth said they were unable to find out all they wanted about their condition, treatment or progress.

“I think I should have been told straight out why they did a total hysterectomy,” said one patient.

“If you asked what the pills were for, you were told to take them and never mind. You were treated like a child,” said another.

What we now call “respect and dignity” were often sorely lacking. Only half the patients reported having curtains around their bed.

Ms Cartwright described hospital doctors as “inaccessible gods” in a system that perpetuated 19th-century “condescension and charity”.

But patients did not want to be inactive – only 10 per cent were “consistently passive” in relation to information. Her conclusion – “Doctors tend to underestimate both patients’ desire for information and their ability to understand explanations” – is echoed in present-day research.

This picture was changing in primary care as younger, NHS-trained doctors came into family practice. “The old family doctors were like little demi-gods [but] you can talk to them now,” said one respondent to the Cartwright study.

The new intake showed far more interest in issues their older peers had neglected, notably obstetrics, gynaecology and cervical smears.

However, today’s fear that patients are too demanding was already foreshadowed; over half of GPs agreed “patients nowadays tend to demand their rights rather than ask for help and advice” and most thought many consultations were for trivial matters.

The Picker Institute’s more recent

work shows that patients want more share in the decisions and that the UK rates poorly for delivering it. But engaging patients in understanding and making decisions about their health can improve their knowledge, confidence and experience of healthcare. It can also create better health outcomes and even contribute to a more appropriate and cost-effective use of health resources.

For the past five years, England has had co-ordinated national surveys of patients’ experiences. Clearly the most demeaning and hierarchical approaches of the hospital sector in particular have largely been overcome; much more explanation is given to patients, who express levels of trust and satisfaction that, among public services, are extraordinary.

Massive improvement is still required, however. In 2006, 42 per cent of primary care patients, 62 per cent of community mental health service users and 63 per cent of people leaving hospital said they did not have enough information on side effects of prescribed medicines. And in any national patient survey,

‘If you asked what the pills were for, you were told to take them and never mind. You were treated like a child’

between one third (primary care) and one half (inpatients) say they were not involved as much as they wanted in decisions.

“Patient and public involvement” remains incoherent, unsystematic and only rarely effective.

Although everyone now signs up to “patient-centred healthcare”, the rhetoric is not new. *Patients First* was the title of the then new prime minister Margaret Thatcher’s first blueprint for health reorganisation in 1979.

The difficulty has been to move forward to find whole-system approaches that embed patient-centredness in the NHS.

Do we stand on the brink of such a system? If, as the government intends, all 25,000 health and social care providers in England are to be registered and inspected against their capacity to support people’s independence, control of care and decision sharing, perhaps we are finally turning a decisive corner. ●

Don Redding is head of policy and communications at Picker Institute Europe.

You might have expected the birth of the NHS to be greeted with a cheer, but it got a muted press reception, says Jo Stephenson

WHAT THE PAPERS SAID

On 5 July 1948 the *Daily Express* said: "Doctors and people collaborate today in a tremendous social experiment. The new National Health Scheme is launched. Wish it success."

And so the NHS began, not with a bang, but more with a very British polite round of applause.

Its birth was not exactly front page news, being eclipsed by an air crash that killed 39 and the Berlin Blockade, one of the first major crises of the new Cold War.

Health minister Aneurin Bevan did make headlines though – for a scathing attack on the Conservatives. He "told 7,000 people at Manchester yesterday: 'I have a deep, burning hatred for the Tory Party,'" reported the *Express*.

In an early warning about reporting of the NHS, Mr Bevan said he did not expect it to be given a fair chance by some sections of the press. "For a while the newspapers of our enemies will give the impression that everything is going wrong. Don't be deceived," he told the Manchester crowd.

In fact most papers – right and left wing – gave a cautious welcome to the service, although not everyone was thrilled. The *Express's* 4.30am slot for breaking news revealed that students had hung a skull and cross bones on the front of St Mary's Hospital in London.

The paper's leader was optimistic but could have been written by the British Medical Association:

"The public should be mindful of the sacrifices and difficulties of the doctors. Their personal skill and knowledge and in certain cases genius, are being nationalised," it said, before urging readers to "be reasonable".

"It is no use pretending that the scheme can begin at anything like maximum efficiency. There are not enough doctors, not enough nurses, not enough hospitals."

The Ministry of Health also "warned the public not to expect too much", reported *The Daily Telegraph*. "People can help enormously by not rushing the new service... and above all by judging the results after a few months and not after one day or one week."

The words of prime minister Clement Attlee, who begged for patience in a broadcast on the eve of the historic day, were also reported.

"There are bound to be early difficulties with staff, accommodation and so on... We shall have to be a bit lenient with the service at first," he said.

Even so, 19,000 doctors across Britain were expected to join the service and "of 3,000 hospitals in Britain, 2,751 passed under the control of the new boards appointed at midnight". All hail the first health service managers.

But there were gloomy predictions about the NHS from some. "No spectacular changes can be expected in Britain's health services," said the *News of the World*. "Why? Because too few of Britain's young girls are taking up nursing as a career." It was hoped a government recruitment campaign including "attractive posters" and a new uniform designed by "one of Britain's top-rank dressmakers" might do the trick.

Meanwhile some doctors were not playing ball, revealed the *Daily Mirror* on 30 June. "It is alleged that in some parts of the country, doctors are applying a 'means test' before accepting patients, refusing those likely to require special care," reported the paper. "Another complaint is that residents in a block of flats had been unable to register because local doctors had made a pact not to accept any person in the block because they were able to pay fees." However, other GPs embraced the scheme. "Some have even sent cards of welcome," said the *Mirror*.

Meanwhile, the dentists were accused of spoiling it all. "Last night members of the British Dental Association in only eight out of 200 areas had decided to take part in the scheme," said the *News of the World*. The *Mirror* was indignant at the news. "The National Health Service has got off to an encouraging start... an example of

how the nation can co-operate in a great enterprise," said the paper's 6 July leader. "Only one bit of bother draws attention like a raw tooth – the odd-man-out isolation of a number of dentists."

The *Mirror* continued: "The State has done well by dentists. Not long ago it gave them professional status and stopped the disgrace of tooth-pullers who toured with brass bands. The financial terms now on offer are good. It is the turn of dentists to help the State."

Unfair, retorted the dentists, whose gripes, reported in *The Times* on 5 July, included the fact few had been sent forms to enrol. "This delay is entirely due to the overworking of the bureaucratic machine, which is creaking to a standstill," said the British Dental

Association. "In contrast to this dilatoriness on the part of bureaucracy, the dental profession was forced by the Ministry of Health to negotiate the complicated scale of fees in three weeks."

Nevertheless *The Manchester Guardian* foresaw a promising future predicting "the scandal of 'under-doctored' areas will slowly disappear". Hmm, where have we heard that before?

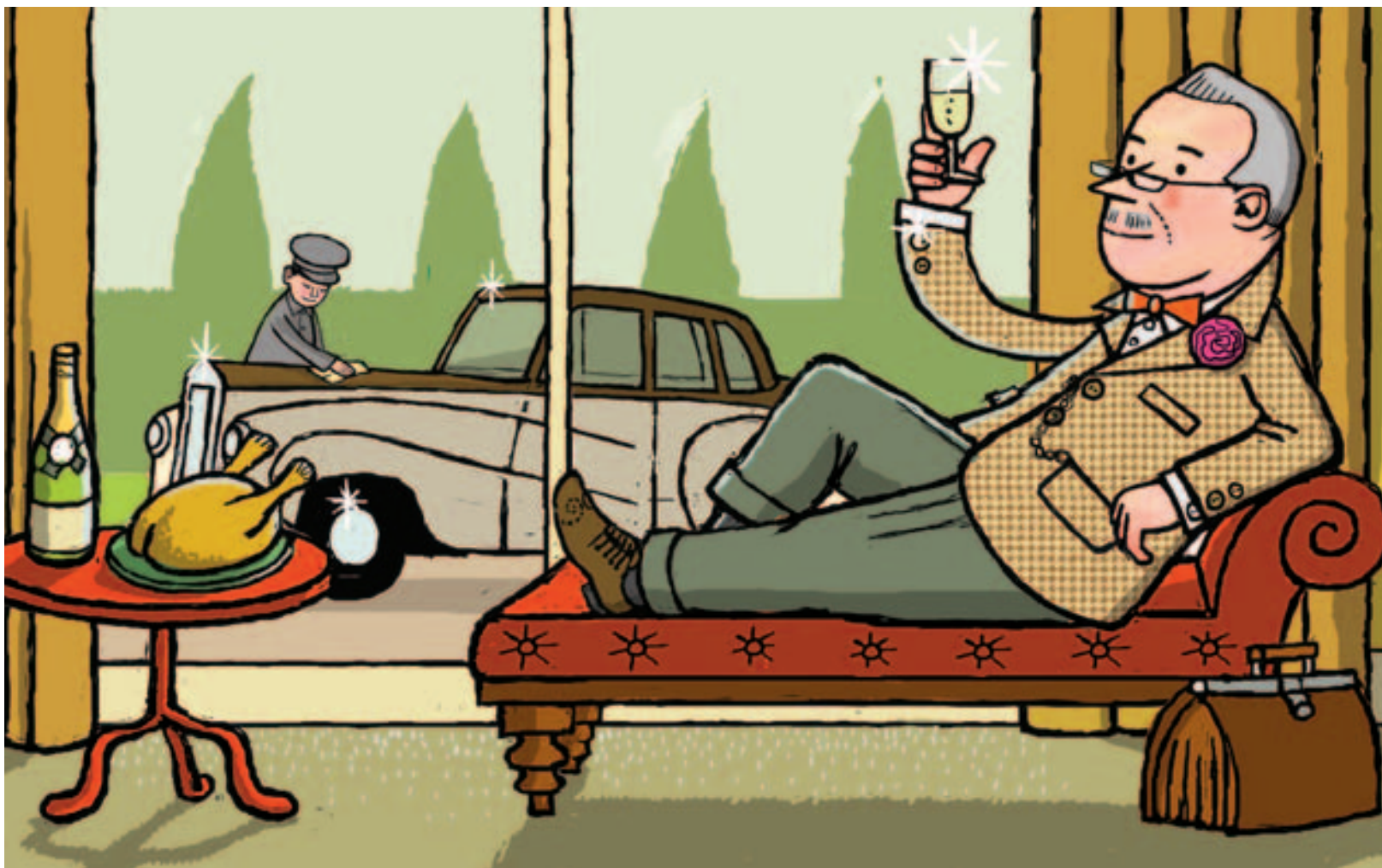
The next day it published a photo showing nurses in capes and frilly white caps greeting Mr Bevan at Davyhulme Park Hospital in Manchester. "The handing over of this hospital to the Minister was a symbol of the transfer that took place all over the country," intoned the caption.

And finally, an early success. "New happiness for the deaf" was the headline in *The Times* on 8 July as it reported one of the first innovations of the new health service: free hearing aids.

"Mr Bevan said that it had been asserted that the aid did not look very handsome and was rather awkward. But the most important thing about it was its efficiency and – he could not entirely ignore the point – its cost." ●

'The scandal of under-doctored areas will slowly disappear, said The Manchester Guardian'





The scene then

The Bentley purred into the reserved parking space opposite the portals of his hospital, at exactly 9.30 am. The most junior member of staff ushered Dr Michael in.

Matron, two ward sisters and four junior doctors of varying rank greeted him for this weekly ward round. Patients were neatly packaged into the two rows of beds as the consultant proceeded from one end to the other, graciously stopping at some beds, questioning with wisdom and insight, probing with manicured hands and discovering hitherto missed or unimagined pathology.

There was also a nurse to hand with a stainless steel finger bowl, a nurse who carried linen hand towels and a nurse to twitter excitedly.

Such was the patients' tension – warned so severely by Sister to be on their very best behaviour – that two elderly gentlemen undoubtedly suffered extensions of their hitherto uncomplicated myocardial infarcts.

Three hours later he met the other visiting consultants in the silver service dining room. He then summoned the hospital superintendent to review his considerable waiting list, did a little teaching and was conducted down to the Bentley at 3pm precisely.

TOUGHER A

Six decades on, how far have the mighty fallen? Perhaps the definitively transformative event in the consultant journey since the inception of the NHS has been the relatively recent adoption of the consultant contract. It is important to remember what the drivers were that led to this potentially revolutionary overhaul of consultant working practice.

The move was rooted in a widely held, predominantly London-centric view that consultant staff regularly abandoned their patients to largely unsupervised junior staff so they could pursue their private practice with relative freedom. I remember august bodies such as the Socialist Health Association getting terribly worked up about “gaps in availability of information concerning consultants’ activities” while seeking to engage the Inland Revenue in the quest for clarity on earnings across both sectors and invoke European Union

Over the past six decades the working life of consultants may have lost some of its glamour. Now their role has to evolve if they are to regain their standing in the health service, writes David Kerr

employment law to limit the working week.

Meanwhile the Department of Health was engaged in a master plan to renegotiate the consultant contract to improve working patterns and introduce management levers to lead to consultant-led service improvement. Five years later it is worth reflecting on how many benefits have been wrought by its implementation. A 2006 authoritative review by the King's Fund (*Assessing the New NHS Consultant Contract*) made it obvious that the DH grossly underestimated the scale of the task and its implementation and failed to provide the quality of national

leadership needed to prevent such a high degree of local variation in interpretation and delivery.

It still seems the process is driven by local cost pressures rather than a true reflection of workload and that objective setting remains weak, indicating a disconnect between job planning and consultant appraisal.

On the plus side, there is greater transparency of consultant job planning and the capacity to link pay progression to agreed objectives.

On the down side, consultant earnings have increased – the cost of which has been far greater than anticipated as the initial funding formula was based on flawed



AT THE TOP

financial and workload assumptions. This must have added to trust cost pressures but has not yielded much in the way of obvious clinical benefit to patients.

How will the consultant role evolve over the next decade? It is likely we will see a greater move on the managerial side towards linking pay to performance and the consultant working week to strategic goals of the hospital. In general terms, medical management needs to be strengthened by improving capacity and competency, greater executive support from the trust board and more oversight and involvement in job planning.

Consultant job descriptions need to be better linked to reform and improvement in service redesign. If competition and contestability are the modern watchwords of England's NHS, I firmly believe we are likely to be much more internally cohesive and externally competitive if it can engage senior clinicians in the redesign

'Consultant job descriptions need to be better linked to reform and service redesign'

movement. This requires training, support from management and incentivisation through the contract to drive consultant support required to lead to sustainable improvement in service delivery.

At a time when policy makers seem to be reconsidering target setting, we should make an effort to reduce the effort that goes into collecting data on irrelevancies and targets for which there is no proof of correlation with outcome. It would be more logical to reaffirm the consultant's role in initiating service redesign which directly links to key clinical outcomes.

In my own field as a medical oncologist, I have a consistent set of measures used routinely in all publications and globally accepted as arbiters of clinical worth.

Yet despite investment in cancer registration and data collection, I quote average figures from publications, often generated in the US, when I describe the relative pros and cons of any therapy, as I do not have available figures from my own practice, hospital or cancer network.

So another 60 years beckons but it is clear the consultant role must evolve further if we are to retain (or perhaps regain) our standing as clinical leaders of the NHS.

I would suggest we describe clinically appropriate targets which if achieved will result in definite, measurable benefits for patients. ● *Professor David Kerr is Rhodes professor of clinical pharmacology and cancer therapeutics at the Department of Clinical Pharmacology, Oxford University.*

The scene now

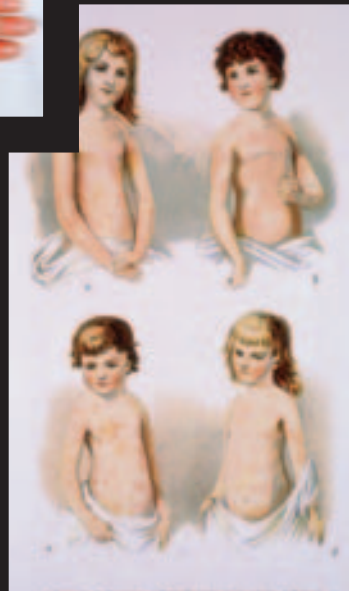
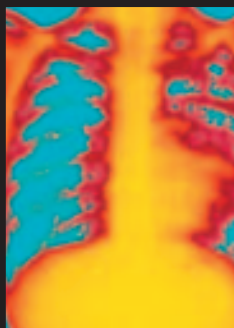
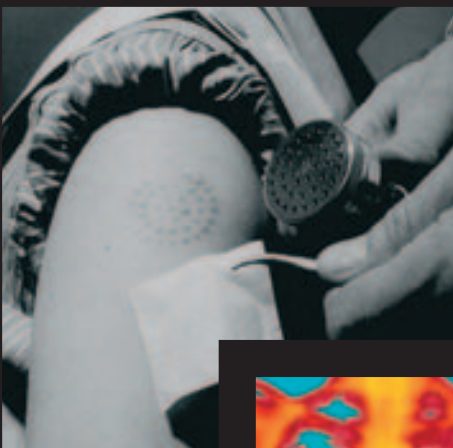
Mike rushes to park his battered BMW, the hefty parking fee being deducted from his salary. It is 7.30am. He bypasses the hospital's handsome portals (now for executive managers only) and pushes past the littered McDonald's restaurant at the new front entrance. He types up yesterday's clinic notes before heading up to do the ward round.

This is something of a lottery, given the lack of continuity between junior medical staff. The nurses seem too busy to attend the ward round, but it goes pretty well until he is told to "bog off" by a patient. After two circuits of the hospital, Mike grabs a sandwich on his way down to the outpatient clinic.

The hospital's electronic booking system has misfired, leaving the first hour empty and 28 patients overbooked into the remaining two hours. As usual, only 50 per cent of the blood tests and scans are available.

Later Mike is summoned by a junior manager to review his clinic waiting times, following complaints. He heads off at about 7pm to the dinner being held by his best friend from medical school to celebrate his general practice's achievement of maximum points and therefore maximum bonuses.

DÉJÀ VU



Healthcare has moved on apace since 1948, with treatments that would have amazed medics of the time. Yet in other areas time seems to have stood still, says Niall Dickson

If by a miracle of medical technology we were able to bring Nye Bevan back to life, how would he regard his creation 60 years on?

He might raise an eyebrow at the scale of the operation – when it was launched, the service cost around £400m (roughly £11.5bn in today's prices), compared with more than £107bn today. He would certainly be impressed by transplant surgery, chemotherapy, how we have combated AIDS and improved the care of mental illness.

On the face of it, today's health challenges are very different. Both disease patterns and the means of combating them bear little resemblance to 1948. For example, antibiotics and vaccinations have transformed the treatment and prevention of infectious disease in children – in the case of polio, eliminating it entirely.

The challenge of infectious disease remains, though. We have not yet found a way round the regular appearance of a flu pandemic or the risk of a new strain jumping from another species. Globalisation and a sexual revolution have led to a huge rise in sexually transmitted infections, including HIV/AIDS. Drug-resistant strains of tuberculosis as well as healthcare-acquired infections present new variations on long-standing challenges. We have not

even yet rid ourselves of the scourge of measles.

But we are seeing a shift in emphasis from infectious to chronic disease, which is largely a product of greater longevity and affluence. Arthritis, diabetes and dementia are all increasing year by year, on top of the impact of rising obesity, much higher levels of drug abuse and probably higher levels of alcohol abuse.

Obesity levels

In his report for the King's Fund, *Our Future Health Secured*, Derek Wanless identified obesity as requiring substantially higher levels of funding over the next 20 years unless worrying trends in unhealthy lifestyles are tackled. The rises in both adult and child obesity are already much greater than even the most cautious predictions of his earlier review for government.

All the same, being concerned about children's weight is nothing new, although in the past we worried they were too thin and undernourished.

Last summer, announcing the Darzi review, health secretary Alan Johnson identified critical issues, including "improving clinical engagement... investing in prevention, providing accessible care closer to home and ensuring services are responsive to patients and local communities". Would

those challenges have resonated with Nye and his colleagues?

Medical scepticism over the role of government in health has a long and, some would say, creditable history. But it has led to a fractious relationship and a feeling, from the outset, that medics were not fully committed to the project.

The fact that the British Medical Association opposed the type of health service engineered by Bevan – describing it as regimented units "repugnant to the tradition of British medical practice" and comparing plans for the new NHS with the healthcare system in Nazi Germany – has allowed critics to portray it as unremittingly reactionary. Bevan in his turn described the BMA as a "small body of politically poisoned people".

At a speech in January this year, prime minister Gordon Brown

'The NHS of the future will do more than just treat patients who are ill'

announced "the NHS of the future will do more than just treat patients who are ill; it will be an NHS offering prevention as well".

And that is precisely what Sir John Maude, permanent secretary at the Ministry for Health in 1941, had in mind for the new health service for the post-war era. He said it must aim at "creating and maintaining good physique, energy, happiness or resistance to disease" and not merely "patching up ill health".

To be fair, the health service has done more to live up to that challenge than is often acknowledged. Screening, vaccination, smoking cessation programmes and statin prescription are testimony to that. Yet it has struggled to secure the right balance, with the urgent calls of the sick taking precedence, especially when budgets are tight.

There is a chance now that the NHS could move to being a much more proactive system that tries to keep people as healthy as possible.



Although focus may have shifted between issues such as disease management, public health behaviour and the role of acute services, most health concerns have persisted since the start of the NHS.



Competition for resources between the well and the sick will remain, however. When the NHS turns 100 in 2048, it is a fair bet the prime minister of the day will be calling for better resourced

‘As Nye Bevan remarked ruefully, “expectations will always exceed capacity”’

preventive strategies.

Other themes continue to resonate. “Special premises known as health centres may be opened in your district. Doctors may be accommodated there instead of in their own surgeries, but you will still have your own doctor.” So said the leaflet on the NHS delivered to every home in July 1948.

“Newly procured health centres in easily accessible locations should be offering all members of the local population a range of convenient services.” So said Lord Darzi’s *Next Stage Review: interim report*.

The London Darzi review proposed that “the polyclinic will be where most routine healthcare needs are met”, including GP practices. In 1942 Sir John Maude envisaged “groups of six to 12 doctors working from health centres serving populations of between 10 and 20,000”. Not much new there then.

The NHS came within a whisker of being run by local authorities.

Bevan rejected the idea, partly to appease the medical profession, which feared local council control, and partly because of the unresolved consequences of allowing party political control over centrally raised resources.

Local accountability

There have since been numerous efforts to make services more accountable at local level, with varying success. With the prime minister promising to increase accountability of local services, more change looks certain.

Another abiding theme is value for money. It was inevitable that once the state took responsibility for funding, it would worry both about the insatiable capacity of the health industry to consume resources and whether those resources were being used wisely. The first financial crisis took place almost as soon as the service was launched. As Bevan remarked ruefully, “expectations will always exceed capacity”.

In this, government has been no different from any other payer. From 1952 to 2007, King’s Fund reports have said that more resources will be needed unless productivity is increased.

So why has the NHS not managed to resolve these long-standing tensions? In some instances they can be found in health systems across the world. Payers everywhere – whether individuals, insurance companies or governments – bemoan rising costs and the apparent failure of more efficient ways of delivering care. Nor is the strain between doctors and payers confined to our system.

Others are simply intractable problems. There probably is no “right” answer for the size of GP surgeries or health centres and the factors pushing change today are not necessarily the same as in the 1940s. Tension between local and

national accountability was born with the NHS and unless it moves entirely in one direction or another (which is unlikely), will remain.

Meanwhile the growth in wealth, rise of consumerism, decline in deference and digital technology will bring new challenges.

Wider access to information will also change the relationship between service and user – the idea of publishing data on individual professional performance would have been unthinkable in 1948.

The 1948 leaflet does mention one familiar theme of modern times – choice. It states that “everyone aged 16 and over can choose his or her own doctor” and (even more controversially) “if you want to change your doctor, you can do so at any time without difficulty”.

Aspirations and challenges – *plus ça change, plus c’est la même chose*. ● Niall Dickson is chief executive of the King’s Fund.

The National Health Service embodies the best of 20th-century medicine. Its public health and primary care systems are the envy of the world.

Now it has the opportunity to develop a health system that reflects our new health problems – preventable chronic disease, new technologies – through pervasive and ubiquitous technologies that allow people to manage their conditions in their homes, outside of traditional clinic settings. New expectations of healthcare include a desire for more independence, personalisation and control.

We can liken the NHS's transition into its new generation to the way the internet has been transformed from its first generation – “Web 1.0” – into its current state – “Web 2.0”.

The first stage of web architecture was built by a network of experts and the user interface reflected an expert-to-user relationship; content was loaded to the web by experts and the rest of us downloaded it. Web 1.0 was the first generation of knowledge transfer over the web.

Social network

In the past five years, though, a new model of information exchange has emerged. Web 2.0 is more densely social, decentralised, participatory, egalitarian and democratically controlled. This new model is built on peer-to-peer sharing, social networking and open platform innovation. It represents a new model of information exchange through group participation, sharing and community support.

Web 2.0 is anti-hierarchical. Fundamentally networked, it enables relationships between and among people. Knowledge is democratised, contributed and organised by users. Expertise is an emergent property of the community, residing in the networks themselves – conferred by the collective judgments of the many rather than the personal judgments of a few.

This is personalisation, independence and equality, conjoined with communication, participation and engagement. The social implications of these technologies are profound and paradoxically profoundly individualising and socialising at the same time.

In much the same way, the first generation of the health system – an “industrial” model typical of mid-

20th century medical practice that was expert-based, illness-focused and professionally controlled – was built around the expertise of the care-givers and not around the needs of individuals.

The operating principles for the next generation NHS have already been adopted. An NHS that is patient centred and patient led. That moves it from being a sickness service to a health service. That embraces the responsibility for health and wellbeing as well as for curing illness.

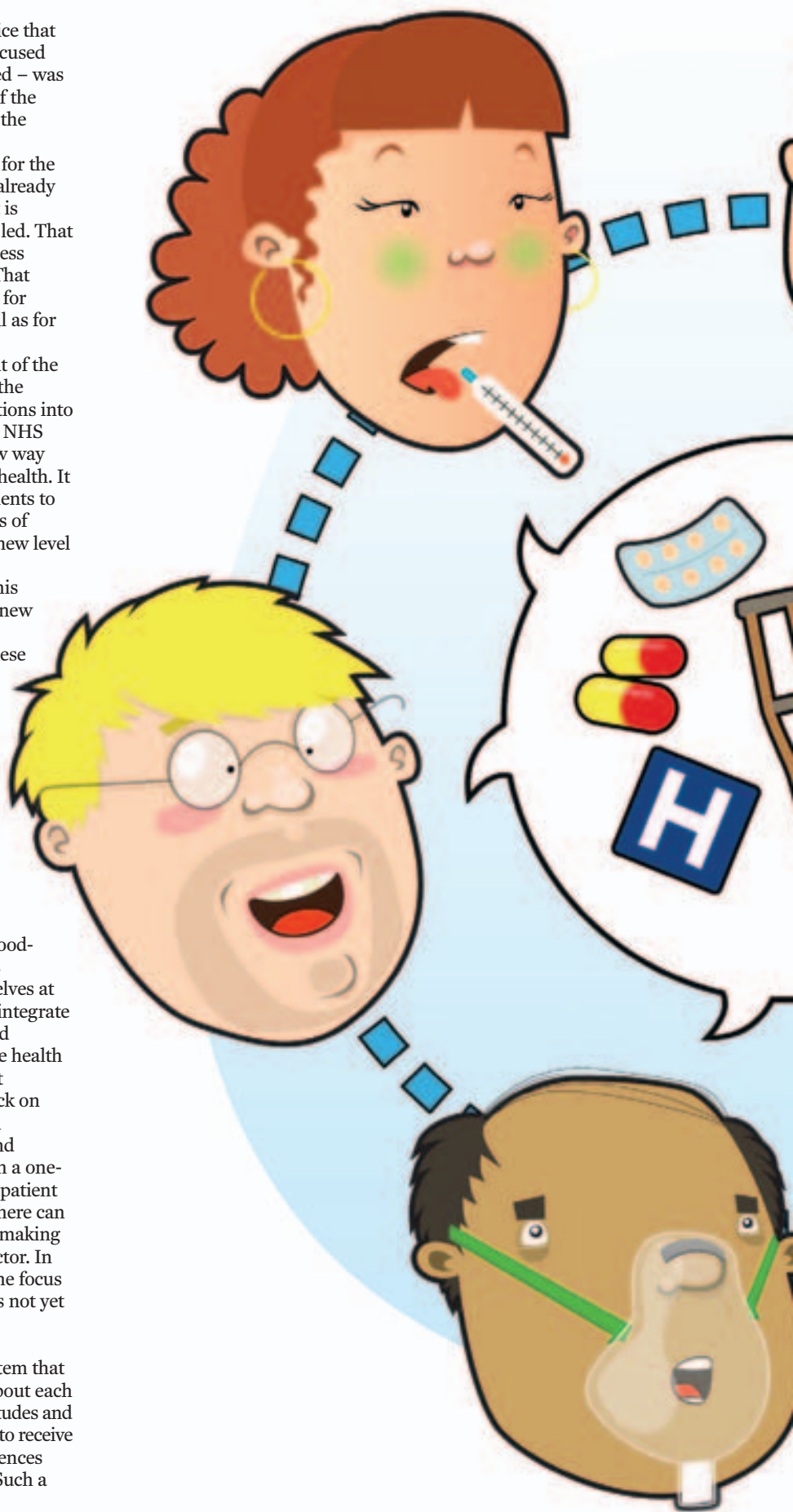
Now, at this turning point of the NHS's 60th anniversary, is the chance to turn those aspirations into reality. The next generation NHS requires us to think in a new way about personalising public health. It requires both NHS and patients to become more active creators of health and it will require a new level of mutual trust.

Technology will enable this change, but at its heart is a new form of social relations.

The first generation of these technologies has already decentralised care, given patients more control and permeated the boundaries between the health system and the community. These technologies support a more personal level of healthcare, more conveniently delivered and more integrated with everyday life.

For instance, personal blood-glucose monitoring enables diabetics to monitor themselves at home, allowing patients to integrate their care into their lives and reducing dependency on the health system. Most importantly, it provides immediate feedback on glycaemic control, based on personal eating, sleeping and activity patterns, rather than a one-time snapshot in a lab. The patient is more knowledgeable so there can be more informed decision making between them and their doctor. In this first phase of change, the focus of care shifts to home, but is not yet supported by systems or communities.

But imagine a health system that is continuously informed about each individual's health risks, attitudes and behaviours, how they prefer to receive information and what influences their healthcare decisions. Such a



THE EXPERT P



'This patient community allows people to track their treatments and experiences'

system could deliver context-sensitive messages to help the individual to adhere to their care plan, take their medicine or talk to their clinician. In this health system, the home glucometer transmits its results to a host computer to be analysed and monitored, so that changes in personal health risk can trigger messages, coaching or other clinical support. And the person is connected to a community of other patients with similar conditions who can

support each other to develop better disease management strategies. These patient communities are already evolving. PatientsLikeMe is an online community of people with amyotrophic lateral sclerosis (a form of motor neuron disease), multiple sclerosis, HIV and mood disorders who share information about their condition and treatment and use online tracking tools to monitor and share their experience in concrete, measurable terms. This community takes the expert patient concept – getting people new to chronic disease to tap into the experience of those who have learned to live with and manage the disease effectively – and scales it, with a difference. Instead of being modelled on a one-to-one interaction, PatientsLikeMe links to a whole community. Instead of relying on the individual experience of a single patient, it exposes people to a collective experience. And rather than rely on anecdote, it provides patients with tools to track their treatments and experiences, creating a real-time experimental environment that generates real-time data in a real-life context.

Communities like this will not only provide better support to patients but make patients better prepared for encounters with their doctors and generate better data for clinicians to learn about the impact of clinical treatment outside of the controlled environment of the clinical trials.

The next generation NHS is as social as it is personal, as technologically sophisticated in the background as it is simple to the user in the foreground. It will create an entirely different experience for the patient. And it will radically democratise healthcare. It democratises medical knowledge, putting it equally in the hands of

patients. It personalises needs assessment, with a rich understanding of personal health risk and personal health trajectory. It individualises health communication, with patient control over when, where and how. It creates an opportunity for every individual to express their health priorities and personal preferences. And it strives, above all, to engage people in their own health.

In NHS 2.0, we have a community to support us and a system that works for us not only when we ask it to but even when we don't. It harnesses the power of data and analytics to understand and anticipate our needs so that it can offer us services that are right for us and that meet us where we are.

NHS 2.0 will be the participatory platform for the co-creation of health, the embodiment of the "full-engagement" scenario envisaged by the Wanless review in 2002.

Bold vision

NHS 2.0 will be an entirely different kind of health service. It will take an ecological and not an industrial approach to health. It will be forward-acting rather than reactive. It will be data-driven rather than event-driven. It will be networked and matrixed rather than hierarchical. It will be distributed rather than centralised. It will be personal and customised rather than one-size-fits-all. We will be community supported rather than being isolated and alone. And our healthcare experience will be integrated rather than fragmented.

This will be the NHS for the next 60 years. Health 2.0 is not as far-fetched as it may sound. Much of the technology underpinning it is already under development. But it will take bold commitment to the vision and deliberate investment in people, technology, experimentation and innovation to create it.

This last point is a true challenge for the NHS. Bold innovation is a challenge for any government programme, because to innovate is to take risks, avoid being bounded by our current experience and reach beyond it to try something new. Yet this is what Sir William Beveridge challenged us to do in 1942. To be guided by our experience but not to be limited by it. Are we up to that challenge today? ●

Tom Granatir is policy and research director at Humana Europe.

PATIENT

Just as the internet has evolved into a web of ordinary people sharing information, we are entering a new age of user participation in health services, says Humana's Tom Granatir

Local government has done more for health than the NHS. In the 19th century, borough councils organised street cleansing, refuse collection, water supply and sewerage systems. Local government secured adequate housing and clean air to complete the key elements that made good health attainable by all.

Local authorities later took charge of physical illness, building infirmaries to cater for infirm paupers which often operated side by side with hospitals supported by charity. In 1885 the law that required people to become paupers before using the infirmaries was abolished. Once publicly provided infirmaries were open to all, something approaching a universal system took shape and local authorities ran over three out of

every four hospital beds until the creation of the NHS.

The medical profession, who saw subordination to local councillors as interfering with their clinical independence and lowering their status in society, strongly opposed a local government takeover of the new service. Having had to stuff the doctors' mouths with gold, health minister Aneurin Bevan was not going to let local democracy frustrate his plans. The local democratic element was removed from hospitals, a step that he later confessed to regretting. Bowing to the doctors, he installed a national system with a command structure going up, in theory, to the secretary of state.

Local authorities had lost the hospitals, but they retained their grip on community health services

and health education. Every county and county borough council had its medical officer of health, who presided over community health services such as child welfare and district nursing and took responsibility for slum clearance.

Needing advice on how to run the hospitals newly under its control, the government turned to their former manager, local government, for expertise. Alderman Albert Bradbeer prescribed the tripartite split of doctors, nurses and administrators, each occupying distinct territories.

Three-way division

Between 1948 and 1974 there was continued misgiving over the division of health services into hospital, GP and community services. NHS planning bore no

MEET THE LOCALS

Councils have done more to improve the nation's health than the NHS – but the relationship between the two is still evolving, says Rodney Brooke



relation to primary healthcare or patients' needs, while chronic disease management required long-term care outside hospital and patients required the social care package provided by local government.

Both the Conservative and Labour parties wanted unification of the NHS and local government services. Former health secretary Sir Keith Joseph became a convert to the cause of local government, after reporting that when he went to a hospital, he would be shown the dingiest and most dilapidated building to demonstrate the hospital's need for more government funds. But in a local authority, which then did not depend on the government for its income, the mayor would proudly conduct him round the smartest and newest residential home.

Ironically, the catalyst for change in the health service came from local government through the 1969 Redcliffe Maud Royal Commission, which recommended that the NHS be brought within a new system of local government.

But the recommendation had the opposite effect. It faced the difficult (though not insoluble) problem of creating an independent source of revenue sufficient to enable local authorities to run the NHS. It also faced the opposition of doctors, who feared that education and other services might receive higher

priority. *The Lancet* said: "administering the health service is too serious a matter to be shared with the citizenry". Richard Crossman, then secretary of state responsible for local government, argued for area health authorities with substantial local authority membership, though he thought the government was being forced into "a miserable middle way".

His Conservative successors did not share his misgivings. The 1974 reorganisation of local government removed the medical officer of health from local authorities and local authority health departments, hospital management committees and teaching hospital boards of governors were replaced by area health authorities. A quarter of their members were nominated by the local authority. Ministers were still not prepared to challenge doctors on behalf of local democracy.

While successive reorganisations of the NHS preserved for a time the minority of local authority members on the health authority, the hybrid system did not work well. Clinician members of the health authorities found the intrusion of politics irrelevant and councillors found themselves impotent to affect much health policy.

Eventually, councillors were removed from health authorities and a succession of bodies were created to represent the community or patient interest to the NHS.

Local authority social services were reorganised, with generic social services departments implemented from 1970; a move unscrambled only in the past three years.

Over the next 20 years, public spending on social

'The shared boundaries of the NHS with local government have greatly aided joint working'

care soared, prompting the 1988 Griffiths Report. It placed responsibility for community care firmly with local government, with budgets redirected to local authority social services departments. Then prime minister Margaret Thatcher thought hard about giving the responsibility to the NHS. The idea floundered over finance. The NHS is free at the point of delivery. Social services are charged for and means-tested. Merger with the NHS would make the difficulty – still a bone of contention – even more obvious. Reluctantly she implemented the Griffiths proposals.

The new shared geographical boundaries of the NHS with local government have greatly aided joint working. Relations have matured and valiant attempts are made to work together. The purchaser/provider split and the creation of primary care trusts co-terminous with local authority boundaries encourage this.

Common goals

Despite public attention to the acute sector, co-operation between PCTs and local authorities increases year on year. A succession of appalling child abuse cases has prompted sharing of information between doctors and social workers. Local authority directors of adult services are routinely co-opted onto PCTs. There have been constitutional changes and pooling of budgets is more common, especially in mental health and learning disabilities. The occasional joint chief executive has been

appointed. Joint children's trusts have been created. Local authorities must establish health scrutiny commissions, through which they can hold to account the local health providers and commissioners. Health and social care inspection are to be merged in the new Care Quality Commission, facilitating a joint examination of both health and social care services.

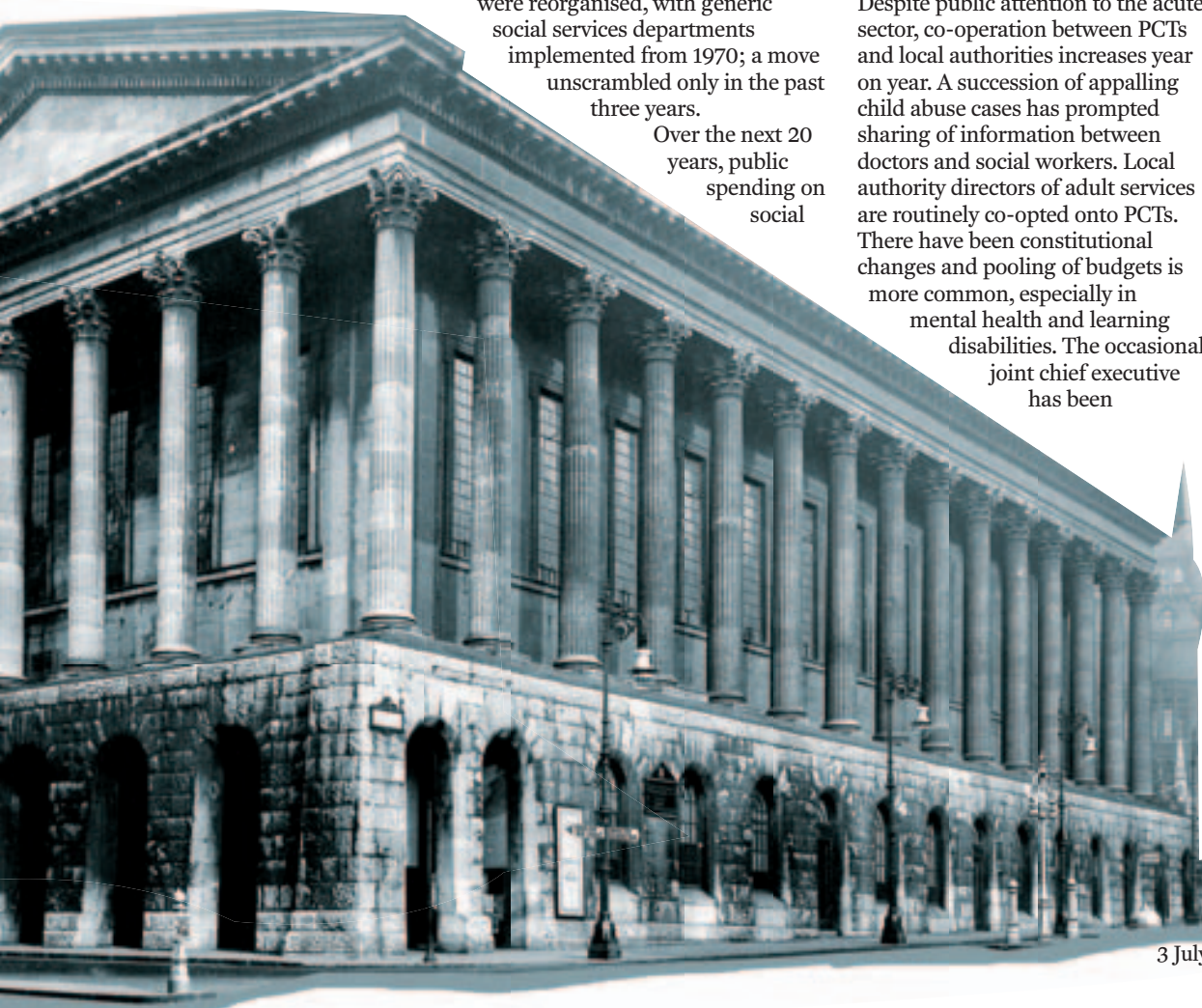
As the 2006 White Paper *Our Health Our Care Our Say* makes plain, the government is committed to encouraging more joint working. An integrated health and social care information system for shared care is planned, through which there can be a joint health and social care plan for those with complex health and social care needs. The White Paper even contemplates GPs prescribing a social care package for patients. One significant advance is the concept of individual social care budgets, enthusiastically advocated by the government. There is talk of individual health budgets. An example: one patient, dependent on oxygen cylinders from the NHS, has had air conditioning installed in one room in her house, saving the NHS its spending on oxygen cylinders as well as greatly improving her quality of life. But the air-conditioning was paid for by the local authority, not the NHS.

Major tensions remain, usually about money. PCTs still fear "bedblocking" by local authorities, and councils believe PCTs shunt costs onto them. The division between free healthcare and charged-for social care is unclear.

Local government continues to hanker after direct involvement in the NHS. Indeed, the gradual transformation of PCTs from providers to commissioners removes one ideological barrier to the idea. It would solve some of the issues over the relationship of the NHS with the wider community and social care. Comprehensive area assessments may increase demand for local democratic accountability.

One thing is certain. The public will expect better and more joined-up services and demarcation disputes between health and social care will not be acceptable. The public finds politics a turn-off. But if their local health services were decided locally and were paid for in a more explicit local way, might that not excite their interest? Might they rebel if decisions continue to be taken without their democratic involvement? ●

Sir Rodney Brooke is chair of the General Social Care Council. He was formerly the chief executive of West Yorkshire County and Westminster City Councils and secretary of the Association of Metropolitan Authorities.



NICK BOSANQUET

Professor of health economics at Imperial College and consultant director of Reform.

On its 60th anniversary, the NHS is poorly positioned to face the approaching "perfect storm"—an ageing population, costly new technology and a more informed society will increase demands and expectations. Medium-term investment is required in many areas but funding will be restricted. So this year has to be seen as a turning point, with two possible futures: a positive one of NHS opportunity or a negative one managing NHS decline.

In the positive scenario, greater efficiency and productivity would release resources for new investment and local innovation. Excellent service and immediate access would be achieved for 9 to 10 per cent of gross domestic product.

The negative scenario would see cost increases eat away at the margin for investment. The service would suffer from the illusion that progress is measured in extra resources. Substandard quality and access would be achieved for 11 to 12 per cent of GDP. The performance gap would widen.

The Department of Health's rhetoric is consistent with the positive view, with 2008 seeing the completion of current reform programmes, bar payment by results. But our research at Imperial College shows this is a national mantra rather than a local reality.

In conception the reforms are good, shifting the balance of power towards consumers and allowing competition and choice to drive innovation while reorienting services towards integrated care and prevention. But in practice programmes are far from reaching full implementation.

Demand side programmes have failed to drive significant change in the interests of patients. Management ability, flexibility and, increasingly, financial surpluses lie on the side of providers. Most primary care trusts have not embraced competition or sought to reorient services.

While practice-based commissioning is widespread, practices still lack timely and credible budgets. The widening of payment by results and its unbundling have been delayed and less than half of patients are being offered choice. The independent sector remains far short of the provision identified by the DH in 2005.

The return to surplus does not signify a new settlement in which investment can take place but is due to a temporary combination of the last major funding rises and a pause in centrally prescribed cost rises, already building up again.

Optimistic outlook

Decline is not inevitable, however. Accelerating real change would unlock the benefits of reform. Key is an economic constitution to define duties to create value at all levels, realign priorities and give more power to consumers. Key elements would include stronger independent commissioning, provider pluralism, flexible labour markets, a clear success and failure regime modelled on the private sector, quality-determined prices and cost, and separation of central regulatory and political/strategic responsibilities.

A constitution could create incentives for better financial management and give staff the capability to achieve value for money and meet the focus on public health and inequalities. A preventive as opposed to a reactive service would be created.

If this was the key outcome of the DH's current landmark review, we could look with optimism towards the 70th anniversary of the NHS.

WHAT'S THE VERDICT?



We invite three health pundits to pull no punches and deliver their judgments on the past and future of the NHS



JOHN LISTER

Director of London Health Emergency and a senior lecturer at Coventry University

In 1948 the NHS replaced chaos and competition with planning and collaboration. But 60 years later New Labour's relentless programme of so-called modernisation and reform is rolling back the wheel of history, fragmenting the NHS structure, bloating its bureaucracy, inflating overhead costs and creating a new market system.

Nye Bevan's 1948 NHS was inevitably far from perfect, but it replaced Britain's failed healthcare market with a system that later offered the possibility of planning services and allocating resources according to population and local need. Access to care free at the point of need liberated doctors to focus on patients' needs.

This model is still popular with all but the present government. Only this government aspires to go back to a system of rival hospitals competing for straightforward elective patients while seeking to avoid complex, chronic and costly cases.

No mass demonstration or patient group ever demanded ministers use private sector cash to build new hospitals, or privatise primary care services, or bring in executives from the inefficient and socially exclusive US healthcare insurance system to advise on commissioning.

Ministers have also lumbered an unwilling public with foundation trusts, now piling up surpluses and answerable only to a regulator which has no brief to ensure universal and

'Amid their hollow rhetoric of a patient-led NHS, perhaps ministers should use this anniversary year to pause and listen'

equitable access to healthcare. They are fragmenting services, forcing PCTs to divest services and set up "arm's-length trading organisations" and "social enterprises". Like foundations, these hark back to what New Labour alone sees as the good old days before the NHS.

Not only are such policies devoid of popular support, they are totally lacking in evidence that they improve efficiency, equity or access to healthcare, instead serving to inflate costs and the private sector at the expense of the public sector.

The private finance initiative is emerging as a monumental financial blunder. Independent sector treatment centres deliver high-cost, questionable care while undermining medical training and research. Every reorganisation adds new costs and tiers of management.

When London Health Emergency was set up 25 years ago, nobody dreamed that the Conservatives' privatisation of support services would be eclipsed by the far more comprehensive reforms of a so-called Labour government.

So amid their hollow rhetoric of a "patient-led" NHS, perhaps ministers should use this anniversary year to pause a while and listen.

Let's invest in public services targeting health needs and not profits. Let's have patient-centred care instead of surplus-centred care. Let's see evidence-based policy. It is not too late to rescue the spirit and principles of Bevan's historic and radical modernisation and keep our NHS public.

TOM CLOUGHERTY

Policy director of the Adam Smith Institute

As the NHS reaches its 60th birthday, it is clearer than ever that it has never delivered on its promise to provide everyone with the best healthcare available, free at the point of use.

Britain has some of the worst survival rates in Europe for cancer, strokes and heart disease, new and potentially life-saving drugs are routinely denied to patients and healthcare-associated infection rates remain high and rising.

On equity, the picture is disheartening. Professional and managerial classes receive more than 40 per cent more NHS spending per illness than the semi-skilled and unskilled. Inequalities in life expectancy are widening.

This all comes at great cost. Aneurin Bevan estimated that the service would cost £132m per year. In fact it cost £305m in its first year and things have not got much better since. In 2007-08 public spending on the NHS reached £92.6bn, yet some NHS organisations remain in deficit.

Low-quality care and poor financial management spring from the same underlying faults: lack of responsiveness to patients and inadequate market discipline. Successive governments have realised this and – in fits and starts – have attempted reforms.

But while delivering benefits, these have been accompanied by centralisation and endless Whitehall-imposed targets. Relentless political interference has discouraged innovation, distorted clinical priorities, encouraged creative accounting and created layers of bureaucracy. More to the point, it has undermined attempts to make the NHS more accountable to patients.

The policy steps needed are clear: internal market reforms must be followed through. A full payment by results tariff should be established so new providers can compete for patients on the same terms as state ones. The government's role should shift decisively away from providing and towards funding medical services.

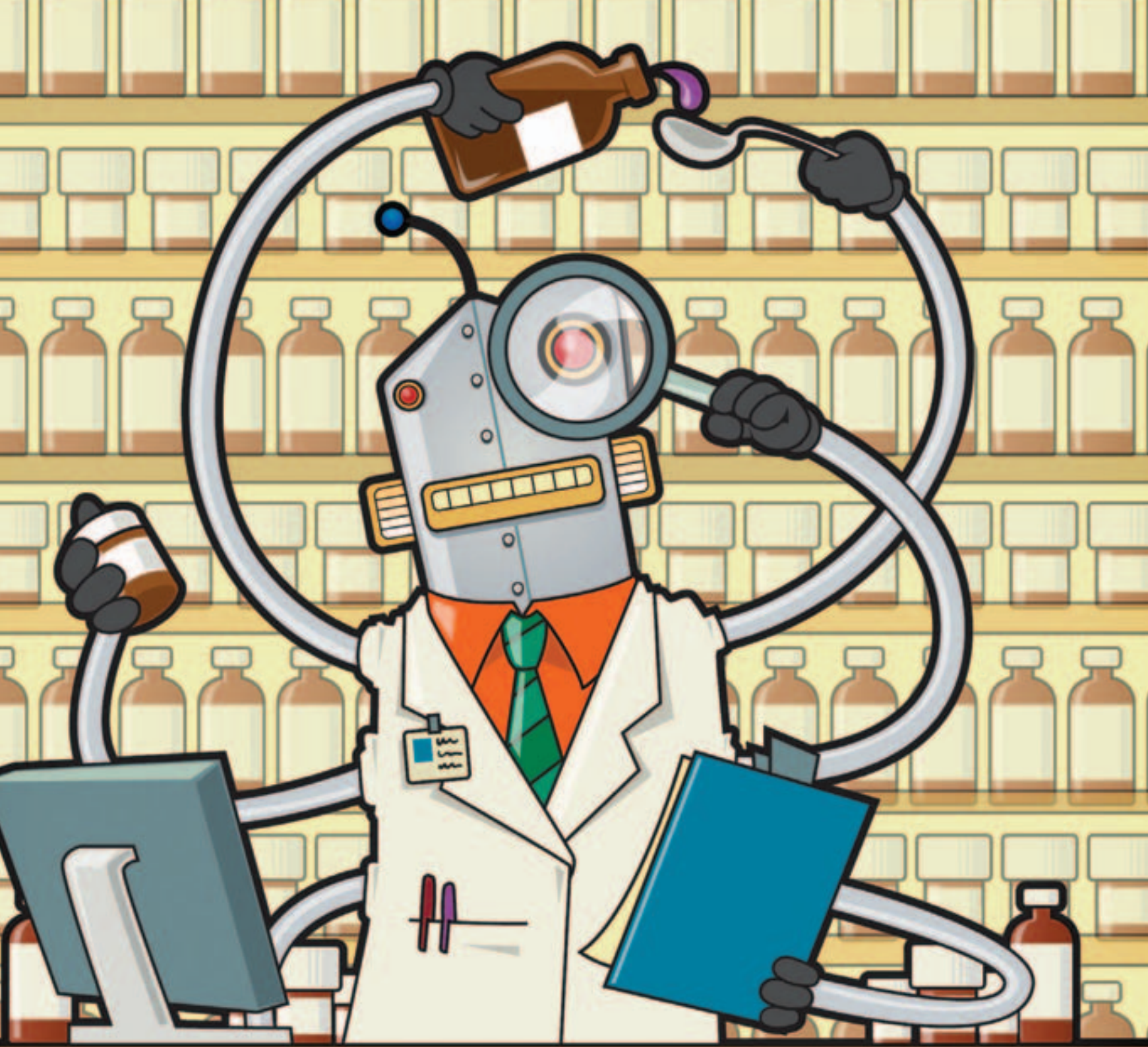
Further steps to empower patients are needed. Publishing patient-based outcome data would create a strong incentive to drive up quality. Allowing doctors to advertise for patients would help exercise choice and encourage new providers. Such moves are taken for granted in other markets, and health should be no exception.

They would give providers autonomy in return for accountability, putting patients first and encouraging value for money. But to really improve the quality and cost of healthcare, Britain should move beyond funding services purely out of general taxation. Introducing medical savings accounts to allow direct payments for smaller healthcare expenses remains by far the best alternative.

Such a scheme would eliminate the excessive costs of processing small service items, giving patients an incentive to demand only services they truly believe are necessary and value for money. Major medical expenses would continue to be financed by the taxpayer.

This could be introduced by diverting some National Insurance contributions into personal medical accounts. Accounts for the poor or unemployed could be topped up as a welfare benefit.

The above moves could create a top-quality health service for the 21st century, without compromising its founding principles of universality and equity. ●



**ADVICE
IS FREE**
JUST ASK

**FRONTLINE
PHARMACY**

In the 19th century people who could not afford a doctor went to their local pharmacist, who made and sold medicines and dispensed advice. In 1841 the Pharmaceutical Society of Great Britain was formed, marking the growing professionalisation in the field. Pharmacies kept up a significant frontline role well into the 20th century. This evolved dramatically with the advent of the NHS, becoming dominated by the need to dispense prescriptions.

More recently, efforts to restore the balance between dispensing prescriptions versus providing healthcare advice and addressing public health issues has proved difficult. Often the “non-prescription” role has lacked meaningful incentives.

The sheer growth of the dispensing task should not be forgotten. In 1937, 65 million prescriptions were dispensed from 13,000 pharmacies. In 2006 the figure was around 750 million prescription items in England, reflecting the spiralling pressures and expectations the NHS faces.

With an ageing population and ever increasing numbers of drugs available to treat long-term conditions, dispensing will continue to be a key requirement. But the way dispensing is done will be radically different in 60 years’ time. Highly efficient, automated and home- or care-facility-oriented, dispensing will be both more convenient for the patient and more cost-effective for the NHS.

Full circle

One view of the future sees the pharmacists’ role coming almost full circle with much more time spent giving advice on health.

Success depends on consumer trust and getting away from the view that pharmacists are just there to dispense prescriptions, argues Andy Murdock, pharmacy director of community pharmacy Lloydspharmacy.

“Frankly, it is a view that is out of date. Community pharmacy chains have made significant investment in recent years to ensure that their pharmacists have the competencies needed to be healthcare advisers, not just dispensers,” he says.

“The challenge now is to raise awareness of pharmacists’ specialist training and ability to treat minor ailments, as well as help with the management of long-term conditions and conduct clinical services. This is the value we think we can add for primary care trusts.”

Mr Murdock goes on: “In the recent white paper *Pharmacy in England: building on strengths – delivering the future*, the government

The community pharmacist’s invaluable role in dispensing prescriptions and advice is sure to expand into delivering some primary healthcare services, says Lloydspharmacy

expressed its continued commitment to pharmacy as an integral part of the NHS’s primary care delivery network.

“Tackling public health issues begins with individuals in the community, something that pharmacy is uniquely well placed to enable. Lloydspharmacy has around 1,700 pharmacies. The majority have private consultation rooms in which highly trained staff can conduct clinical services, provide advice and guidance on healthy living and be a place for those with long-term conditions to stay connected to the community.”

One of the most significant differences between the health consumer (or patient) of the 1840s and today is education. With more access to health information, people are now bombarded about what is “healthy” and “unhealthy”.

But in areas of health inequality where there is a requirement for basic health education this will be better heeded if given by a trusted and easily accessible source.

“Pharmacies give advice verbally, in print and online – and in Lloydspharmacy’s case we also have in-store radio – in an effort to reach out to the people we help through our stores,” says Mr Murdock.

“But the profession also realises consistency of public health advice and education is critical. To achieve a discernible result, for example on heart health, we need all interested stakeholders to agree it is a priority and communicate to the most at-risk people in ways that will appeal to them.

“An example is the Birmingham exercise in which the city’s Health and Wellbeing Partnership engaged Lloydspharmacy to provide 10,000 ‘at risk’ over-40 men with access to evening and weekend screening services. This was done at the city’s two biggest football clubs and the Millennium Point visitor centre as well as health and community centres.”

The potential for information prescriptions to become an accepted part of healthcare provision is another area in which the professional pharmacist may well help to bring together NHS and social information.

“Many people have very little contact with healthcare professionals; it is generally the ‘worried well’ who proactively seek advice, while those requiring care

often avoid any form of consultation,” continues Mr Murdock. “Beyond health education, redressing the blight of health inequality requires pharmacies to be given greater powers to deliver a wider range of services to people with long-term conditions. That’s one of the reasons I would like to see healthcare provision remaining as a mixed economy, providing a variety of points of contact for patients.”

More than one way

“There is never just one answer. The danger in this case will be if everything gets consolidated into polyclinics and ends up destroying the infrastructure and network that is already there,” he continues.

In just the next two years it is anticipated pharmacy visits will increase in the UK by 41 per cent to over 420 million a year. This increase is expected to be driven in part by a 5.4 million increase in medicine use reviews, over 100 million more prescription visits and an increase in visits for minor ailments services from 500,000 to around 800,000 a year.

“This is not about challenging GPs as the patient owner but it is about providing well qualified support to enable GPs to focus on more serious health issues. By treating minor ailments in-pharmacy we can save every GP the equivalent of one hour per day. Equally pharmacists could manage an estimated 8 per cent of people attending accident and emergency departments,” says Mr Murdock.

The white paper’s emphasis on pharmacy provision of clinical services maps out a clear future for primary care, particularly in the context of national screening programmes. Advantages to the consumer of convenience in terms of time (no appointment necessary) and location (close to where people live and/or work), combined with competitive costs make this a viable long-term proposition.

Mr Murdock cites his own company’s record in the provision of screening services free to the consumer at the point of delivery.

“Since 2003 we have carried out more than one million diabetes tests, identifying 50,000 people who had a high, very high or extremely high probability of developing the condition. These are all people who in all likelihood would not have

recognised any symptoms or risks. We have also carried out 500,000 separate free blood pressure tests and over 400,000 medicine use reviews.”

Mr Murdock wants to see the government setting primary care tariffs for screening services and providing guidance to PCTs on how best to commission these services to meet local needs.

“PCTs would identify health priorities, agree their expected outcomes, accredit a range of appropriate service providers and establish contracts for providing screening services that would be effective as well as value for money,” he says. “Community pharmacies would then be in a position to compete to deliver services both for testing and for the provision of behavioural advice tailored to each patient’s needs.”

The government’s oft-stated aim is for the NHS to be patient-centred, a policy that plays to the strengths of the community pharmacy and is likely to see pharmacies extending their support to the NHS in under-doctored areas and those where health inequalities are still rife.

Accessibility is the key to the delivery of effective healthcare in

‘This is not about challenging GPs as the patient owner but about providing qualified support’

both these cases, taking healthcare out of its conventional confines and into the community with innovative programmes such as the recent provision of heart “MoTs” to men waiting while their cars were serviced at Kwik-Fit garages.

Another solid bet is that funding will continue to be a controlling factor in both the quantity and quality of healthcare services.

“The challenge is to develop services and sustainable business that will be value for money and sufficiently flexible to meet local health needs by utilising the competencies and potential of pharmacy in an innovative way to increase capacity,” says Mr Murdock.

“The framework for innovation must be funded in a way that will encourage competition and investment in a comprehensive quality service delivering fair return. The funding mechanism must be fair, effective, sustainable and accessible to all accredited health and social care providers to deliver primary care services.” ●

ALWAYS ON OUR

The regimented tyranny of the old asylums that came into the NHS in 1948 is consigned to history, but the rhetoric of community care has struggled to win adequate resources and understanding, says Simon Lawton-Smith

In an article for the *British Journal of Psychiatry* on the 50th anniversary of the NHS, the then president of the Royal College of Psychiatrists Robert Kendell suggested that it was “easy to forget, in the face of our present difficulties and discontents, that psychiatric services have improved out of all recognition in the past 50 years”. On its 60th anniversary, this sentiment still rings true.

In 1948, mental healthcare for those with serious disorders was largely provided in more than 100 asylums dotted around the countryside or suburbs. These had 145,000 residents. Out of sight was out of mind. There was minimal independent supervision of standards of care, while treatments were limited and – to our modern sensibilities – pretty barbaric. Outpatient clinics or other forms of community support were few and far between. Those with less serious problems generally made do as best they could in family settings.

Yet mental health services nearly did not make it into the NHS. The chief medical officer's report of 1946 which looked forward to its creation made no mention of mental health, and some politicians argued that it should be the preserve of local authorities rather than the NHS. The eventual decision to include mental health services was hugely important in bringing psychiatry into the broader family of medical disciplines, legitimising its professional aspirations and establishing mental hospitals and staff within the same operational framework as other health services.

The most evident change in the provision of specialist mental health services over the past 60 years has been the move from first-line treatment in hospital to first-line treatment in the community. The mental hospital population has fallen from 145,779 in 1948 in England and

Wales to 32,000 in 2006-07 in England alone. The number of patients resident as certified or formally detained under the Mental Health Act has plummeted from 123,464 in 1948 to 15,300 and the proportion of people per 1,000 population certified or detained has dropped from 2.89 to 0.3.

A range of factors has been cited for this change. New medication that better controlled symptoms of mental illness allowed many patients to be discharged. The increasing cost of inpatient care turned politicians' thoughts towards cheaper community care. The Percy Commission of 1957 highlighted concerns about hospital conditions and occasional hospital scandals hit the headlines through the 1960s, 1970s and 1980s. Social policy developed a more libertarian view of mental illness and new welfare benefits enabled people to survive in the community, even if they were not capable of work.

However, there were no overnight changes. For many years after 1948, life in mental hospitals continued much as before, with bed numbers peaking at over 150,000 in the mid-1950s. Asylums only started to close in any numbers in the late 1970s and early 1980s, although many had by then transferred some patients to general hospital psychiatric wards or to the community.

Community care

Alternative community services were prompted by new legislation setting out local authority responsibilities of care. The Mental Health Act 1959 gave impetus to local authorities to develop a range of community support such as group homes and day centres for those who did not need hospital care. In 1961, at a conference of the National Organisation for Mental Health (later

Mind), the then health minister Enoch Powell spoke passionately against the grim isolated asylums “brooded over by the gigantic water-tower and chimney combined”. This speech cemented the shift in focus from asylum to general hospital and community care and the 1975 white paper *Better Services for the Mentally Ill* led to more day hospitals, day centres, residential homes, hostels and community nursing provision.

Sadly, the rhetoric of community care was not backed up by adequate NHS or local authority resources. Progress was slow and public perceptions of its failings were formed by occasional high-profile incidents involving care in the community patients, which continue to this day. But community services were boosted by the NHS and Community Care Act 1990, which provided a backdrop for multidisciplinary community mental health teams and the care programme approach, which gave some patients an assessment, a care plan and a key worker. Despite this, implementation was inconsistent.

‘There have been radical improvements since 1948. But the job is by no means done and we are faced with new challenges’

An attempt to address these inconsistencies was behind New Labour's generally admirable programme for modernising mental health services. This involved a national service framework for mental health and specific service provision targets overseen by a National Institute for Mental Health, all driven from the centre by a national director. Importantly, all this was backed by significant new money.

There have been radical improvements since 1948. The regimented tyranny of the old asylums is a thing of the past. There is a national framework for services, some good empirical evidence for what works best and comprehensive guidance for professionals on best practice. The workforce has expanded and achieved greater

STAFF, PRACTICE AND PATIENTS: CHANGES FOR ALL SINCE 1948

Workforce

Since 1948, the mental health workforce has seen enormous growth in numbers and professional acceptance.

Psychiatry was then a relatively new medical discipline and the establishment of the Royal College of Psychiatrists in 1971 proved a landmark. Staff working in mental

hospitals in 1948 would be amazed by the range and nomenclature of mental health professionals today: psychiatrists, psychologists, psychiatric nurses, primary care mental health workers, support, time and recovery workers, specialist advocates, prison inreach staff, approved social workers, child and adolescent services staff,

community development workers... the list goes on.

Treatment

The 1950 Ministry of Health report set out the various treatments available in hospital. It highlighted therapeutic convulsion treatment (“a potent weapon for cutting short depressive illness”), insulin shock treatment

(“particularly valuable” in the treatment of schizophrenia) and prefrontal leucotomy (believed to have a “usefulness” in “properly selected cases”).

It would be good to think that a considerably more humane and evidence-based approach to treatment exists today – which of course it does,

with much covered by guidance from the National Institute for Health and Clinical Excellence.

However, the continued focus on medication, the efficacy of which has been publicly questioned and which can have severe side effects, the sheer quantity of prescribed drugs (over 90,000 prescription items for antidepressants issued a

Simon Lawton-Smith is head of policy at the Mental Health Foundation.



But the battle for genuine participation is a long way from being won, with real choice, involvement and influence still only a distant dream for many service users.

CORBIS SCIENCE PHOTO

A ramshackle collection of impoverished hospitals dotted the NHS landscape in 1948. Anthony Harrison charts the transformation that has created the modern secondary care scene

THE REINVENTION

The hospital sector today bears little resemblance to that of 1948. Back then the NHS took over around 3,000

hospitals previously run by local authorities or charities. Now a few hundred much larger institutions are carrying out much more work, with far more staff, and treating a much wider range of conditions than was possible in 1948. How has this transformation come about?

The hospitals the NHS inherited were in poor shape. According to NHS historian Charles Webster, it was “a system verging on a state of dereliction”, with decaying buildings, out-of-date services and “untenable” staffing arrangements. Turning this “ramshackle and largely bankrupt edifice” into a modern system was inconceivable “without revolutionary reorganisation and a secular increase in capital and revenue expenditure”.

Surveys both before and after the Second World War had identified large variations in different parts of the country in both the quality and quantity of hospital provision.

A third of consultant staff were located in London while some parts of the country had virtually none. Facilities were duplicated as a result of parallel developments by local authorities and voluntary bodies.

A maintenance backlog remains even now and some hospitals built before 1948 remain in use. But the gross disparities between different parts of the country have been reduced and most of the physical fabric of the hospital sector has been transformed through a massive building programme set in motion by the New Labour government in 1997.

It took a long time, however, before the task of updating the hospital sector was addressed.

While the need for both an upgrading of the hospital system and a rebalancing of its resources in favour of areas of under-provision were evident, economic difficulties in the post-war period ruled out any immediate rationalisation and modernisation. It was not until the

1960s that a serious attempt was made to reshape those assets into a national system of hospital provision.

The 1962 *Hospital Plan for England and Wales* represented the first national attempt to provide an acceptable standard of hospital services across the whole country.

The plan proposed that the future pattern of hospital services should be based on the “concept of the district general hospital”. This would bring together a dispersed pattern of provision into a single institution offering nearly all the services required to serve a population of 100,000-150,000 people.

It acknowledged some hospitals would provide some specialised services for a larger catchment area and also that small hospitals would remain to provide maternity and long-stay geriatric services, particularly in more remote areas.

Second thoughts

But almost as soon as the plan was published, second thoughts began to emerge.

For the next 40 years, a series of documents – official, professional and academic – argued for bigger and for smaller hospitals, for general and for specialised hospitals and for various combinations of these. Only a small amount of solid evidence was available to enlighten the continuing debate.

In the meantime, while the debate continued, the role of the hospital changed radically. Two conflicting trends soon became apparent: further concentration of services beyond that envisaged in the 1962 plan on the one hand and dispersal away from the hospital sector on the other.

From the time of its inception onwards, the NHS reduced the number of hospitals under its control. Many facilities such as isolation hospitals had outlived their purpose while others were physically worn out.

The 1962 plan lent impetus to the process. Its emphasis on “general” meant that both very small and specialised facilities were to be



OF THE HOSPITAL



closed and their activities transferred onto a single site.

But other forces came into play that made for further concentration. With rapid and sustained growth in medical knowledge, the number of specialties rapidly increased.

In 1962 the district general hospital was expected to serve nearly all its population's need for hospital care with a handful of general physicians and general surgeons. No hospital could claim to do that now without a much wider range of specialties available, each with its own team of consultants and supporting staff. The more the hospital could do, the larger, in terms of staffing, it had to be. In more recent years, professional

'From the time of its inception onwards, the NHS reduced the number of hospitals under its control'

opinion, sometimes supported by evidence linking care outcomes to the scale of provision, has favoured larger hospitals, where expensive equipment can be better used and larger numbers of medical staff can offer a higher standard of care.

Emergency care

This trend is perhaps best illustrated through the development of emergency medicine. Until very recently, the emergency function was regarded almost as a sideshow to the main business of the hospital. This meant patients admitted as medical emergencies found themselves under the care of whichever specialist team was "on take" at the time, whatever the nature of their condition. They might be seen in accident and emergency by an unsupervised doctor in training.

In recent years, however, this area has become a driving force for change as concern about the quality of the service on offer has risen. Although accident and emergency

was only established as a specialty in its own right in the 1970s, by the mid-1990s some accident and emergency consultants were seeking to ensure there was an emergency consultant presence in the hospital at all times. But this was only feasible in units serving a much larger catchment area than a small district general hospital, while proposals to close A&E departments in the name of safety and quality of care have become common in recent years.

Similar trends have been apparent in maternity, stroke and cancer care, led for the most part by clinical concerns about quality, particularly safety.

While hospitals were expanding their role into new areas as more treatments became available, they were losing their role in old ones. Long-stay care for the elderly and people with learning difficulties and most mental health services moved into other settings or out of the NHS entirely.

As a consequence, the dominant role of the hospital is now in acute care. Lengths of stay are typically short. Many procedures do not require any inpatient stay at all. Every broad indicator linked to hospital activity – be it the number of clinics, number of admissions, number of diagnostic tests – over the past 60 years shows they have moved upwards, except for the number of inpatient days, which is now in decline.

And activity has moved from hospital to community. When the hospital plan was published, the vision it embodied was that the hospital would do what only it could do. It noted that "any plan for the development of hospital services is complementary to the expected development of the services for prevention and for care in the community".

That vision has been only partially realised. The health centres or polyclinics the hospital plan expected would be developed in the community did not materialise. Hospitals continue to treat emergency cases that could be dealt with effectively in other settings ➔ **38**

37 ← and to carry out tests and procedures that do not require access to their expensive and specialised facilities.

Nevertheless their role has been effectively diminished as a result of new medical technology, particularly drugs. This has enabled GPs and other professionals to care for patients, especially those with long-term conditions such as diabetes without recourse, except in emergencies, to hospital facilities. This development has been strengthened in recent years by changes to the GP contract and other measures which reward the provision of structured care to people with long-term conditions.

Closer to home

In addition, governments from the early 1990s onwards have actively promoted the notion of “closer to home” through schemes such as hospital at home.

This policy gained a new impetus with the 2005 publication of the white paper *Our Health, Our Care, Our Say*, the government’s response to the finding of patient surveys which supported the notion of care closer to home. This set in train a number of initiatives designed to reduce the hospital’s role; the latest manifestation of which can be found in Lord Darzi’s proposals for a network of polyclinics for London.

But the debate about the appropriate structure of the hospital system and its relationship with the community services continues.

From 1997 onwards, government has supported, largely through the private finance initiative, a massive hospital building programme – by far the largest in the NHS’s history. And the 2000 NHS Plan provided for a rapid growth in consultant numbers.

But these commitments were made with only limited consideration of what the future role of the hospital and structure of the hospital system should be. The NHS Plan paid little attention to either. So while government encouraged hospital trusts to enter into contracts with the private sector for up to 60 years, it has also embarked on a series of initiatives designed to reduce demand for their services. Lord Darzi’s proposals suggest it is set to pursue that aim even more vigorously.

At the same time, pressure for the creation of larger units continues to be driven by the same combination of factors that has operated for the past 20 years but with the addition of new ones. In restricting the hours of junior doctors, the European working time directive has made it harder for small units to maintain 24-hour cover. And the introduction



‘The only safe prediction is that healthcare will keep being transformed by new technology’

of new private sector providers has taken away some of the acute hospital’s bread and butter business.

As a result, the smaller acute hospital – often a district general hospital built in line with the precepts of the 1962 plan – is beset by a range of forces tending to reduce or undermine its role.

On the one hand it is under threat from pressure to transfer some services to large institutions and others to private sector or community providers.

In many parts of the country, proposals are on the table – typically made in the face of fierce local resistance – for either closure of facilities or more commonly for a reduction of roles from general hospital to community facility with a narrower range of services.

But although so much has changed during the past 60 years, the essential issues remain the same: how to get the right balance, for the full range of hospital services, between quality, access and cost. The same lack of evidence about the benefits of different configurations also persists.

The authors of the 1962 plan could not have anticipated as they wrote it how soon the main

assumptions on which it was based would be undermined by developments in medical technology that transformed the hospital sector. Any prediction now is subject to the same risks.

The only safe prediction is that the healthcare sector will continue to be transformed by new technology. There will be wider use of technologies such as telecare, implants, robotics and gene therapies; new technologies such as nanotechnology will lead to innovative forms of diagnostics and entirely new therapies.

Online advice

We might imagine a new form of medicine in which specialties are replaced by a new integrative discipline based on a more fundamental understanding of the genome and the functioning of the body’s many sub-systems.

The information resulting from much more effective diagnostic procedures would allow patients, advised by professionals, to take charge of their own treatment much more effectively than they can now. They would be able to put themselves online for monitoring, advice, or even resetting of their inbuilt control panels.

The hospital would remain – as it always has been – a place of last resort, but for ever fewer numbers of people.

In the shorter term, news of the hospital’s imminent death may be exaggerated. The future that current trends suggest is one where more resources are devoted to

prevention or anticipation of need and care is more widely dispersed. In such a world, the demand for large acute hospitals would tend to shrink.

But unless prevention is more effective than it currently shows signs of being, dealing with emergencies will continue as the hospital’s core business. And unless mobile intensive care units become an economic as well as a clinical possibility, complex procedures – albeit procedures carried out by clinician-controlled robots in whatever country offers the best combination of clinical skill and cost – will continue to be performed in a central “place of safety”.

One message of the past 60 years is that the hospital can reinvent itself by introducing new treatments and therapies. Any attempt to guess its future role involves taking a view as to where the introduction of new technologies will lead. After decades of promoting large units – not just in healthcare – the tide now seems to be flowing in the opposite direction. But whether it will continue to do so for the next 60 years is anyone’s guess. ●

Anthony Harrison is a senior associate of the King’s Fund and the co-author of Acute Futures, a study of hospital policy.

Find out more

→ *The Health Services Since the War, Volume 1: Problems of Health Care*, Charles Webster, HMSO, 1988

→ *The Hospital: from centre of excellence to community support*, Norman Vetter, Chapman and Hall, 1995

WANTED: FEMALE ORDERLY, MUST BE CHRISTIAN

Emma Dent on six decades of job adverts in *HSJ* – and how they have been a barometer of policy

BEARSTED MEMORIAL HOSPITAL, LORDSHIP ROAD, STOKE NEWINGTON, N.16
COOK (Resident), Female. Wages £6 10s. per week of 48 hours. Additional pay for overtime and Sunday duty and if in possession of recognised Cookery Diploma. Board-residence, £2 1s. 3d. per week. Apply at once, in writing, to Matron.

THE HOSPITAL FOR SICK CHILDREN, THE COUNTRY BRANCH HOSPITAL, TADWORTH COURT, TADWORTH, SURREY
WARDMAIDS, DINING-ROOM MAIDS and PANTRY MAIDS required. Resident or non-resident. A.S.C. rates of pay. Apply immediately to Sister Superintendent.

ROYAL NORTHERN HOSPITAL, HOLLOWAY ROAD, LONDON, N.7
COOK (female) required, resident or non-resident. Small numbers. Whitley Council scale. Apply Catering Officer.

COOKING STAFF required at Joyce Green Hospital, Dartford, Kent. Wages: COOKS (men) £8 4s. 6d. per week; (women) £6 10s. per week. ASSISTANT COOKS (men) £7 14s. 6d. per week; (women) £6 per week. Plus extra payments for late shifts and Sunday work. Accommodation available if required. Dartford is only 15 miles from London with frequent train and coach services. Applications to the Group Secretary, Dartford H.M.C., The Bow Arrow Hospital, Dartford, Kent.

RESIDENT DEPUTY HEAD COOK. Wages 13s. per 48-hour week, less 4s. 3d. for board-residence. Application should be

The birth of the NHS saw the *Public Assistance Journal* and *Health and Hospital Review* get a new name. But in the first few issues of the *Hospital and Social Service Journal*, there were few advertisements for the then new role of administrator.

Indeed, in the first weeks of the new service, most jobs continued to be for roles advertised by councils rather than the new hospital management committees.

Roles in local authority on services such as children's homes, foster homes, homes for elderly people and approved schools were still common. Domestic jobs such as resident cook, laundry superintendent, maids or even barbers were as likely to be advertised as those for nurses, physiotherapy or matrons.

When hospital management committees did begin to advertise, it was still for nursing and midwifery roles, perhaps unsurprisingly as many pages in the *Journal* were still taken up with discussions over what remuneration and service conditions should be for NHS administrative and clerical staff.

Gradually however adverts began to appear for roles such as senior salaries and wages clerk. It was the start of a trend for *HSJ* adverts to act as a barometer of policy in the emerging health service.

By late 1948 more jobs such as supplies officer, finance officer and chief clerk in charge were appearing, although nursing and domestic jobs continued to dominate. Whatever the role, discrimination was given little thought. In addition to salary, the age, gender and religion a candidate should be were also often stipulated.

As the NHS turned 10, job adverts had changed little, although there

were now separate sections for professional and technical appointments and for administrative, clerical and supervisory roles. Jobs as diverse as home work organiser, home teacher of the blind, and handwork instructor all appeared in the former section. The latter covered everything from a shorthand typist to male clerk and organising secretary (woman). But adverts for nursing and ancillary staff, as orderlies, cooks and "experienced steam stokers" were now termed, still took up many pages.

The hard sell

By the 1970s the jobs pages took on a more professional look. On adverts for senior posts, the logos of organisations began to appear, giving candidates the opportunity to compare the design taste of varying health authorities. Organisations also began to actively sell themselves on their location, and facilities for staff. "A new and demanding post in a magnificent setting," trilled one.

But although in the post-Sex Discrimination Act days of 1978 references to the gender of prospective candidates were a no-go, subtle references to potential candidates' ages still made it in. The most senior administrator posts such as district administrator were also appearing in job pages.

Adverts for clerical officers were appearing in force, but those for building, engineering and ancillary staff still featured. Clinical jobs such as occupational therapists and audiologists and those in social work were also still being advertised, catering, one presumes, for the broad church of *Health and Social Service Journal* readers.

By the time the NHS turned 40 in 1988, the magazine had become *Health Service Journal*. While social

work posts no longer appeared, public health positions – particularly those working in HIV/AIDS services – were featured regularly. The private sector increasingly reared its head, with overseas and private healthcare firms promising higher pay than the NHS. The service fought back, using glossy recruitment companies to appoint to senior roles.

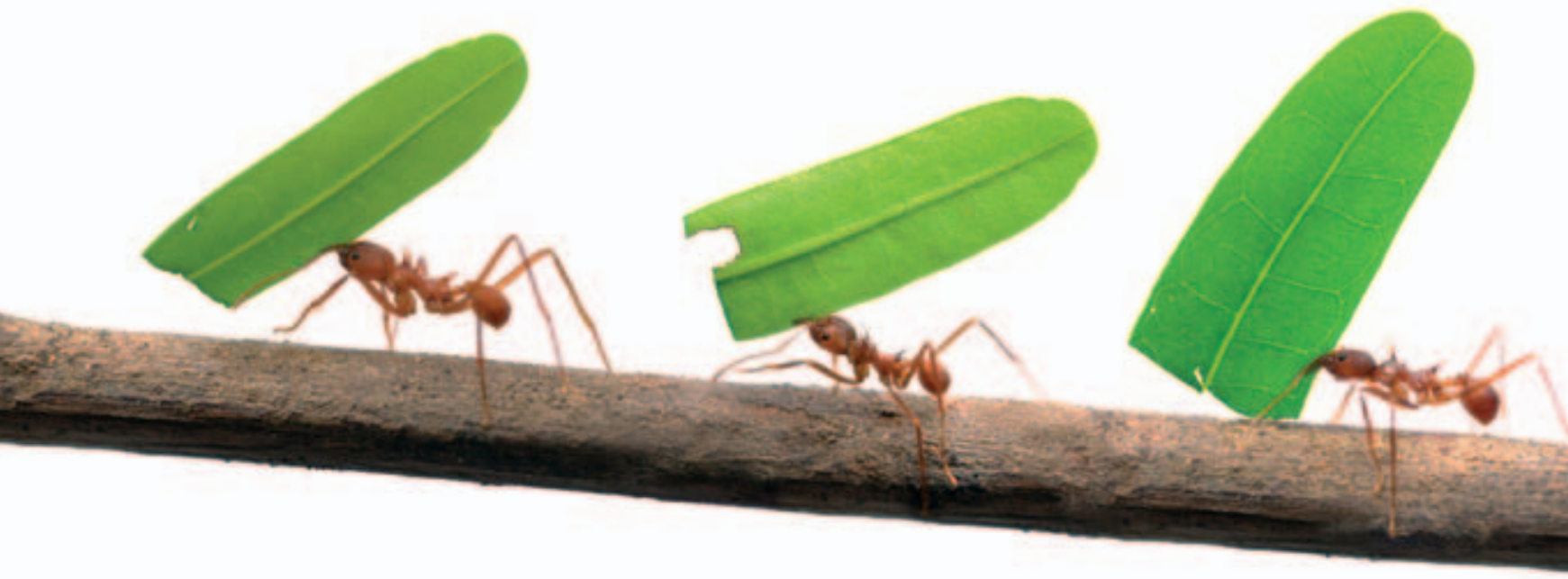
Fast forward to the 1990s and a post-internal market and more business-like NHS. Although readers in 1948 might have recognised adverts for jobs such as outpatients manager and patient services manager, areas of work such as corporate services and

'What, readers in 1948 might have asked, is a business manager doing in the NHS?'

commissioning would have not been so familiar. What, they might have asked, is a business manager doing in the NHS and what is a director of strategic development?

In 2008, many of the ads are for posts that would have not been heard of in 1948, including many roles in the private sector. Salaries are at a level beyond the dreams of 1948 staff. The commercialisation of healthcare is also increasingly in evidence, with roles for contracts managers and risk managers.

But some things remain: organisations still assert that joining them could be a life-changing experience; and if a job in healthcare is worth having, it still appears in the jobs pages of *HSJ*. ●



THE TEAM DREAM

The germ of multidisciplinary teamworking existed even in 1948 and has blossomed in recent years, reports Stuart Shepherd

Multidisciplinary teamworking is well established throughout every sphere of NHS activity, clinical and beyond. In fact, it is hard to imagine a type of care where the mutual collaboration and reliance it engenders is not central to doing best by the patient.

Its universality, however, is matched by a lack of uniformity across and even within organisations. Membership can vary and is often fluid, in turn an indicator of the informal origins of many multidisciplinary teams and their organic qualities of development.

To what extent they existed in 1948 is debatable. For those such as Mary Verrier, who at the time was a

clinical tutor at St Mary's Hospital in Portsmouth, something of its ethos was evident in the pioneering spirit associated with the formation of the NHS.

"We were very much a family, working together and relying on each other at a very exciting time, to improve standards, fight hospital infections and work with new processes and equipment. You had to have good working relationships and a regard for each other. It was the only way to survive with such a changing patient population," she recalls.

It is a sentiment that Geoffrey Rivett, a former GP and civil servant and now NHS historian shares and one that challenges common

perceptions. "Doctors weren't ruling the roost. It was much more the case that they and nurses formed parallel hierarchies, where each group and each level within it knew its place and responsibilities," says Dr Rivett.

"Senior nurses had no problem looking after their own interests and God help the young house officer who was disrespectful of a ward sister. His chief and the matron would have had him for dinner."

Mike Cheshire, who qualified in 1976 and has since gone on to become clinical vice president of the Royal College of Physicians and a consultant at Manchester Royal Infirmary, believes that while they might have gone by a different

name, multidisciplinary teams have been around for a long time.

"The role of the senior nurse was pre-eminent as a director of quality and they were usually just the person the junior doctor would learn from and go to when they were stuck," Dr Cheshire explains. "Teams have certainly grown, with occupational therapists and speech and language therapists for instance joining them."

"In my experience, it was only where things weren't working well that doctors had an undue influence over the functioning of a team. I have worked with nurses, therapists and medical colleagues who have all equally been team members and tremendous clinical leaders."

Pyramid of power

Others, however, including Robert Arnott, director of the Centre for the History of Medicine at University of Birmingham, are less persuaded.

"Multidisciplinary teams have only really emerged in the last 20 years," says Professor Arnott. "You just to have to look at films like *Doctor in the House* [made in 1954] to get an accurate sense of how the hierarchy operated. The consultants were at the pinnacle, with junior doctors, nurses and others beneath them. This pyramid of power existed before the NHS came along and 1948 did nothing to change it."

According to Professor Arnott, the make-up of the modern-day team depends to some extent on the personality of the medical consultant. The occasional irascible Sir Lancelot Spratt can still be



found, but is far from being any kind of role model.

"I recently sat on admissions panels for medical students and when I asked candidates what attributes make a modern doctor, I was looking for two things: good teamwork and communication skills. If they thought that doctors are at the top of the pile, some kind of commander-in-chief, we didn't look favourably on their chances of surviving the course.

"They need to understand that they are signing up to become members of an integrated team," adds Professor Arnott.

"These are exciting times. New professions such as the clinician's assistant and anaesthesia assistant are emerging, nurses and allied health professionals are gaining increasing amounts of autonomy and in many ways the team is becoming more integrated."

Many and varied factors have been at play in the fashioning and refashioning of the clinical team over the last 60 years. Some have come about as different groups or associations sought to reposition themselves within the system. Others include forces beyond the walls of the hospitals and outside the spheres of influence of collective colleges, societies and unions.

"Come the 1960s, with a relaxing of discipline and a widening of the eligibility for entry into nursing and medical schools, neither profession, even unconsciously, considered itself any longer as simply a cog in an effective machine. Boundaries were

challenged, educational influences in nursing began to rewrite roles from a feminist perspective and the unions marched with placards proclaiming themselves as workers, not angels," says Dr Rivett.

Professional status

Improvements in the standard of living, shifting social mores and increasing personal liberties all contributed to the renegotiating of roles and responsibilities. Welcome as they were, some of the resultant changes in status and practice may, by today's standards, have seemed a long time in the making.

"Our royal charter was granted in 1920, but it wasn't until 1977 that it was agreed physiotherapists should be entitled to function as autonomous practitioners," says Chartered Society of Physiotherapy chair Sarah Bazin.

"Prior to this we had been seen more or less as technicians. But it was clear even by then that we knew more than the doctor about what we could and did achieve for patients with our armoury of treatments."

Such boundaries are now often broken down. "Just a few years ago the Royal College of Nursing and Royal College of Physicians released a joint statement saying that the role of clinical lead in a team is not a matter for one particular profession but rather a position to be taken by the person best suited to deliver it," says policy adviser at the Royal College of Nursing Jane Naish.

Dynamics within multidisciplinary working continue to be shaped by

'A modern doctor needs two attributes: good team work and communication skills'

internal and external forces. In recent years the European Working Time Directive has changed working patterns particularly of junior medical staff and created difficulties around continuity of care and team cohesion.

Modernisation has also had a huge impact on the parts played by professional groups. While the modern matron now looks after the care environment, nurse consultant, clinical specialist and nurse practitioner roles mean team members other than the doctor are single-handedly managing patient care at times.

Teams without walls

With the shift to care delivered nearer the home and more emphasis on supporting patients with long-term conditions under self-management, the arena where multidisciplinary working is perhaps undergoing the most dramatic changes is the community.

"The next place that we really start looking at teamwork is in the service spanning the primary and secondary care interface, with a model that can work, for instance, across general practice and foundation trusts," says Dr Cheshire.

"The Royal Colleges of Physicians and General Practitioners have coined the embryonic term 'teams without walls' to start looking at how we might get rid of multiple transaction costs and form flexible new services that belong neither in the hospital nor the community." ●

IF THIS CARE PAYS

There has been no overarching policy on the future role and nature of primary care since the Conservatives left power in 1997. Although the Labour government has presented a raft of initiatives, shifting care out of hospitals, re-investing in community services and increasing the focus on prevention and self-care, these objectives have not been articulated into a real vision of what primary care should look like. So says Nick Goodwin, a senior fellow in policy at the King's Fund.

"You have a conflicting vision at the centre and that filters down to GPs and others providing the care," says Mr Goodwin. "They are saying 'what do they really want us to do?'"

What patients require is changing. If the 20th century was characterised by the demand on episodic hospital care for acute illnesses, there is now a growing need to manage the long-term incurable conditions of an ageing population. Although the government has recognised that this will require integration of services – both lateral and vertical – it has not made it clear how the work should be done.

Mr Goodwin says the demand for more personalised care will require multidisciplinary "medical homes" rather than GP practices. Such homes will not only care for common illnesses and refer patients on but also help co-ordinate medical and social care. He predicts the quality and outcomes framework will evolve to "some collective incentive to manage the person".

Health consultancy Newchurch chief executive Kingsley Manning believes such care management organisations will evolve to reflect patients' requirements and characteristics. "I think we are

Experts predict a future in which primary care will be delivered by a variety of suppliers in integrated packages tailored to individual needs, reports Ingrid Torjesen

going to see gay and lesbian suppliers, ethnically based suppliers and in particular long-term condition suppliers," he says.

"If you have Parkinson's, that is the dominant factor in your existence and you want somebody who is going to manage your care with that in mind. It's bonkers that if you suffer from that sort of condition, you still have a GP who doesn't know anything about it."

Mr Manning anticipates that the review by health minister Lord Darzi will take the first steps towards integrated suppliers by allowing foundation trusts to move into primary care, effectively cutting out the primary care trust as middleman. He adds that extension of choice may allow patients to opt to have their care provided by practitioners from outside their PCT patch, particularly in urban areas.

He believes it is "inevitable" that there will be some kind of co-payment system. "The government will be driven down that route simply by the fact that legally they won't be able to stop it."

One patient with cancer has recently taken legal action after health secretary Alan Johnson ruled she was not allowed to top up her NHS chemotherapy with drugs bought privately. If she or someone else is successful in court, the market for co-payments will explode, says Mr Manning.

Director of the NHS

Confederation's PCT Network David Stout does not think top-up payments would have much impact on the way care is commissioned because he sees commissioning becoming much more individualised. Patients could even start commissioning, as has been intimated by Gordon Brown.

"You can pitch it as choice rather than budget-holding, that sense of individual control over what it is they actually access, making choice of not only provider but also type of care for themselves," he says.

Potential changes

Just as primary care is being encouraged to take work from secondary care, Mr Stout expects to see some hospitals running primary care services. He says going fully down the route of a US-style insurance-based system would not be impossible, but would be "hellishly disruptive" as it would require massive reorganisation.

However, if world class commissioning does not deliver, this is a potential route forward. But the general view is that world class commissioning cannot fail, only PCTs can – and if they did, there would be consequences. "A health system that appears not to be working tends to get reorganised," Mr Stout says.

Clinical engagement will be vital to the success of world class commissioning, he adds. "You can't be a successful commissioner unless

you have successful clinical buy-in into what you are doing. You can write lovely plans but they may never come to fruition."


But NHS Alliance chair Dr Mike Dixon says a lack of clinical engagement remains. "We still have a very strong hierarchical managerial culture in the NHS which contains intrinsic antibodies to real clinical engagement and real public involvement. There is almost a tussle between the PCT and the practice-based commissioner as to who is to commission. The patients and frontline clinicians should be the commissioner. The PCT's role is to make sure that they are enabled and empowered to do so."

Mr Goodwin of the King's Fund says that, although he can see the benefits of taking commissioning closer to the patient through practice-based commissioning, retaining a commissioning role for PCTs is vital. "While a GP is good at assessing the needs of the patient in front of them or perhaps the patients on their list, they are really not capable of being able to understand what the future demographic needs are of the people in their community."

Professor of health policy and management at the University of Birmingham Chris Ham says the problem with world class commissioning is that the PCT is the commissioner and separate from providers, whereas it is important to "muddy the waters".

"If you are both a commissioner and provider and the incentives are strong enough, it enables you to do a lot more work in a cost-effective way under your own steam rather than always having to place contracts with other people."

He acknowledges this arrangement results in a conflict of



interest but says what is needed is more effective PCT oversight of services provided by commissioners to ensure they are value for money.

Empowering clinicians to tailor services to communities is also the right way to go about integrating services rather than rigidly imposing models such as polyclinics, Professor Ham says. "If you give entrepreneurial GPs and nurses in primary care the tools to do the job they will work out what is most appropriate for their areas. I don't think the government's job is to come up with a blueprint for a new polyclinic-type model because it is not going to work everywhere."

GPs worry polyclinics are a way of bringing competing private firms

'I think we are going to see gay and lesbian suppliers and ethnically based suppliers'

into primary care. Professor of social policy at the London School of Economics and a former Number 10 adviser Julian Le Grand does expect big corporate players such as Virgin and United Health to get more work, especially as United Health's experience in Derbyshire (where it runs two GP practices) has been positive. But he adds: "I don't see the GP driven out of business."

Instead he says competition will "ginger up" GPs a bit and improve their services with, for instance, longer opening hours. "In 30 or 40 years' time, I see a fairly competitive environment but still with GP small businesses being the dominant provider," he says. ●

It is unlikely there is an NHS chief executive in the land who has not experienced first hand the emotional cycle of policy introduction. Best described as a transition curve (Fisher 2006), it starts on a high when an initiative is first introduced. At this point, people are highly motivated, inspired by the promise of a better way forward and the vision of a brighter future for patients.

Later, on realising the enormity of the work involved, enthusiasm begins to dip. Frustrations creep in, perhaps caused by unforeseen resistance to change, lack of capacity or resources, or simply delays in getting things off the ground. At this lowest ebb, it is easy to lose focus and find justification for lesser performance.

But the policy implementer's job is not to return the policy to whence it came, saying "sorry, it can't be done" but to carry on and find the way back up. A strong vision of the destination point which is clearly and consistently articulated by leaders can help the tide to turn and start to improve things. Some early and tangible results help to grow a broader support base. This might be a start date for a new development or a reduction in waiting times.

"The point is not to fight the emotional cycle, but to understand that it will happen and that it is usual," says Tribal business development director Tim Keenan. "Once implementers accept this, they can start to plan how they might best manage the dip to make

it as shallow and as short-lived as possible."

A typical public-private partnership scheme, especially the large new hospital private finance initiative schemes currently being built, provides an example of the natural curve at work. Everyone is

'Communicate to all stakeholders at the start that things will go wrong but this is part of the journey'

on a high when the investment proposal is approved by the Department of Health, but confidence begins to fall as they spend two or three years waiting for it to reach financial agreement with private sector partners.

It often falls a little more when they realise the facility will not be as they envisaged, or that time has moved on and it needs to change shape with new service models. It is at this nadir in the emotional cycle that some good news arrives as innovative health planners and architects work out how a new facility and service can be made affordable. A start date is set and the curve is back on the up.

The point at which everyone hits the base of the curve is obviously too late to start managing expectations. Instead it is imperative

to recognise and acknowledge the emotional cycle associated with transition at the start of the process. Part of this is to communicate honestly to all stakeholders at the outset that things will go wrong and will fail, but to see this as part of the implementation journey and to focus more on the destination and the steps to reach it.

Final prize

"If people know it's going to happen, they will not be surprised," says Mr Keenan. "But nor will they expect to be kicked when they are down. The chief executive's job is to support them through the low ebb and keep them believing. Tribal's role in working on NHS policy implementation is often to keep everyone's eyes on the final prize through being less emotionally attached."

Of course, it is not enough to deliver the warning, stand back and hope for the best. For any policy to succeed, a leader has to first ensure the seed of change falls on fertile, not stony, ground. Gleicher's change equation $D \times V \times F > R$ provides a useful framework here.

According to Dr David Gleicher, associate professor of economics at Adelphi University, New York, in order for change (or policy) to be successful, the product of Dissatisfaction with the status quo, the Vision of a more desirable future and the knowledge of the First concrete steps to moving towards that future, must be greater than the Resistance to change.

If any of the first three factors is missing or low, then change will not take place successfully because the policy will not be capable of overcoming resistance.

Tribal director John Farenden says: "Gleicher's equation is a really useful tool for NHS policy implementers. It's also highly desirable that it is applied locally, because the value and applicability of any new policy will vary from one place to another.

"If, in carrying out an assessment, the implementer finds that any of D, V or F are absent or low, it is up to them to devise strategies to strengthen the first half of the equation and ensure the product of the factors for change is greater than resistance or inertia."

Rather than ignore resistance or inertia, implementers should work to understand where it comes from so that they can successfully identify the levers available to help them tackle it. Strategies aimed at helping stakeholders recognise that

The Tribal consultancy says policy change sets off an emotional cycle in those affected – but resistance can be smoothed out

OIL IN THE WHEELS



dissatisfaction exists would include highlighting trends and opinion polls and pointing to best practice to show the benefits of change. Using strong role models and designing an articulate communications programme can clearly help map the first steps.

If we apply Gleicher's equation to world class commissioning we can see there is dissatisfaction with the commissioning status quo because lots of people are signing up to the new vision. Work is underway to sell the vision via roadshows and first steps include publication of the Framework for procuring External Support for Commissioners, which provides expert support for primary care trusts.

The DH recognises resistance or inertia may be caused by PCT fears about their own skills and effectiveness at commissioning. But by providing clear and consistent messages about competencies and central support for training programmes and development, it

can tackle this by helping them implement world class commissioning and procure world class suppliers.

Another way to prepare for the dip is to bring in external support – a critical friend well versed in helping organisations stay focused on the end vision, while managing the dissonance associated with change. By drawing on the expertise of consultancies such as Tribal, chief executives can increase interim capacity without having to divert the energies of all their own people to the implementation of new policy. This often means that when the critical friend leaves at the end of the change period, normal balance is restored earlier.

It is up to chief executives to make the decision about how it all fits – to manage the mix – but they should be acutely aware that there is only so much management energy to go round. Support from an outside organisation could give them the momentum they need to

keep driving forward when energy is at its lowest. And it can supply a much needed injection of positivity around the implementation task.

Chief executives also need to stagger the start point of each policy introduction. It is a fine balance between introducing new policy and

'Delivery of energy, enthusiasm and emotional support is often where most value is added'

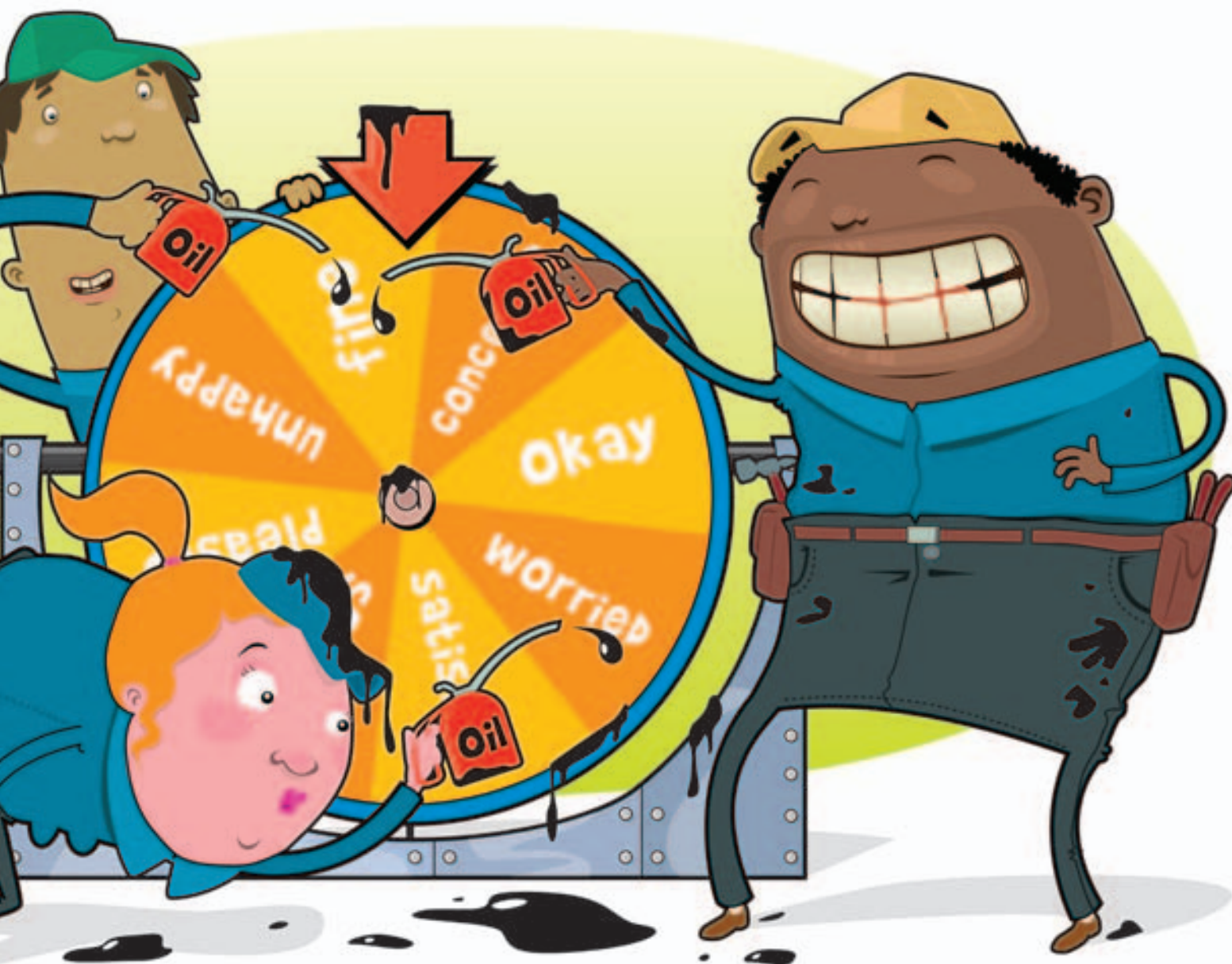
making sure existing policies are working effectively

Clients often ask Tribal to help "deliver tasks", but rarely do they ask for delivery of energy, enthusiasm and emotional support and yet that is often where most value is added. For example at

Dudley Hospitals trust we worked with our partners Boxwood alongside the trust staff to drive forward changes as part of the Programme Enterprise, aiming dramatically to improve effectiveness, efficiency and profitability.

We also ensure we design a strong communication programme, as in the West Midlands where the Investing for Health strategy formed the basis for a series of consultation events with NHS staff, patients and carers on how to operationalise new thinking, so that everyone knows what is happening.

Mr Keenan says: "We get the momentum going by focusing on programme deliverables, ensuring there are some quick wins along the way that we can celebrate with the change team. We then transfer skills to develop confidence and capacity so that it's all sustainable. Our success, come the end of the programme, is that the client thinks they did it themselves." ●



RUN WITH A ROD OF IRON

From large London teaching hospitals to modest municipal facilities and public assistance institutions, the foundation of the NHS covered a vast array of organisations.

Along with this mixed heritage came staff, many already imbued with, and stridently loyal to, the histories and traditions of their own particular place of work.

And while most of the 1,100 voluntary and 1,500 municipal hospitals would fall under the control of new regional health boards, teaching hospitals remained accountable to the secretary of state.

“The Ministry of Health was not going to get too involved in telling these landmark institutions – which had previously been answerable to nobody other than the Charity Commission – how to set out their management structure. So they simply rolled the previous one forward,” says NHS historian Geoffrey Rivett, a former GP and civil servant.

“In fact, such was their relative autonomy, it is said that the chief executive at Bart’s (then known as the treasurer) never opened a letter from the ministry unless he knew in advance it contained a cheque.”

In a large voluntary hospital, the treasurer, otherwise known as the governor or bursar, was accountable to the management board. They typically worked with the consultant head of the medical committee, a matron and finance officer.

Local authorities ran municipal hospitals, which by 1948 provided at least three out of every four hospital beds. The medical officer of a county or city council oversaw several hospitals, each in turn managed by a salaried medical superintendent, supported by various advisory committees.

These traditions of management existed side by side until the 1954 Bradbeer report introduced a more uniform national model to the service (with hospital secretaries in charge of administrative affairs, a hospital management committee and a medical staff committee) that

The formation of the NHS brought together many different organisations, with their own ideas of hierarchy, writes Stuart Shepherd

tended towards the practices of voluntary hospitals.

Eric Smith, who at the time held junior clerical roles in Hampshire, says: “Virtually on the appointed day of the start of the NHS, the house governor of the Royal Southants voluntary hospital became group secretary of the hospital management committee. This made him responsible not just for what had been his own hospital but also a number of other hospitals and institutions in the 20-mile radius of the new catchment area.

“There was a deputy group secretary under him and then gradually posts like group engineering manager, group catering manager and so on were recruited too.”

The real power

In Torquay, Fred Payne had been working as an administrator in public health. The 1948 reorganisation saw him offered the committee clerk job at Torbay for the South Devon hospitals group – a management committee made up of hospital staff, GPs and lay members.

“There weren’t many of us on the administrative side and we worked long hours, including Saturday mornings. The group secretary was in charge of the hospital secretaries and ran our hospital under a tripartite system with matron and the chair of the medical staff committee,” he says.

Consultants and medical committees were powerful bodies, and working alongside them often

called on a hospital secretary’s talents for discretion and diplomacy. But it was rare for junior management and clerical staff to have written protocols on how to conduct themselves. Their proximity to local power brokers was reminder enough that they were honour-bound to uphold the hospital’s reputation and traditions.

But one rule extended to just about everybody working in a 1948 hospital: you did not wander on to a ward without sister’s permission. Nursing was a prestigious career that attracted talented candidates. Competition for training places at the teaching hospitals was tough and matron, the senior nurse who also ran each institution’s school of nursing, had her pick of the crop. It is widely held that sometimes she picked a certain “look” with which a hospital became associated – pale and willowy at London’s St Thomas’ Hospital, for example; petite and outgoing at the Royal London.

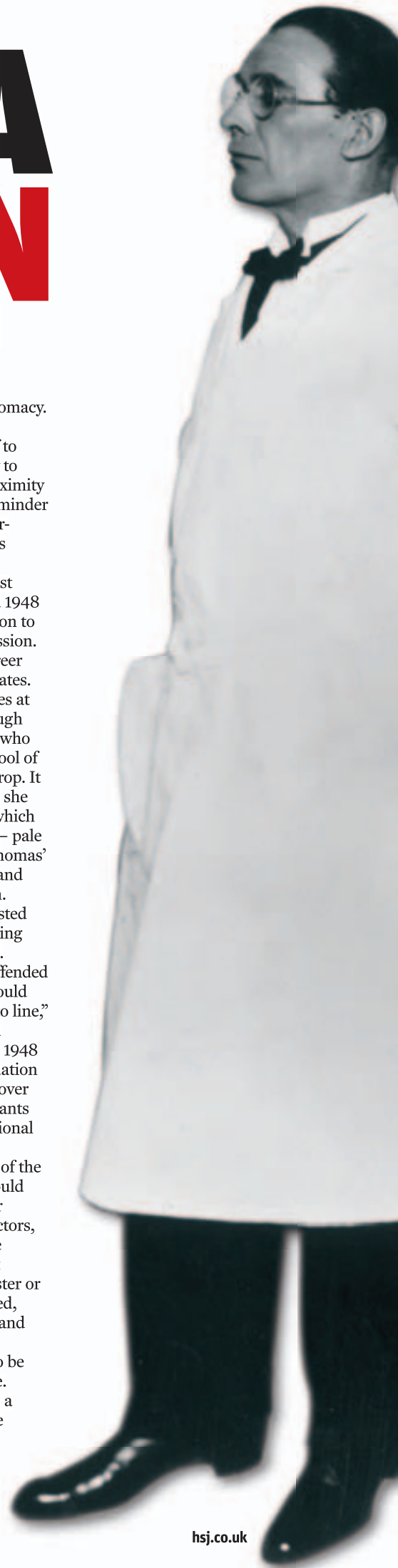
A mutually high regard existed between the matron and nursing sisters and senior consultants.

“As a junior doctor, if you offended your ward sister, your boss would soon find out and pull you into line,” says Dr Rivett. “Sisters were a permanent fixture and even in 1948 many of them had accommodation on the ward and would sleep over some of the time. The consultants took their long-term observational experience very seriously.

“Sister was also the keeper of the consultant’s protocols and would educate house officers to their individual ways. As junior doctors, we lived in the mess and were always on call, but if a patient became ill in the night and sister or staff nurse knew you were tired, they would try to protect you and ask for someone else.”

Yet nurses were expected to be hardworking and subordinate. Self-discipline meant keeping a spotless starched uniform, the shades and hues of which designated seniority.

“You stood up when sister came into the room and you





‘When the consultant was about, you stood with your hands behind your back’

opened the door for them in the dining room as they left,” recalls Olga Spavin, a student nurse in 1948 at the now defunct Western General Hospital in Hull. “When the consultant was about, you stood with your hands behind your back.”

Nurses lived in and observed a curfew. Marriage was a bar to continuing in the profession.

“One evening we were allowed to see a midnight screening at the local cinema, but we had to be escorted by the housekeeper,” says Ms Spavin. “We were always supposed to back by 10, so we used to keep a key on a piece of string through the letterbox – until the home was burgled and all the furniture from the ground floor was stripped out.”

Other clinical professions such as physiotherapists and radiographers were present in most hospitals in 1948 but in relatively small numbers. Considered supplementary by some, they

tended to have little to do with anyone outside their own departments.

As a former student at the radiography school of the Newcastle upon Tyne United Hospitals group, Ethel Armstrong clearly remembers that its standards of discipline were the equal of any nursing school.

“The superintendent ran his department with a rod of iron and a strong sense of correctness,” she says. “We had inspection every morning at 8.45 to make sure our white coats were clean and properly buttoned, that our brown brogues were shining and our stockings free of ladders.”

“We used to sit with the physiotherapists at lunchtime. Like us they belonged to an isolated team. The sisters had their own dining table, as did the staff nurses. If the students were allowed in, they would be at the back of the queue. Until matron had served everybody and said it was all right, nobody thought of starting their meal.” ●

ON YER BIKE: MEMORIES OF A 1948 MIDWIFE

Having worked as a general nurse for several years, Mona Williams began midwifery training in 1948. As a county midwife for Cheshire council, she attended

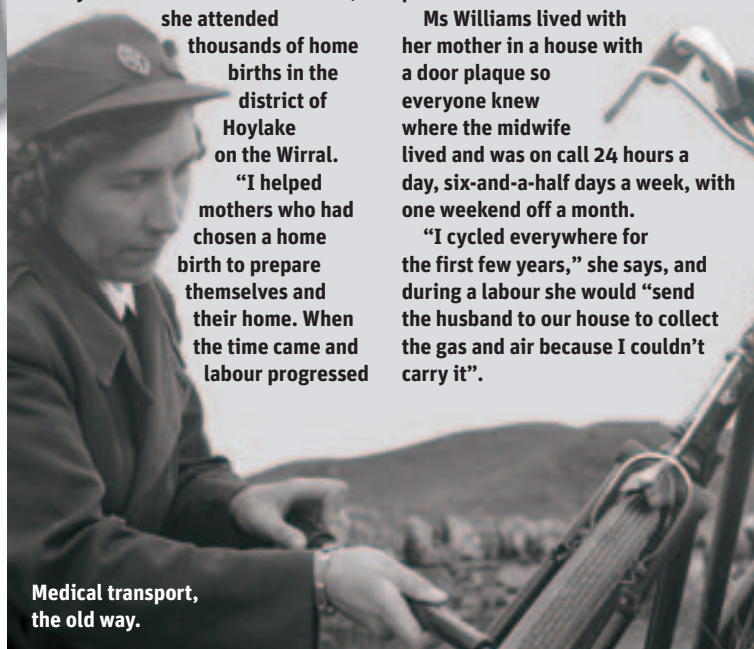
thousands of home births in the district of Hoylake on the Wirral.

“I helped mothers who had chosen a home birth to prepare themselves and their home. When the time came and labour progressed

without complications, I would deliver the baby on my own and only called the doctor for abnormal presentations.”

Ms Williams lived with her mother in a house with a door plaque so everyone knew where the midwife lived and was on call 24 hours a day, six-and-a-half days a week, with one weekend off a month.

“I cycled everywhere for the first few years,” she says, and during a labour she would “send the husband to our house to collect the gas and air because I couldn’t carry it”.



Medical transport, the old way.

GETTY, HULTON ARCHIVE

A DAY IN OUR LIFE

It is easy to see the changes of the past six decades in terms of the big political shifts. But there is another story to tell about the small changes to daily life.

Managers of the early decades of the NHS describe a world that is almost unrecognisable today. Almost no one drove to work, everyone wore a collar and tie and addressed seniors as Sir or Mr – there were no senior women to address.

“Ties were a must,” says John Roberts, who started work as a national trainee in the service in 1962. “I remember one trainee turned up in a black jacket and striped trousers, but it was still common to be wearing stiff collars, double cuffs and cuff-links.”

As a trainee, he attended Thursday evening dinners at the King’s Fund, where “they complained at the cost of passing the port round twice”.

Mike Brown, who joined the management training scheme in 1967, recalls a daily ritual at a regional hospital board where he worked for one of the directors.

“He would get the post in the morning and have his whole team gather for the post meeting,” says Mr Brown. Eight to 10 staff would watch as the director took the first letter from the pile and ritually opened it, before discussing its contents with the room.

As the pile was not sorted beforehand, this might be

something utterly mundane. But this ritual would go on for an hour, after which the director would jump to his feet and announce that he had to rush to a meeting.

“I thought that if I ever got to a position of authority, I would not run an office in that way,” adds Mr Brown.

Formally speaking

Forms of address remained formal until quite recently: no one would have dreamt of calling a senior by their first name before the 1980s.


As Mr Roberts says: “It was usual to address the chairman as Sir well into the 1980s, but then where I worked, most of them were knights. In 1978 some were shocked when the new regional chief medical officer breezed in, telling everyone on his staff to address him by his forename.”

Even as recently as the 1990s, etiquette was very different from the way it is today. Lyn Darby, who joined the NHS on its 50th anniversary in 1998, says: “The relationship with senior managers and particularly the senior medical staff was quite formal, though this may just have been because I was a management trainee.

“Some nurses still wore belts with ornate buckles, although

infection control saw this change within my first year and female managers were asked to wear skirts, as trousers were felt to be untidy. Before my first day in one trust, I received a phone call tipping me off about the no-trouser dress code. But as I didn’t even own a skirt, I went to work on my first day in a smart black trouser suit and

was promptly sent to town to buy a skirt and not to return till I had done so. Embarrassing at the time to be sent away on your first day, but both incredible and funny to think of it now.” ●



The daily life of an NHS manager has changed hugely since 1948, says Daloni Carlisle

LORDS, LADIES AND FREEMASONS: LIFE ON THE STAFF OF AN ASYLUM IN THE 1970s

Former manager Alan Randall recalls his first job at Herrison Hospital (the county asylum) in Dorset in the 1970s with tales that could have come from the pages of an Edwardian novel.

“Nothing on the two-year national training course helped me to fathom the hospital power structure,” he says. “I naively assumed that the chairman was the most important member of the committee. But despite

his title, he fell well down the hierarchy. His first handicap was that he was a mere pig farmer, while other members of the hospital management committee were landed gentry.

“Of the committee members, Sir Joe Weld was the Lord Lieutenant of Dorset, lived at Lulworth Castle and seemed to own much of East Dorset. Lady Williams lived at Port Bredy and appeared to own all of West Dorset.

Also on the committee was Caroline Bond, a wonderful person who later on became chair of Great Ormond Street Hospital. When I tentatively tried to find out where she fitted into the pecking order, I was left in no doubt by her comment that her family gave its name to Bond Street.”

He goes on: “I was taken aback to be addressed by the members as ‘Randall’. It had to be explained

to me that this was a compliment in that it put me on a par with their butlers.

“There was also a second hierarchy at work, as many of the senior staff and members were freemasons. All big decisions had to be referred to the head gardener, who was grand master of the lodge and spent his days smoking a pipe in a rather grand building out in the magnificent grounds.”

Negotiating the asylum’s hierarchies also provided Mr Randall with “one of the most embarrassing moments of my 33-year NHS career”.

“I tabled one of Lady Williams’ reports of a departmental visit she had made,” he explains. “She had handed me her handwritten report just before the meeting and I passed it to a temporary secretary to type copies for the members. Unbeknown to me, the

temp did not know what OT stood for, but she decided to take an inspired guess. Oh how I wish I had checked it! When invited by the chairman to speak to her tabled report, Lady Williams announced in her fearsome, deep, resonant voice that ‘contrary to the report, I did not visit the outside toilets and find morale high’.

“For the rest of my career, I could never take OTs seriously.”

IT WAS THE TWO YEARS

Being in the top job at the Department of Health means overseeing the biggest political football of all. Peter Davies and Daloni Carlisle hear six former health secretaries' memories



TOUGHEST OF MY LIFE





Norman Fowler:
“Whatever you did, there was a massive row”.

Fascinating, fulfilling and worthwhile. Many agree that being secretary of state for health is one of the biggest – and most difficult – jobs in government. With so much at stake it is characterised by battles with the prime minister (particularly Margaret Thatcher) and the ever-present influence of organisations such as the British Medical Association. But past incumbents largely look back with pride, as reforms introduced as far back as the 1980s continue to shape policy and old foes forget their grievances. As Alan Milburn observes: “They all love you when you’re dead.”

NORMAN FOWLER

September 1981 to June 1987

Norman Fowler was social services secretary, running the gargantuan Department of Health and Social Security during six of the most turbulent years of Margaret Thatcher’s premiership. Assailed from the right by colleagues who thought the NHS a costly folly and from the left by opponents convinced the government wanted to privatise it, he recalls: “We forget just how hysterical the health service debate was in the 1980s. Whatever you did, there was a massive row about it.”

He says his key to survival was to build the best possible team.

“It sounds obvious but it’s not what every secretary of state did. Some didn’t want the best ministers around them because they felt it might detract from their star quality. The one thing I did insist on with Margaret Thatcher was that I should pick my own people.”

Among his team were future prime minister John Major, future health secretary Kenneth Clarke and health minister Edwina Currie.

Lord Fowler says heading such a vast and diverse department meant he avoided getting stale and enjoyed significant fire-power in the cabinet, although he would have preferred

not to have been in the same job for so long.

Mrs Thatcher regarded him as “a good defensive player” but not one to transform the NHS. “I believed in evolution,” explains Lord Fowler, who says that behind the scenes he repeatedly opposed “batty” alternative funding proposals.

“Those putting forward these ideas had no concept of the upheaval involved and the politics would have been totally disastrous. People didn’t want a privatised health service.”

His long service at the DHSS was invaluable in launching the groundbreaking AIDS awareness campaign of 1986.

“If I’d been new I wouldn’t remotely have been able to spend the time I did on it.” Initially planned as conventional public health advertising “with dense text”, even this took months to get past ministers.

Only after persuading Mrs Thatcher to “stand to one side” and let a cabinet committee take charge did policy develop. “We made more and quicker progress on that issue than any other issue I can remember in government,” he says.

KENNETH CLARKE

July 1988 to November 1990

Kenneth Clarke became health secretary in the middle of Mrs Thatcher’s NHS review, when she decided to split health and social security into two separate departments. The review – prompted by a funding crisis and conducted behind closed doors – contemplated replacing the NHS with private medical insurance.

Mr Clarke had previously been health minister for three years until 1985.

“I was rather surprised to be given the post of secretary of state because she must have realised I was a supporter of the NHS as it stood and I didn’t think it was a department to which Margaret was



Kenneth Clarke: “We had ferocious meetings”.

likely to return me. She thought the NHS should be a service of last resort for people who couldn’t afford to insure themselves. I was strongly opposed to that.”

The review of the service, says Mr Clarke, “had really got nowhere in particular” other than to suggest tax relief for those taking out private insurance, an idea the then chancellor Nigel Lawson was resisting. Mr Clarke set about reviving proposals for a purchaser-provider divide that had been looked at but had not progressed.

“The department wasn’t at all keen on reforming. It wanted a quiet life with a minimum of trouble from the trade unions. It thought there was nothing wrong except we’d got to do better in next year’s public spending round. I remember the permanent secretary explaining to me he couldn’t spare any staff to help me on the review.

“I left the Department of Health as I arrived – wondering what on earth these 6,000 people I supposedly employed were doing. It took quite a struggle to get a team together that I wanted.”

The work meant making regular progress reports to Mrs Thatcher, with the chancellor and the then Treasury chief secretary John Major.

“These were ferocious meetings. This was Margaret’s way of

‘The department wasn’t at all keen on reforming. It wanted minimum trouble from the unions’

working. It was very good if you could stand the hassle. She’d challenge everything you said. It made you do the work and go away and think.

“Early on I tried to bury her under detail, which was a complete waste of time. All she wanted was more detail. You could deliver it late the night before and she’d have read it by next morning and be ready to continue the battle.

“We had lots of these meetings, tortuously thrashing out the details and getting them into the shape she wanted. We all enjoyed a good row.”

Eventually a paper was put to the cabinet. “People think Margaret’s cabinet was like *Spitting Image*, but she usually ran genuine cabinet government. We could sometimes have long policy discussions. But one of her classic techniques worked: instead of letting me present my paper, which she should have done, she presented it herself



Virginia Bottomley:
"A fearful battle".

from the chair. She went through it and made it clear she agreed with it. Frankly, she bounced it through. Here was this fundamental reform of the NHS, which the present government is still having difficulty completing and getting right, which went through with five minutes' discussion."

The subsequent white paper, *Working for Patients*, was launched amid "very daring and slightly off the wall PR razzmatazz", with TV presenters hosting simultaneous video-linked roadshows. "I've still got the souvenir photographs. It looks very corny now."

Exhausted, the next day Mr Clarke went to a cricket match at Lord's, only to be summoned to take a phone call from Mrs Thatcher congratulating him on her perceived triumph of the white paper's launch, which had got a good press.

"I told her all hell would let loose and not to be deceived by the first 24 hours. I warned her the BMA would go berserk and they did."

Almost 20 years later, Mr Clarke says that the present government "is following exactly the same principles as I did".

"They've gone much further than I could possibly have contemplated, using the private sector. I envy their freedom of action because they haven't got a political opposition. I had one for whom this was the biggest topic."

He now deplores the "explosion of staffing and pay, reduced workloads and contractual obligations and declining productivity" in today's NHS, noting that "ministers left to themselves tend to want a quiet life on the industrial relations front". The service's "huge surge" in spending was "very badly planned".

But the NHS has, he says, "improved in every way and always has ever since 1948, not least because of clinical advance but also because it's always had ever more resources put into it. Most citizens' experience of the NHS varies from good to excellent."

'My colleagues were constantly calling me Nanny Bottomley but I'm quite stoical and resilient'

VIRGINIA BOTTOMLEY

April 1992 to July 1995

Becoming health secretary after three years as a health minister realised a long-held ambition for Virginia Bottomley.

"Until I die I'm sure this will be the job that has most marked my career," she says.

Educated in the social sciences, Ms Bottomley had been a social worker and Lambeth magistrate before entering the Commons. She felt ideally suited to a role she found "with all its pressures, totally absorbing; completely fascinating, fulfilling, demanding and worthwhile".

Her unusual pedigree for a Conservative MP gave her a different outlook from most of her party colleagues, "those who used the Thatcherite language of the market to antagonise the old Fabians". Many felt she was "too much of a *Guardian* woman for their liking".

Ms Bottomley pushed through a public health white paper, *The Health of the Nation*. "I had a fearful battle and was nearly kneecapped by all my colleagues, who hated it. They were constantly calling me 'Nanny Bottomley' but I'm quite stoical and resilient."

Regarding the job as custodial, not party political, she tried to recruit as her special adviser Philip (now Lord) Hunt, then director of the NHS Confederation; he later became a Labour health minister.

After the 1992 general election the heat had been taken out of the reforms as a political issue and her main role was to bed them in. "In politics you sometimes want a window-breaker and sometimes a



Stephen Dorrell:
surprising consensus.

glazier. Ken Clarke was definitely a window-breaker and I'm much more a glazier."

She remembers the BMA giving her a standing ovation, such was her commitment to cutting junior doctors' hours. "I thought – rather vainly – 'perhaps this will be in the newspaper'. But it wasn't because I was naïve about how the press operates. I never rang journalists, ever. In today's age of spin, that's extraordinary."

Her style was "earnest", she says. "I laugh at myself looking back now. I was always criticised for using too many statistics. Now brilliant politicians are people who paint big pictures and I don't think I'm good at that. Having that lightness of touch is a skill I certainly don't have and I rate it a lot."

STEPHEN DORRELL

July 1995 to May 1997

"If you take office for the last two years of an 18-year spell, the chances of your leaving great monuments are relatively remote," says Stephen Dorrell, who was health secretary in the last days of John Major's government.

He says: "By 1995 most of the heavy lifting had been done. I'd like to think in my time we gave the reform programme a chance to breathe. We drew some of the political venom out of the argument."

And despite lingering opposition "there was a developing willingness to see the point of what we were trying to do. People were relatively weary of the arguments of principle and more interested in making it work. I tried to focus on solving practical problems rather than having great ideological debates."

In fact, Mr Dorrell achieved surprising consensus. His white paper, *A Service with Ambitions*, can be seen as the precursor of much Labour health policy, and his Primary Care Act was passed with all-party support. Some colleagues questioned why the Conservative government was "giving political oxygen" to the NHS so near to what was clearly going to be a difficult election.

Drawing up the white paper, Mr Dorrell says he gathered senior

managers and told them: "You'll never get me to say this on a public platform but you'll be thinking about how you're going to live under a change of government. I can't be part of that process, but the reality is there's a shared agenda between myself and most Labour health ministers, in particular about pathways of care and focusing on responsiveness to patients." I told them this was their opportunity to put their priorities on paper.

"There's very little that comes out of the DH now that couldn't – with some changes – be reconciled with what we were doing in the mid to late 1990s."

He sees "big improvements" in today's NHS but bemoans the "over-centralising managerial dead ends" represented by too many targets and too little respect for healthcare professionals.

"If we'd followed through the consensus that was emerging I think we'd have made a lot more progress in the last 11 years with the money that was provided."

ALAN MILBURN

October 1999 to June 2003

Ask current senior NHS managers to name their top three health secretaries and Alan Milburn is nearly always among them.

Mr Milburn himself laughs at this. "They all love you when you're dead," he jokes. "That's not my memory of how it was but it is very nice people feel like that."

He came to the job of secretary of state for health from the Treasury in October 1999, having previously been a health minister for a year under Frank Dobson.

Almost immediately he ran into one of the worst winters the NHS had experienced. Trolleys were stacked up in accident departments and the press was full of pictures of the patients on them.

"It was a dreadful winter, one of the worst on record," he recalls. "It was tough for the health service and tough politically. Getting through that was one of the most difficult times."

The 2000 NHS Plan was already being worked on and it fell to Mr Milburn to implement it.

"That was the second most difficult period: pushing through some of the reforms that are now broadly accepted as the right direction of travel."

He did it by setting himself up as the patient's champion. "My number one job as secretary of state was to look after the NHS patient," he says. He remains convinced the NHS Plan set the health service in the right direction.

"We redesigned the health service around the needs of patients. → 54

REX, PA

53◀ I am very proud of that and very pleased with the progress that's been made on a lot of the changes I was responsible for."

He lists these as choice, standards and inspection regimes, the creation of foundation trusts and primary care trusts and introducing diversity in provision.

"These are all now part of the accepted architecture of the modern health service."

Mr Milburn is sometimes accused of "throwing mud at the walls in hope that some of it would stick" rather than having an overall strategy in place.

He admits the NHS has been through a period of unprecedented change in the last 20-30 years, which certainly accelerated in the last 10 years. But a lack of overall strategy? No.

"When I became secretary of state, there were lots of good things about the NHS but lots of things wrong as well, such as a lack of responsiveness and poor waiting times. People often look for a magic silver bullet but the truth is that in an organisation as large and complex as the NHS you have to fire a lot of bullets.

"You have to have national standards, local autonomy, inspection, a system of rewards and incentives for individual members of staff and organisations. Then you get some progress."

And there has been progress, he emphasises.

"I think back 10 years and what was then regarded as the core problem in the NHS was a woeful infrastructure and capacity, leading to long waiting times. It's not been solved completely but we are in a different position and that's as much about reform as investment."

Mr Milburn remains the politician and won't admit to difficult relationships with any of the key players with whom he engaged. He prefers to accentuate the positive.

"The joy of being health secretary is you meet [such a] wonderful and diverse range of committed people who want to make the system work."

He attributes some of his reforms to these meetings. "The idea for foundation trusts basically came from discussions with NHS managers from some of the best organisations in the country."

His only reservation today is whether the NHS will finish its journey.

"I talk to people in the NHS almost on a daily basis and [the NHS Plan] is still regarded as the bedrock of what people are trying to do. The NHS is on a journey. It was a 10-year plan and we are broadly

making progress in the right direction. The question now is whether the journey will be completed or truncated. There is, in my view, no third way."

PATRICIA HEWITT

May 2005 to June 2007

Patricia Hewitt is remarkably frank about her time as secretary of state for health.

"It was the toughest two years of my life but it was also the most rewarding."

Perhaps that is no big surprise. Ms Hewitt arrived in post a few weeks before news of the NHS deficit broke and forced the health service to address this in a period she acknowledges was "incredibly difficult and painful" for everyone.

And although she successfully wooed doctors at the 2006 BMA conference, she was booed at the Royal College of Nursing congress, a first for a Labour health secretary.

Ms Hewitt also oversaw the legislation that banned smoking in public places.

"That is the really big change that is already making more difference to people's health, as distinct from how we look after them when they

'It's one of those mistakes you can make when you are very new as a minister'

are ill, than anything in the last decade."

She adds: "It's one of those areas where you really have to think through how you reconcile individual freedom with protecting people, especially for a government that's always being taunted with being the nanny state."

But she admits that what really made her time in the post so difficult were the NHS's financial problems. "Everybody was shocked that, given the tens of billions of pounds we had invested, it could end up with a deficit."

It was not so much the size of the deficit – which compared to the overall NHS budget was small – but the fact that it was doubling every year. There were several underlying problems contributing to this, says Ms Hewitt, the biggest of which was a culture in which the NHS was said to be dealing with life and death and therefore money did not matter.

"I was constantly being criticised for putting money before patients," she says. "What I kept trying to say to people was that it was because

Patricia Hewitt: "Everybody was shocked that we had a deficit".



the NHS deals with life or death we have to get the money right. Every penny being wasted is a penny being denied to a patient who needs care."

She felt the old NHS system of balancing the books by taking away from those that had made a surplus to pay off the debts of those with a deficit was grossly unfair and no incentive to improve.

And the fact that the NHS was wasting vast sums was apparent in the wide variation in performance that, thanks to Alan Milburn's reforms, was becoming transparent. "There was no longer any hiding place for poor performance," she says. "But I never had any doubt that it had to be done."

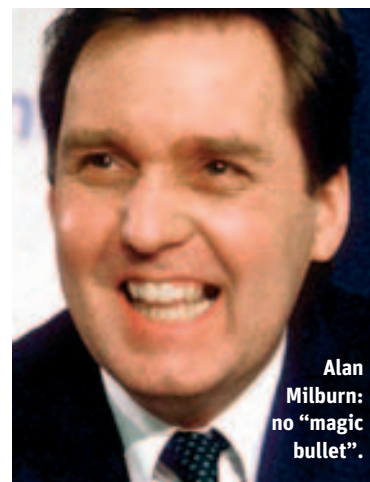
"Now I have heard so many people say 'God, it was tough but now we have freedom and can do what we want to do'."

Ms Hewitt also admits to one major regret. "The mistake we made with *Commissioning a Patient-led NHS* in creating terrible uncertainty for health visitors, district nurses and primary care trust staff."

Commissioning a Patient-led NHS, concerned with realigning PCTs so that they could become efficient commissioners, came out in July 2005. Meanwhile the DH's commercial directorate issued a tender document which seemed to open the way for tendering all PCT provider functions.

There are various versions of these events and here is Ms Hewitt's: "My focus had simply been the issue of the PCTs," she says. "It was very clear we needed to allow at least some of them to merge and I was clear this should be a genuinely bottom-up process."

"While I was focused on that, the department had been pursuing the idea of a complete separation of the purchaser-provider roles, which understandably caused immense distress. When I realised what was going on I just stopped it."



Alan Milburn: no "magic bullet".

Her excuse? "That's one of those mistakes you can make when you are very new as a minister, and we had to spend several months unwinding that and reassuring people they were not going to be cast off."

The separation of purchaser and provider remains a live issue and Ms Hewitt's feeling is that it will evolve according to local need.

"But I think [current NHS chief executive] David Nicholson is absolutely committed to what we were trying to do to devolve power to the service within a framework that puts the focus on the patient. And I am confident the Darzi review will take that forward."

She also dismisses as "absurd rhetoric" accusations of privatising the NHS by bringing in the independent sector. Patients want choice and trusts respond by upping their game, she says.

Ms Hewitt was not a popular health secretary but has been praised for improving policy making and engaging professions in the reform process.

"I think it is true I spent more time than any health secretary for a long time just listening to staff and engaging with the professions," she says.

"I feel very lucky to have had the chance to do the job." ●

Manager bashing is a national sport – but try not to believe your own bad press. Ken Jarrold asks why administrators have become unpopular and argues that it is still worth taking a few knocks



DON'T BEAT YOURSELF UP

Some advice for those in the dating game: if you want the object of your desire to swoon at the mention of your job, do not be a health service manager. However, if you are content to impress with who you are rather than what you do and want to be useful in a good cause, then it could be the career for you.

Management is not a caring or glamorous profession. In fact, it is not a profession of any kind. However, it is a necessary and – done well – a very useful occupation in which I was proud to spend 36 years.

Manager bashing has long been a popular sport. Just as people of a minority race or nationality are often blamed for social problems by those unwilling to deal with the complexities of migration, so managers are often blamed by those unwilling or unable to grapple with the “wicked issue” of providing comprehensive healthcare in a world of scientific advance, an ageing population, increasing demand and cash-limited budgets.

I joined the NHS in 1969 when we had both just turned 21. As we reach

60, manager bashing has become steadily worse, for four reasons.

First, cash limiting came to public services in the late 1970s. This new discipline reinforced the restrictions of annual budgets and administrators policed the regime.

Second, the 1983 Griffiths report transformed us from administrators who were equal members of management teams with doctors into general managers in charge. It separated us from colleagues.

Third, governments in the late 1980s began to realise they could make the NHS do things, and so the review system and targets were introduced. Managers were forced to interfere in the real work of the NHS.

Fourth, the coming of trusts and the chief executive role

‘No one expected me to cut waiting times – that would have been seen as an invasion of clinical freedom’

brought higher salaries, lease cars – and many more managers.

In a reverse of combat history, red coats have replaced battle fatigues. Managers are visible and often resented by the press, most of public opinion and even many colleagues.

Need for questions

Administrators in early years did not have high status or salary. They were members of a triumvirate of doctor, nurse and administrator, and belonged to a management team. They administered a low-cost system undisciplined by cash limits and were not expected to do a great deal.

When I became a deputy superintendent in 1971, no one expected me to cut waiting times or even know how long patients waited. To do so would have been regarded as a gross invasion of clinical freedom. It is no wonder manager bashing has increased when managers today are high profile and well paid and have to question clinical practice and change process.

Much of this cannot and should not be changed. A modern health system needs effective and appropriately rewarded managers.

But the bashing can be limited and managers can increase appreciation of their role, using four simple rules.

First, remember managers exist to support doctors, nurses and everyone else in the main business of treatment and care delivery.

Second, demonstrate your commitment to patient care and your interest in and knowledge of the real work of the NHS.

Any challenge or change must be because it improves patient experience. So third, show by your words and actions that you value and respect the people of the NHS.

Fourth, be one of management guru Robert Greenleaf’s “servant leaders”: listen, heal, persuade, conceptualise and build community; and show empathy, awareness, foresight, stewardship and commitment to people’s growth.

If I were 21 again, I would still apply to enter the NHS. It has been a privilege and has used all I had to offer. I felt useful in a good cause and valued – worth a little bashing. ●

Ken Jarrold is a senior consultant at Dearden Consulting and a former strategic health authority chief executive.

STEPHEN THORNTON

Every NHS chief executive lives with the knowledge that they could one day face a drubbing in the *Daily Mail*. Stephen Thornton was one of the first NHS managers to face heavy media attention, when, as chief executive of a health authority, he was caught up in a controversy over whether a child should be given an unproven treatment for cancer.

Now he believes the mid 1990s marked a sea change for NHS managers.

"In the past, media interest had either been political or clinical; there was rarely any public understanding that the NHS was managed in some way," he says. "I had got to the Appeal Court before I put in a call to Alan Langlands [then chief executive of the NHS]. That would not happen now because accountability kicks in at such an early stage."

He says: "It is the whole collection of accountabilities that is debilitating, particularly when the main accountability line up to government is so managed. While the last 10 years have been tremendous in terms of seeing a government keen on investing in

healthcare, that has come at the cost of a top-down approach to managing health services."

Mr Thornton believes managers also have multiple accountability they did not have before – to regulatory bodies, local authorities, the media and above all upwards to the Department of Health. This has contributed to a tougher climate for managers.

He left the NHS 11 years ago, became chief executive of the NHS Confederation for five years and now runs the Health Foundation.

"There is a very heavy political pressure group overlay on the NHS which tends to be very fraught, very negative, with a lot of pressure groups able to say no to things."

But NHS managers also learn to be adept at looking upwards and spotting the next political move.

"That kind of political adroitness is really important in any line of business but NHS management spends so much time on it that it neglects to look inwards and downwards and takes its eye off the quality ball."

He believes top NHS managers stand comparison with those in other sectors, but is concerned there is a "long tail" of less able

managers, which he suggests was most evident during the rapid expansion of primary care trusts.

"We have some real capacity problems in finance and in HR and in those people who are knowledgeable and adept at continuous quality improvement. That is what the ethos of NHS management should be about."

He adds that working with clinicians and others through the Health Foundation has convinced him there is an enormous vitality and energy in the NHS – although some of this is lost as staff struggle with its inherent bureaucracy.

ANDREW WALL

Andrew Wall spent 50 years working in the health service – or lecturing about it – after initially joining as a nursing auxiliary in 1955. After working as a porter during his university degree, he joined the NHS as a junior administrator and then worked his way up to become chief executive of the Royal United Hospital in Bath. After retiring from Bath he spent 13 years lecturing at the health services management centre at Birmingham University before finally retiring to Somerset.

"It used to be said that you could do anything in management as long as you did not take the credit for it," he says. Before the days of management, administrators in hospitals were meant to be first among equals but in reality Mr Wall believes the clinicians were so busy that the administrators actually were in charge, although careful not to boast about it.

This discretion, which he believes has now vanished from the service, allowed him to make improvements to services which would probably not have been possible in today's target-ridden culture.

"I am a bit critical of today's managers," says Mr Wall. "I was known for being one who challenged ministers and asked: 'Do you know what it is like to implement that policy?'. I was used to speaking my mind. There were certain things you did not do and one of those was overspending but now overspending seems to be something everyone does. The

ALAMY

RETROSPECTIVE

money that is available now is phenomenal compared with what we had. But a lot of it is being wasted. The amount of money that has been poured into the health services with little result is a scandal.”

Mr Wall admits to being surprised at the numbers of managers in NHS organisations now, compared with when he started in managerial jobs in the 1960s. But this reflects the number of things they are being asked to do now, he adds.

“I don’t believe things were much better in the past – they weren’t – but there has been a big shift, and not only in healthcare, towards the rise and rise of managers.”

Mr Wall’s own more recent experience of the NHS has been pretty positive. He says he was amazed how quickly his notes were available when he attended casualty at his old hospital in Bath – something he believes would not have been possible in his day.

BRIAN EDWARDS

NHS managers today have a tougher job than in the past, with a plethora of targets and central interference, says Brian Edwards.

Mr Edwards spent 10 years as chief executive of the Trent regional health authority and three years as regional director of the West Midlands before leaving the service in 1997. He says he is “immensely proud and privileged” to have worked in the NHS and is still chair of a consultancy firm specialising in healthcare.

He says a major difference between the NHS now and then is the amount of direction from central government.

“The regions had a chance to work out their priorities and get on with it,” he says.

“There was an acceptance from the centre that they did not try to run the NHS – it was a job for the authorities in the field. The other sharp difference is that managers are much more involved in clinical processes now because that is where the targets are.”

Professor Edwards thinks life is “certainly different and probably tougher” for managers now.

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than it used to be and the environment in which managers work is much more controlled.”

He says that while it would be impossible to have an NHS totally independent of government, ministers should step back from operational details and concentrate on the bigger picture.

TIM MATTHEWS

Once one of the highest paid chief executives in the NHS, Tim Matthews was the one who famously guided Guy’s and St Thomas’ through their merger.

But after 20 years in the health service, he left and has spent the past eight working at first the Highways Agency and then US-based engineering firm Parsons Brinckerhoff.

“I learned a huge amount about managing large organisations, complexity and change, all of which are as relevant in non-NHS government agencies and in the private sector.

“There are a lot of differences in working between the public and private sectors but when you are running large complex organisations, there are a lot of similarities,” he says.

One of the complexities Mr Matthews encountered in the health service was managing change in a very public environment with lots of stakeholders, a situation which is not mirrored in the private sector. But working for a company with substantial government contracts still involves “handling the politics”.

“The NHS was a fantastic place to work. It was always complex, always going through change. But personally, I have to say there are only so many bouts of reorganisation that you want to go through and they come round with wearying frequency,” Mr Matthews says.

Although he believes that for all its frustrations and slow pace of change the NHS is an enormously rewarding environment, he says it has become increasingly tough.

“Being a chief executive in a big city has been a tough road for the past 15 years. ➔ 58



Former chief executives and health authority leaders compare their challenges and ambitions with the picture they see emerging for managers today. By Alison Moore

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OSPECTIVE

57 ← Expectations are very high and your ability as a chief executive to deliver is always going to be limited.

“You have an impact and you lead and direct change but there are so many forces in the NHS that can slow you down or stop you. That is one of the differences between the NHS and the private sector; in the latter once you decide to do something the imperative is to get on and do it. In the NHS the decision is just the start of the debate.”

After several years in New York Mr Matthews is now returning to the UK. At 56, he is not ready for retirement and does not rule out another NHS role.

BARBARA STOCKING

Barbara Stocking had a meteoric rise in the service. After running the King's Fund she was appointed as general manager of the Oxford regional health authority, before heading Anglia and Oxford and finally the entire South East region.

But in 2001 Ms Stocking left to run the UK arm of international development charity Oxfam. It was a change of direction that surprised many – especially as she had been tipped for the top job – but one where she says there are tremendous similarities.

“People in the NHS are not there to make lots of money. They are there because they believe they have a vocation and they believe in the NHS,” she says.

“People in Oxfam are passionate about ending poverty. So it is very hard to tell people what to do. You know what consultants are like, well it is the same here. You have to really explain to people why they should do things or go in a certain direction.”

She adds that the main difference between the two organisations is the highly political environment in which the NHS operates – this made it hard to lead towards long-term objectives. “Certainly at the level I was working at, where the government not only sets priorities but wants to intervene and change priorities.

“At Oxfam I really do lead the organisation. I have a board but it is not the same as having ministers who are involved in the day-to-day running of the health service. Although in a way Oxfam is a public institution it is not so publicly challenged as the NHS. In the NHS you can't hide anything – everyone experiences it.”

She believes one of the service's

most difficult periods was in the early years of Labour's first administration. “It felt tougher and tougher,” she says. “The real failure was that expectations were set out to the public as if they could be delivered tomorrow. That caused huge tensions at the front line.” But she adds going out to the front line and seeing what was being done was always “a joy”.

She has no plans to return, however: “I felt I had done what I could.”

MAURICE NAYLOR

Now 87, Maurice Naylor started his career in local government before the Second World War but moved to the NHS seven years after its birth.

He spent the next 26 years working at regional level, first in Manchester and later in Sheffield, and then became chief executive of the National Association of Health Authorities – forerunner of the NHS Confederation – when he retired from the NHS in 1981.

“The regional level was responsible for building new hospitals, training of staff and so on. I would not say that it was all different from today. It may be more complicated now,” he says.

Mr Naylor also notes the changes in the relationship between the NHS and central government.

“The government now is much more hands on, wanting targets to be met. We were not micro-managed in my day.

One of the main differences is that until 1980 there were regional authorities which were a regional level interposed between central government and the coalface. Managers and senior civil servants were not involved in quite the same way. I regret the loss of that.”

Mr Naylor now lives in Leicester and several of his family have followed him into the NHS. His nephew Sir Robert Naylor is chief executive of University College London Hospitals foundation trust.

“From the patient's perspective, I don't think things are very much better now,” he says. “Although medical science means that all sorts of things can be done, I don't feel there was a great difference lying in a ward now to having my appendix out in 1956.” ●



FLASH OUTFIT

The light pulsing on top of a modern NHS emergency vehicle signals a mobile unit packed with staff expertise and impressive technology, says Airwave's David Sangster

Emergency services pre-date the NHS, with a direct evolutionary path from the stretchers and wheeled litters used on ancient battlefields to the modern "blues and twos" we have today. But it was Aneurin Bevan's legislation that made it compulsory for ambulances to be available to all who needed them. Before then, the provision of emergency care was solely the responsibility of charitable organisations. Emergency services became, in a stroke, egalitarian.

The role of the emergency services was at first clear cut: the carriage of persons in need of medical attention but unable to proceed to a doctor unaided. This original role remains, but the paramedics of today have in addition a raft of new duties and responsibilities. They are now the front door of the NHS, giving initial (and often life saving) treatment to those in need of medical attention and taking the lead in dealing with accidents and emergencies. Recognised as a healthcare professional on a par with nurses and physiotherapists, today's paramedics have come a long way from their original role as porters for the sick.

Dangerous conditions

Paramedics have engaged in a corresponding change in their professional practices. The modern paramedic needs to master a range of technologies. The proficient use of medical equipment, from defibrillators to heart monitors, is obviously important, but there are less well-known technologies that paramedics have grown to rely on.

Paramedics can work in dangerous conditions and often the

very people they need to treat can present a danger to them. To keep them safe, the emergency services have evolved a number of techniques.

Radio communications have been central to these changes and in recent years we have seen a vast improvement in the quality, coverage and usability of the radios employed. The introduction of Airwave, a nationwide, digital communications system for the emergency services, has changed how they can communicate with each other.


Following the 2005 Bradley Report *Taking Healthcare to the Patient: transforming NHS ambulance services*, ambulance trusts are now moving to treat more patients at home or at the roadside. This can only be achieved with advances in technology. The Airwave service facilitates this approach and is working to deliver more benefits. These include giving access to electronic patient records in the mobile environment and enabling tests and procedures traditionally done in hospital to be done closer to home, and linked to the national Care Records Service. These can range from blood tests to respiratory function.

Advances in technology will also make the workforce more efficient. If communication at the touch of a button also allows the transfer of data records, it negates the need for community nurses to return to the hospital so frequently, enabling them to give care where they are needed.

Looking forward, mobile data will play a major role in the day-to-day workings of all out-of-hospital health and social care staff. The



'In the future live video feeds and instant data could allow doctors to authorise risky treatments remotely'



ability, among others, to update patient notes, prescribe medication and refer to specialty doctors will lead to a reduced error rate as there are fewer handoffs, improved and more timely information flow and increased productivity of NHS staff.

In a troublesome situation, paramedics may call in police assistance. But this is not always possible. In some cases paramedics may not have time to radio for help and so their Airwave handsets have a panic button.

Previously, ambulance staff worked in teams of two but this is set to change as ambulance trusts are always looking for new methods to enhance patient care and reduce inappropriate admissions to A&E departments, while guaranteeing the safety of their workers.

One way they intend to do this is by changing the way healthcare is provided in a range of situations. If the accident is known to be non life-threatening and the treatment does not require a visit to hospital, it is both a better use of resources and a better patient experience for a paramedic to visit a patient and treat them at the site.

For such small-scale treatments one paramedic is sufficient. There is, however, a duty of care to the NHS employee working alone, leading to a government-backed plan to provide all such workers with panic buttons similar to those on radio handsets, to improve their personal safety when carrying out their duties.

The solution would allow mobile health workers to alert a control room about an incident, also pinpointing their whereabouts, so help can be sent.

Paramedics have traditionally been limited in the procedures they can carry out while on route to the hospital, because many treatments

can be risky and doctors need to be consulted before they are undertaken. This decision is sound and has saved countless lives by avoiding misdiagnoses.

But the flip-side is that arguably more lives could be saved if there was a way to deliver these treatments more quickly. Ideally the problem would be solved by having a doctor in every ambulance: obviously impossible because of the sheer numbers that would be needed.

Specialist skills

However, paramedic training is evolving with the advent of emergency care practitioners. These highly trained and skilled individuals specialise in far greater levels of patient assessment and drug and treatment regimes, often assessing patients with complex and varied medical conditions.

The ability to access a doctor if needed is of great benefit to the emergency care practitioner, a gap now being bridged with technology. Radio telemetry means vital information on the health of a patient can be radioed to the hospital well in advance of arrival, either to give staff plenty of time to prepare or to ensure the correct treatment plan can be commenced while keeping the patient out of a costly hospital bed.

Paramedics can consult with doctors over the radio to speed up the provision of life-saving drugs. The future could see much development in this area. Live video feeds and instant data on a patient could allow doctors enough information to authorise potentially risky treatments remotely.

The paramedic is doing far more than ever before and is increasingly becoming a bridge between the doctor and the patient and a conduit for the doctor's expert opinion.

The challenge for the next 60 years is for the technology to keep pace with the NHS and help it to deliver a world class service. ●

David Sangster is general manager for health, Airwave.

KELLY DYSON

The NHS may be the biggest employer in Europe, but in global terms it only comes in at number three. The NHS's 1.3 million strong workforce is dwarfed by the People's Liberation Army of China, which has around 2.3 million troops and can call on a reserve of 1.2-1.5 million, not to mention an armed police service of 1.1 million. Less alarming but equally mind-boggling in scale is the Indian state railway, which employs some 1.4 million staff, transports 16 million passengers every day, covers a total length of 63,140km and runs 14,444 trains.

Does the NHS have anything to learn from these enormous organisations when it comes to productivity, motivation and morale?

For China's army, recruitment is a simpler matter than for large-scale organisations operating in a democracy. All Chinese adults are required to do at least two years' military service and joining the army is seen by many as a way of acquiring essential skills for a later civilian career.

But it does have issues when it comes to getting the best quality candidates. More than 2,000 style-conscious Chinese youths have recently been ruled out of the military because they have tattoos: any over 2cm long are a no-no, say military chiefs. The PLA turns away recruits who are overweight or who test positive for drugs or HIV. Even chronic snorers are given their marching orders because their "nasal sound... disturbs collective life", according to official guidance.

Once in post any recruit to China's army can expect to be part of a fast-changing organisation increasingly putting an emphasis on high-tech warfare.

Since the early 1990s the Chinese army has focused on modernising and streamlining its troops. But problems with desertion, declining relations between officers and troops, reluctance to train with obsolete equipment, high spending by officers, anti-corruption audits which restrict outside earnings and food shortages have all been reported in the Chinese press. Low

How does the NHS match up to the other biggest employers in the world? Sally O'Reilly reports

pay compared with other segments of Chinese society is a big factor.

Professor of Chinese business and management at the School of Oriental and African Studies Laixiang Sun points out money is a more powerful motivator in the UK. "There is more of an Americanisation of Chinese society than Europeanisation. People are prepared put in a 10 or 14-hour day and a seven-day week if that is what it takes to be successful," he says. "Maybe when they get richer, people will get lazier!"

Working life at the Indian state railway may be a little less arduous and is certainly likely to be better paid in the near future. Railway minister Laloo Prasad Yadav is credited with engineering a dramatic financial turnaround, changing the railway from being a notorious loss-maker to making an annual surplus equivalent to over £1bn.

An Indian government pay commission is reviewing the pay structure of public sector staff. Its recommendations are due out by the end of 2008. Based on its findings, the salaries of all railways officers and staff are expected to be increased, including back pay until 1 January, 2006. But pay is not everything.

Stress is an issue in India as it is in the UK. According to the VV Giri National Labour Institute, nearly three in 10 employees will have a mental health problem in any one year. Now some divisions of the Indian Railway are combating workplace stress with health promotion policies.

One example is Konkan Railways in western India, which has piloted a project called Chaitanya – Sanskrit for awakening or

awareness – in which employees not only address the issue of stress at work, but also have the chance to understand and reduce the stress of bringing up children at home. Employees are invited to embark on a "journey of togetherness" in "enlightened parenthood".

However, perhaps the most significant cultural change brought in by the railway in recent years is the philosophical change from politicised decision-making to business-oriented decision-making. For instance, it has had to respond to competition from the aviation sector with improved information for passengers via call centres and improved passenger information.

Can the NHS learn from such examples? According to Cary Cooper, professor of organisational psychology and health at Lancaster University Management School, the essential point the NHS needs to take on board is that being a monolithic organisation can only work if its component parts are given a measure of autonomy.

"One hospital trust or PCT may have problems that are very

'The Chinese army turns away recruits who are overweight or who test positive for HIV'

different from any other. The comparison with China's army or the Indian railway is accurate, in that all these large organisations are state-controlled and there is a political agenda."

Chartered Institute of Personnel and Development adviser on employee engagement Mike Emmott says employees of any large organisation need to feel a sense of identity with a smaller unit within that whole and are likely to be engaged and inspired by managers they can relate to.

"The trouble with large organisations with a public profile is that there is a lot of external comment about targets and performance and this is the last thing that people doing the actual job want to hear," he says.

For Ashridge Business School public leadership centre director Mark Pegg, the besetting sin of a huge organisation is that staff can lose their sense of personal responsibility.

"It's about taking pride in what you do and being passionate about it. And that includes people in back office roles as well."

It is vital that the people who fill such roles understand the priorities of frontline staff.

"Bureaucracy grows and grows and you need to get back to what the organisation actually does," warns Mr Pegg.

"But the great thing about working for the NHS is this – if you can't feel passionate about health, what can you feel passionate about?" ●

MANAGING A



FACTS AND FIGURES

The People's Liberation Army of China

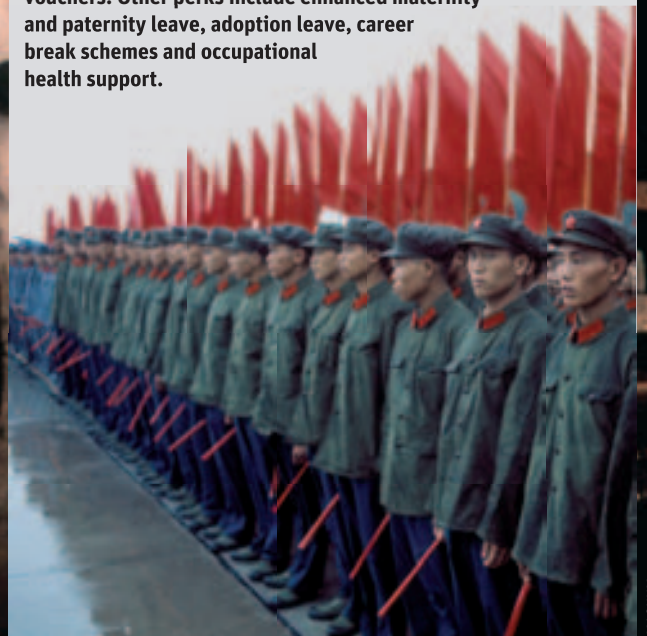
- Established in 1927 as the military wing of the Communist Party of China, it was known as the Red Army until 1946 and has a standing army of 2.3 million.
- China recently announced extra spending: military salaries will be increased, training updated and the quality and variety of the military diet improved. Soldiers stationed in remote areas are also entitled to special subsidies for winter clothing.
- Soldiers usually undergo two years of selective service before choosing between returning to civilian life or continuing military service. They are usually given many preferential policies on employment after they are transferred to civilian life.
- Job security is not what it was. The military has seen a 45 per cent reduction since 1987 and recent years have seen protests by uniformed and retired military personnel over pay and pensions. Last year the army announced improved support for demobilised troops, including help with food and housing.

Indian Railways

- The number of the railway's employees, which peaked at 1.65 million in 1991, was reduced to 1.47 million by 2003 and to 1.41 million by 2006.
- Railway workers in India have their benefits linked to those of civil servants, with a living allowance linked to the cost of inflation. The pension scheme was reformed in January 2004. Benefits include help with education costs, subsidised accommodation, healthcare and free rail passes across India.
- Some families have worked on the railway for generations.

The NHS

- The NHS is the biggest employer in Europe. Over 10,000 NHS employers employ around 1.3 million staff.
- Every year the NHS recruits around 35,000 people to healthcare professional courses and the number is increasing. At least this number are also recruited to other NHS jobs.
- The NHS runs a "key workers living scheme" in London, the south-east and east of England. This helps staff to buy or rent a home. All employees should have access to a childcare co-ordinator and some have creche facilities and/or childcare vouchers. Other perks include enhanced maternity and paternity leave, adoption leave, career break schemes and occupational health support.



MAGNUM

A MULTITUDE

Diamonds



'Nye Bevan was determined the new health service would "universalise the best", not just be a safety net for the poor'

Second Sixty

NYE BEVAN

When the NHS came into being on 5 July 1948, an astonishing 94 per cent of the public were enrolled with it and more than 2,500 hospitals were nationalised. It had taken health minister Aneurin Bevan just three years to get his proposals for the service up and running, to popular acclaim. The scheme was implemented almost as he had conceived it, but until close to the appointed first day of the new service, its future often seemed uncertain. Mr Bevan had to deploy political skill and determination that would have been beyond most.

Inheriting a ramshackle structure and only vague ideas for reform from his wartime Conservative predecessor, he was determined the new health service would “universalise

the best”, not just be a safety net for the poor, and that it would be free to all, funded from taxation.

First, Mr Bevan had to convince sceptical colleagues keener to channel spending towards re-armament rather than healthcare. Then he faced 18 months of bitter resistance from the British Medical Association, which still intended to wreck the plan by boycotting the NHS as late as February 1948.

Mr Bevan’s strategy was to split the profession. He won over the hospital consultants by agreeing they could use NHS “pay-beds” for private care. In hindsight he said he had “stuffed their mouths with gold”. Then he withdrew proposals to force GPs into a salaried service. At the time these appeared minor compromises that left the essentials of the NHS intact, although they stored up problems for the future.

Mr Bevan might have expected promotion to chancellor or foreign secretary, such was his achievement. At this time he was also heading the

post-war housing programme. Yet support for him in cabinet was always fragile, not least because he was identified with Labour’s left. As the service ran into financial problems – its funding had been based on wartime estimates – he proved unable to secure a flow of adequate resources.

Impassioned protest

When cabinet voted in 1951 to introduce charges for dentures, spectacles and prescriptions, Bevan – now labour or employment minister – resigned in protest. He wrote to prime minister Clement Attlee: “It is the beginning of the destruction of those social services in which Labour has taken a special pride and which were giving to Britain the moral leadership of the world.”

Mr Bevan was born the sixth of 10 children to a mining family in Tredegar, South Wales, which gave him first-hand experience of poverty and disease. Two of his five brothers died in infancy, a third at the age of

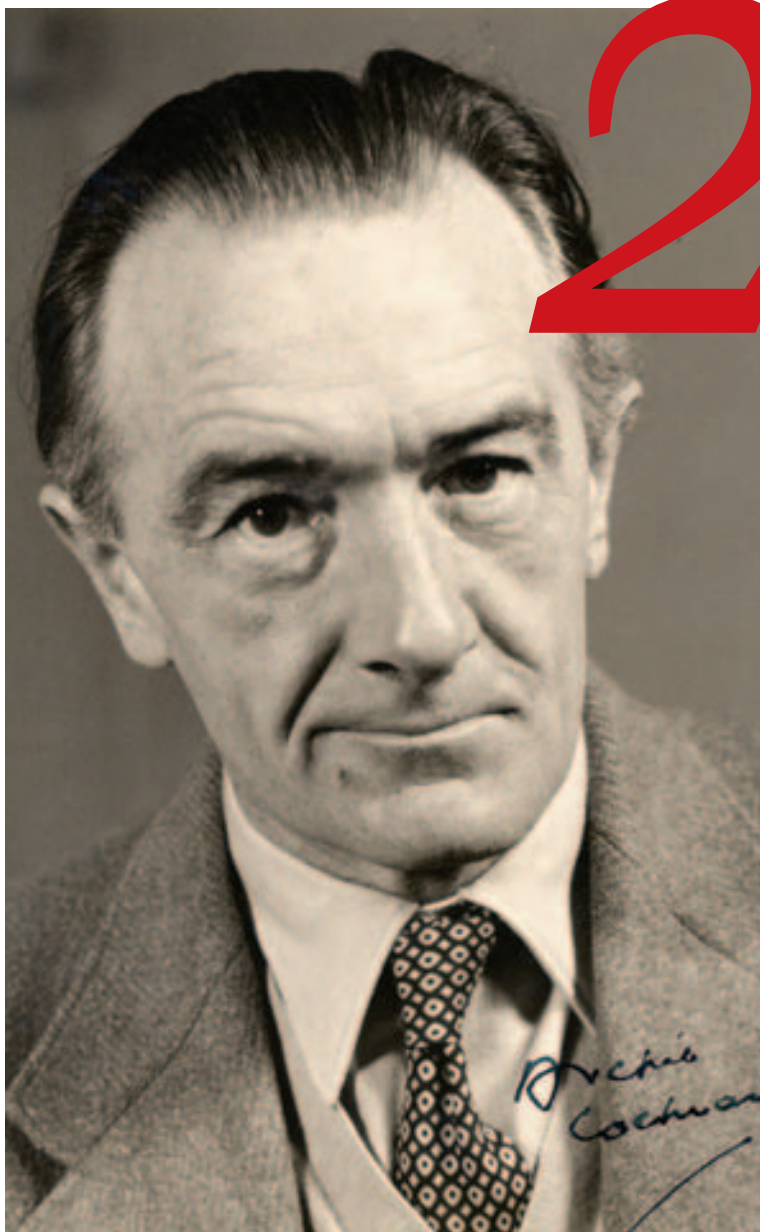
Who are the most influential people in the history of the National Health Service? *HSJ* invited a panel of prestigious judges to pick 60 people who have been central in shaping today’s NHS. The list includes politicians, managers, professionals, campaigners, civil servants, historians and designers. Is anyone missing? Send your thoughts to hsjfeedback@emap.com.

By Peter Davies and Alison Moore

eight and his younger sister when she was a teenager. His father died of pneumoconiosis, a lung disease caused by inhalation of dust. Unsuccessful at school and suffering with a stammer, Mr Bevan too joined the local colliery at 13.

As a union activist he won a scholarship to study in London. In the 1926 general strike he was a leader of the South Wales miners, later becoming a Monmouthshire county councillor and in 1929 MP for Ebbw Vale. In his first Commons speech he attacked Lloyd George and Churchill. By the second world war Bevan was a figurehead of the left and edited its newspaper, *Tribune*, from 1941 to 1945, recruiting George Orwell to its staff.

Despite his cabinet resignation and leadership of the left-wing Bevanites during the 1950s, Mr Bevan was elected Labour’s deputy leader at the end of the decade. But he already had cancer. Twelve years and one day after the beginning of the NHS, he died.



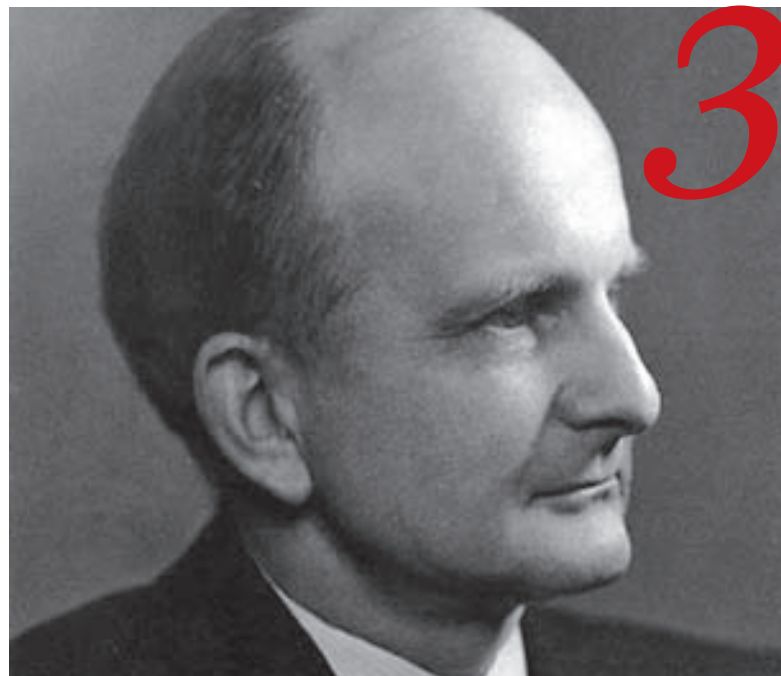
ARCHIE COCHRANE

Archie Cochrane was an epidemiologist whose work gave great impetus to the concept of evidence-based medicine. In his 1972 book, *Effectiveness and Efficiency: Random Reflections on Health Services*, he suggested that because resources would always be limited, they should be used to provide healthcare shown to be effective in properly designed evaluations. His thinking was shaped by his experiences in the Spanish civil war and as a prisoner in Greece and Germany during the Second World War. Support for his views led to the opening of the first Cochrane centre in Oxford in 1992 and the founding of the Cochrane Collaboration in 1993.

RICHARD ASHER

Richard Asher was an outstanding essayist who challenged prevailing medical practice. His famous 1947 article in the *British Medical Journal* on "the dangers of going to bed" argued against confining patients to bed and called for day rooms to be attached to every ward. "Get people up and we may save our patients from an early grave," he wrote. He also listed the "seven sins of medicine" as obscurity, cruelty, bad manners, over-specialisation, love of the rare, common stupidity and sloth.

A physician at the Central Middlesex Hospital in London, Dr Asher coined the term Munchausen's syndrome.



GEORGE GODBER

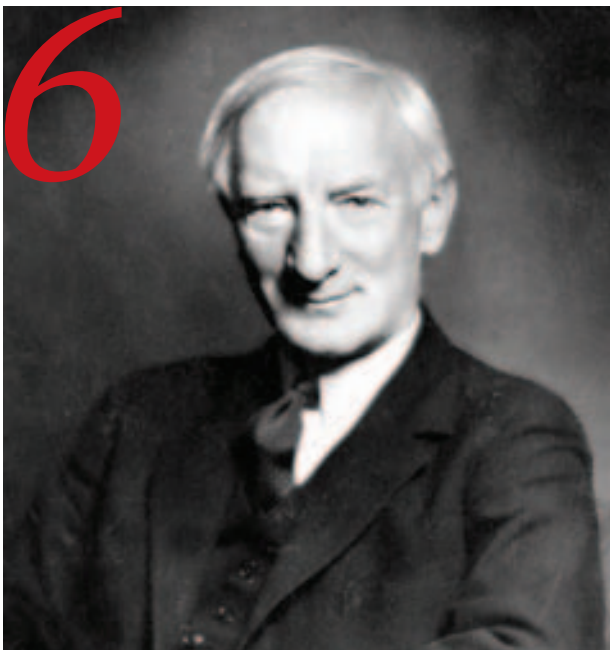
Sir George Godber was chief medical officer from 1960 to 1973. As a doctor he had disliked taking fees from patients so went into public health and joined the Ministry of Health in 1939, where he was closely involved in setting up the NHS. He strove to rectify pre-war deficiencies in healthcare, arguing for specialists to be evenly distributed in district hospitals, GPs to work in teams in health centres and for doctors to keep up to date. His other initiatives included making the contraceptive pill available on prescription and several public health campaigns, particularly against smoking. He famously wore a monocle and slept on a camp bed in his office two or three nights a week.



RICHARD DOLL/AUSTIN BRADFORD HILL

Sir Richard Doll (right) and Sir Austin Bradford Hill were the first to demonstrate that smoking was linked to lung cancer and heart disease. Doll was a doctor working on a Medical Research Council project on asthma when he met Hill, an outstanding medical statistician and epidemiologist who introduced the principle of randomisation in clinical trials. Studying lung cancer patients in 20 London hospitals, they initially suspected tarmac or car fumes were to blame before discovering tobacco was the sole factor in common. Doll and Hill published their first paper in 1950 and went on to carry out a long-term study of the smoking habits and health of 30,000 British doctors.





WILLIAM BEVERIDGE

Mr Beveridge's 1942 report on post-war reconstruction provided the blueprint for the welfare state, identifying its task as overcoming the "five giants" of want, disease, ignorance, squalor and idleness in order to take care of citizens from "the cradle to the grave". It proposed: "Medical treatment covering all requirements will be provided for all citizens by a national health service." An economist, Beveridge had been a leading authority on unemployment insurance. He helped organise a national system of labour exchanges and his ideas had influenced the 1911 National Insurance Act. He later became leader of the Liberals in the House of Lords.



TONY BLAIR

No prime minister has ever tied their government's reputation – or their own – so closely to the NHS as Tony Blair. He portrayed the election that brought him to power as a "last chance to save the NHS". Yet despite rhetoric about modernisation, he had been in office for three years before conceding – on *Breakfast with Frost* – that the service was chronically underfunded and spending should match "the European Union average".

Spending on health had almost doubled by the time he left Downing Street – although the private sector's role had expanded beyond the wildest dreams of the Conservatives, whom Labour once scorned for "commercialising" the NHS.



CLEMENT ATTLEE

After public school and Oxford Mr Attlee became a barrister, but developed an interest in social problems while working as a volunteer in a boys' club in Stepney. Labour leader for 20 years from 1935, he was also deputy prime minister in the Second World War, responsible for domestic policy. Quiet and unassuming, Churchill described him as "a modest man who has much to be modest about", although in 2005 academics voted him the best prime minister of the 20th century. As well as creating the NHS, his government nationalised a fifth of the economy. He lost the 1951 election despite winning more votes than the Conservatives.

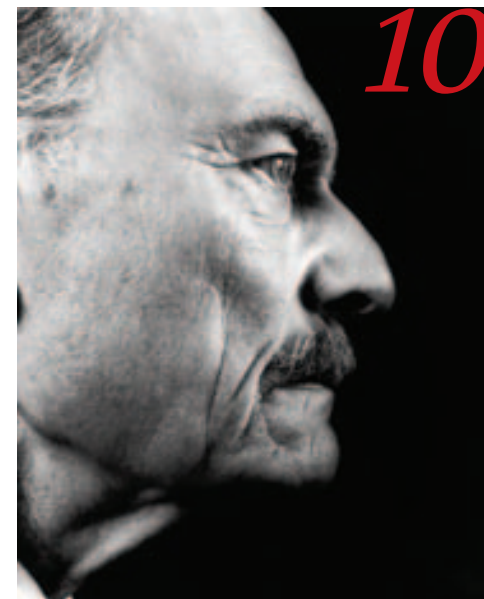


KENNETH CLARKE

First as health minister and later as health secretary, Kenneth Clarke forged a reputation for being forthright, fearless and argumentative, not least in his legendary confrontations with doctors over the limited list, GP contract and internal market. He dissuaded the then prime minister Margaret Thatcher and right-wing colleagues from scrapping the NHS in favour of an insurance system during her 1988 review and was an unequivocal advocate for the health service when it was unfashionable in Tory circles. He was a favourite of managers, who felt he gave them reliable support and trusted them to get on with the job without interference.

ENOCH POWELL

Enoch Powell's stint as health minister from 1960-63 has been overshadowed – like the rest of his career – by his later "rivers of blood" speech opposing immigration, but he pioneered two measures that had lasting effects. With his "water tower" speech of 1961, Powell began the process of closing long-stay mental hospitals, while his Hospital Plan of 1962 launched a 10-year building programme to make district general hospitals the backbone of the NHS, although it was never completed. As a former Treasury minister, Mr Powell was convinced the NHS was a legitimate target for cuts in public spending – possibly the last health minister to think so.





11 CICELY SAUNDERS

Dame Cicely Saunders founded the hospice movement in the UK when she set up St Christopher's Hospice, the world's first purpose-built hospice, in London in 1967. Her concentration on providing both effective palliative and holistic care has led to a better experience of death for thousands of people and their families.

She had a strong Christian faith, opposed euthanasia and believed dying was as natural a phenomenon as being born. While her views were opposed by some doctors, she influenced the care of the terminally ill across the NHS and worldwide. The Cancer Plan in 2000 acknowledged the NHS should fund specialist palliative care and now many hospices receive some element of NHS funding.

12 ROY GRIFFITHS

Sir Roy Griffiths is often credited as being the father of modern NHS management. As part-time adviser to Margaret Thatcher, Sir Roy proposed radical changes to the way in which the NHS was managed.

Famously remarking that "if Florence Nightingale were carrying

her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge", his proposals included general managers, management budgets, emphasis on value for money and a greater emphasis on training for management.

This led to the end of consensus management and increasing professionalism in the management of the NHS. However the reforms contributed to the "them and us" attitude which still persists between managers and clinical staff and to the demonisation of NHS managers in the media.

13 BRIAN ABEL-SMITH

Professor Brian Abel-Smith's work influenced understanding of the embryonic NHS and of the lives of the poorest in the UK. A special adviser to the Labour governments of 1964 to 1970 and 1970 to 1979, his work was already influential by the time the NHS was established after he wrote a seminal study of voluntary hospitals which showed how they were no longer financially viable. He went on to produce an analysis of the young NHS's costs and later wrote widely on both the



NHS and other health systems abroad, as well as acting as a consultant to the World Health Organisation.

'Alan Milburn was the health secretary who surprised the left by introducing policies that might have come from the Conservatives'

14 MARGARET THATCHER

Margaret Thatcher still provokes a range of passionate views among *HSJ* readers. On one hand, she emphasised proper management of the NHS and did much to break the doctors' near-monopoly of power in hospitals. But opponents will point to her lack of interest in health inequalities, her support for private healthcare and insurance and the financial strictures of the late 1980s as evidence that she did little to promote the NHS, despite her

famous assertion that it was "safe in our hands".

But there is no doubt that Lady Thatcher's influence persists in the purchaser-provider split, the internal market and the idea that giving GPs the "right" to influence hospital services through holding their own budget can lead to better, more responsive care.

15 ALAN MILBURN

Alan Milburn was the health secretary who surprised many on the left by introducing policies that might have come from the Conservatives. Foundation hospitals, a concordat with the private sector and a blunt star ratings system were hated by many within the political and NHS establishment and came as a shock after the more conventional approach of Frank Dobson.

But Mr Milburn's reign from 1999 to 2003 included massive improvements in NHS planning and delivery, including the NHS Plan of 2000. No one could deny Mr Milburn had vision and enthusiasm for reform and managers sometimes still miss his honest approach. But there remains a question over

THE JUDGES

- **Jessica Allen**, head of health and social care, Institute for Public Policy Research
- **John Appleby**, chief economist, King's Fund
- **Virginia Berridge**, Professor of History, Centre for History in Public Health, London School of Hygiene and Tropical Medicine
- **Dame Yves Buckland**, chair, NHS Institute for Innovation and Improvement
- **Andrew Corbett-Nolan**, head of governance, Humana Europe
- **Deirdre Doogan**, director of government relations and NHS services, Lloydspharmacy
- **Nigel Edwards**, director of policy, NHS Confederation
- **Tim Keenan**, chair, Tribal health services group
- **Noel Plumridge**, consultant and *HSJ* columnist
- **Geoffrey Rivett**, former GP and civil servant and NHS historian
- **Dominic Robertson**, client director, Airwave
- **Paul White**, chief executive London NHS Programme, BT
- **Richard Vize**, *HSJ* editor

20



'There is no doubt Thatcher's influence persists in the purchaser-provider split, and letting GPs hold their own budgets'

17



19



whether he did enough to ensure the extra money that started to flow into the NHS was used to the greatest benefit.

16 JULIAN TUDOR HART

Julian Tudor Hart has spent his working life as a GP and researcher, often approaching the NHS from a rigorous Marxist-socialist perspective. Much of this time was spent as a GP in the South Wales coalfields, where his observations of poverty and ill health led to much of his research work, but he also challenges doctors and others to think about the wider picture of how the NHS can be a civilising influence on society.

A passionate advocate of high-quality primary care and general practice, he is best known for propagating the inverse care law – that the availability of good medical and social care varies inversely with the need of the population served.

17 ALAN LANGLANDS

Sir Alan Langlands was chief executive of the NHS in England during a period of rapid change. His six years at the top, from 1994 to 2000, spanned the election of the

new Labour government and included the Bristol inquiry, the rise of concern about healthcare-acquired infections and pressure for changes in working practices in the NHS. He also oversaw the setting up of bodies such as the National Institute for Clinical Excellence and the Commission for Health Improvement, which drove improvement and consistency across the NHS. But for many in the NHS his time at the top was marked by structural upheaval – notably the abolition of regional health authorities and the establishment of primary care trusts – and financial restrictions.

18 MARJORIE WARREN

Marjorie Warren's work laid the foundation for the modern specialty of geriatrics and changed the emphasis of care for older people from maintenance of the chronic sick to rehabilitation and enhancing their ability to live as normal a life

as possible. Many elderly sick patients had been discharged during the Second World War, exposing the inadequacies of the care available to them in communities. Dr Wallace was highly critical of the lack of medical leadership, inadequate diagnostics, lack of rehabilitation and absence of a multi-disciplinary approach in the field. She advocated a focus on rehabilitation and discharge from hospital only after assessment.

19 KENNETH CALMAN

Professor Sir Kenneth Calman was chief medical officer for Scotland before becoming the Department of Health chief medical officer for seven years.

A prominent oncologist, he was co-author of the Calman-Hine review in 1995 which led to restructuring of cancer services with an emphasis on specialist multi-disciplinary teams. Much of the philosophy of this review underpinned the later Cancer Plan.

As CMO he had to deal with the BSE crisis and initially gave assurances about the safety of eating beef. He remains an important government adviser in Scotland.

20 DOUGLAS BLACK

Professor Sir Douglas Black was an able medical researcher – helping our understanding of the importance of fluid balance in the body – and popular president of the Royal College of Physicians.

His name is writ large in NHS history because of his chairmanship of a committee into health inequalities which was commissioned by a Labour government but only reported after Margaret Thatcher took power. The controversial conclusions of the committee – that poverty was behind many inequalities (it found the death rate for the poorest men in society was twice that of the richest) and that changes to the NHS could reduce this – were anathema to the new Conservative government.

The report was eventually released on a bank holiday Monday with only a limited number of copies made available.

YOUR CHOICE

We also asked readers to name their top five most influential people, from a list of over 20 names. Here are the results.

- 1 Aneurin Bevan
- 2 William Beveridge
- 3 David Lloyd George
- 4 Roy Griffiths
- 5 Kenneth Clarke



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21 DAVID STEEL

Sir David Steel, the former Liberal party leader, steered the 1968 Abortion Act through the House of Commons, ushering in an era where abortion moved from the back streets to clinics and hospitals.

22 JOHN SMITH

A senior civil servant, John Smith chaired the Resource Allocation Working Party whose 1976 report backed the use of population and mortality as the basis for distributing NHS money, rather than historical spending.

23 BRIAN JARMAN

Professor Sir Brian Jarman developed an important index showing the effect of social and economic factors on health status – and the consequent demand for primary care services – and worked on mortality rates in hospitals.

24 IAIN CHALMERS

Sir Iain Chalmers is a former director of the UK Cochrane Centre and leading researcher into medical trials and their evaluation. His work has helped the public and clinicians make informed decisions about healthcare interventions.

25 JEAN MCFARLANE

Baroness McFarlane of Llanduff was the holder of the first chair of nursing in an English University when she was appointed at Manchester in 1974.

26 DAVID SALISBURY

Professor Salisbury is the long-standing head of immunisation at the Department of Health, where he

has most recently been involved in the introduction of a cervical cancer vaccine for young girls. His previous battle honours include defending the MMR vaccine and the government's record on pandemic flu preparation.

27 KENNETH ROBINSON

Kenneth Robinson was health minister under Harold Wilson. His time in office saw TV cigarette advertising banned, prescription charges reintroduced and an accord with GPs on a GP's charter.

28 JERRY MORRIS

Professor Jerry Morris carried out pioneering work on heart disease in the 1950s and proved conclusively the link between exercise and good health, particularly to a lower incidence of heart attacks.

29 SHEILA SHERLOCK

Sheila Sherlock put hepatology on the map in the 1960s and 1970s, with a renowned unit at London's Royal Free Hospital, where she was professor of medicine.

30 JOHN WEEKS

Architect John Weeks worked on modern hospital design for the Nuffield Trust. Many of his ideas were influential from the 1960s onwards, including the belief that design should reflect the central position of patients in hospital care.

31 JOHN CHARNLEY

Professor Sir John Charnley carried out the first full hip replacement in England in the Wrightington Hospital in Wigan in 1962. He tested the material on his own leg

and asked his patients if he could have their hips back after they died for examination.

32 DAVID CARTER

Professor Sir David Carter led a key review of NHS commissioning arrangements and was also Scotland's chief medical officer until 2000, where he highlighted many key risks to public health. He is also chairman of the Health Foundation.

33 BRUCE KEOGH

An eminent cardiac surgeon, Professor Sir Bruce Keogh was appointed NHS medical director in 2007. He has played a leading role in opening up surgeons to scrutiny through the publication of mortality and survival rates for individual heart surgeons and units.

34 GODFREY HOUNSFIELD

Godfrey Hounsfield was a Nobel Prize-winning electrical engineer who developed the first practical computed tomography device in 1972. CT scanners allowed doctors to see a detailed image of cross-sections of the human body for the first time.

35 MAGDI YACOB

Professor Sir Magdi Yacoub has carried out more heart transplants than anyone else in the world. He developed Harefield Hospital as a leading transplant centre and in 2002 was appointed an NHS special envoy.

36 LIAM DONALDSON

Sir Liam Donaldson is the chief medical officer for England and the UK's chief medical adviser. His nine

years in the top job have seen increasing emphasis on public health issues and patient safety, but he was criticised over the 2007 debacle over reforms in the way junior doctors were appointed.

37 SIMON STEVENS

Simon Stevens was an influential health adviser to both Alan Milburn and Tony Blair but now works for US firm UnitedHealth. Mr Stevens is often thought to be a prime mover in opening up the NHS to outside competition.

38 ANDREW DILLON

Andrew Dillon has the unenviable task of leading the National Institute for Clinical Excellence. As chief executive since it was set up in 1999, he is often called upon to justify decisions that appear to ration or deny care – and to explain the delicate balance of clinical evidence and cost considerations that underlie these.

39 GORDON BROWN

The prime minister has had incredible influence over the NHS since 1997, controlling the purse strings as chancellor for 10 years. Many people thought that he would roll back some of the reforms from the Blair/Milburn years but, although approval of new projects involving the private sector have been slow, there is little sign so far of a major change in policy.

40 RICHARD TITMUSS

The first professor of social administration at the LSE, Richard Titmuss did much to bring contemporary social policy into the



academic mainstream. A fierce defender of the NHS, his work included health inequalities and an analysis of the cost of the service.

41 EDITH KÖRNER

Dame Edith Körner led a steering group on health services information. Its report in the early 1980s led to the development of better statistical information which has aided health service planning.

42 JOHN AND ROSEMARY COX

John and Rosemary Cox (on right of picture above left) set up the NHS organ donor register after their son died in his 20s and his organs were transplanted. They argued for legislation presuming consent to organ donation, unless stated otherwise.

43 ALAN WILLIAMS

A professor at York University for 40 years, he applied economics to funding and providing healthcare and did much to clarify the economic thinking behind decisions on NHS resource allocation, such as the use of quality-adjusted life years.

44 MURIEL POWELL

Dame Muriel Powell was an exemplary matron in the 1950s and 1960s who believed changes in hospital practice could benefit patients and who championed graduate nurses. She went on to serve as chief nursing officer of Scotland.

45 HAROLD RIDLEY

Sir Harold Ridley pioneered the use of artificial lenses in cataract

surgery, based on observations of wartime airmen with eye injuries. The technique has saved the sight of 200 million people worldwide.

46 JOHN YATES

Dr John Yates' research on NHS consultants' private work caused a furore in the 1990s and may have helped to shape tighter controls on how they work. He also advised the government on waiting lists.

47 DONALD IRVINE

Sir Donald Irvine was president of the General Medical Council in the turbulent 1990s. In the face of public criticism of the institution, he supported self-regulation, but warned doctors that this needed to be earned.

48 TREVOR CLAY

Trevor Clay was RCN general secretary for much of the 1980s and clashed with the government over health policy. He did much to forge nursing as a profession with an identity and role of its own rather than one subservient to doctors.

49 RUDOLF KLEIN

Professor Rudolf Klein is a leading social policy researcher and commentator on the NHS who has written widely on "rationing" of services and the politics of the NHS.

50 IAN KENNEDY

Professor Sir Ian Kennedy is a leading academic lawyer who has specialised in the law and ethics of healthcare and has consistently advocated a patient-centred healthcare system. He chaired the inquiry into children's heart surgery

at the Bristol Royal Infirmary and chairs the Healthcare Commission.

51 DAVID LLOYD GEORGE

As chancellor, Lloyd George laid the groundwork for a welfare state in his 1909 budget which provided tax-funded welfare schemes.

52 PETER TOWNSEND

Professor Peter Townsend wrote seminal works on poverty in the 1960s and 1970s dispelled the myth that the welfare state had eliminated poverty.

53 BRUCE ARCHER

Professor Bruce Archer was a designer and engineer who worked on solving practical hospital problems. He designed a standardised hospital bed in the 1960s for the King's Fund which is now used throughout the country.

54 JILL PITKEATHLEY

Baroness Jill Pitkeathley has been a tireless campaigner for the voluntary sector, especially in her role as chief executive of the Carers' National Association, where she put the needs of Britain's six million carers on the political agenda.

55 MARJORIE WALLACE

Journalist Marjorie Wallace set up mental health charity SANE after writing about the lives of people with schizophrenia. She was critical of the discharge of patients into the community without sufficient support in the 1980s.

56 BRIAN RIX

Brian Rix, the master of the bedroom farce, has been a tireless

campaigner for better understanding and care for mentally handicapped people. His daughter Shelley was born with Down's syndrome in the 1950s, after which the family were told they should "put her away and forget about her".

57 BARBARA ROBB

Barbara Robb's groundbreaking book, *Sans everything; a case to answer*, brought the issues of the treatment of elderly people in long-stay wards to a wider audience. She founded the Aid to the Elderly in Government Institutions pressure group to campaign for better treatment.

58 THOMAS MCKEOWN

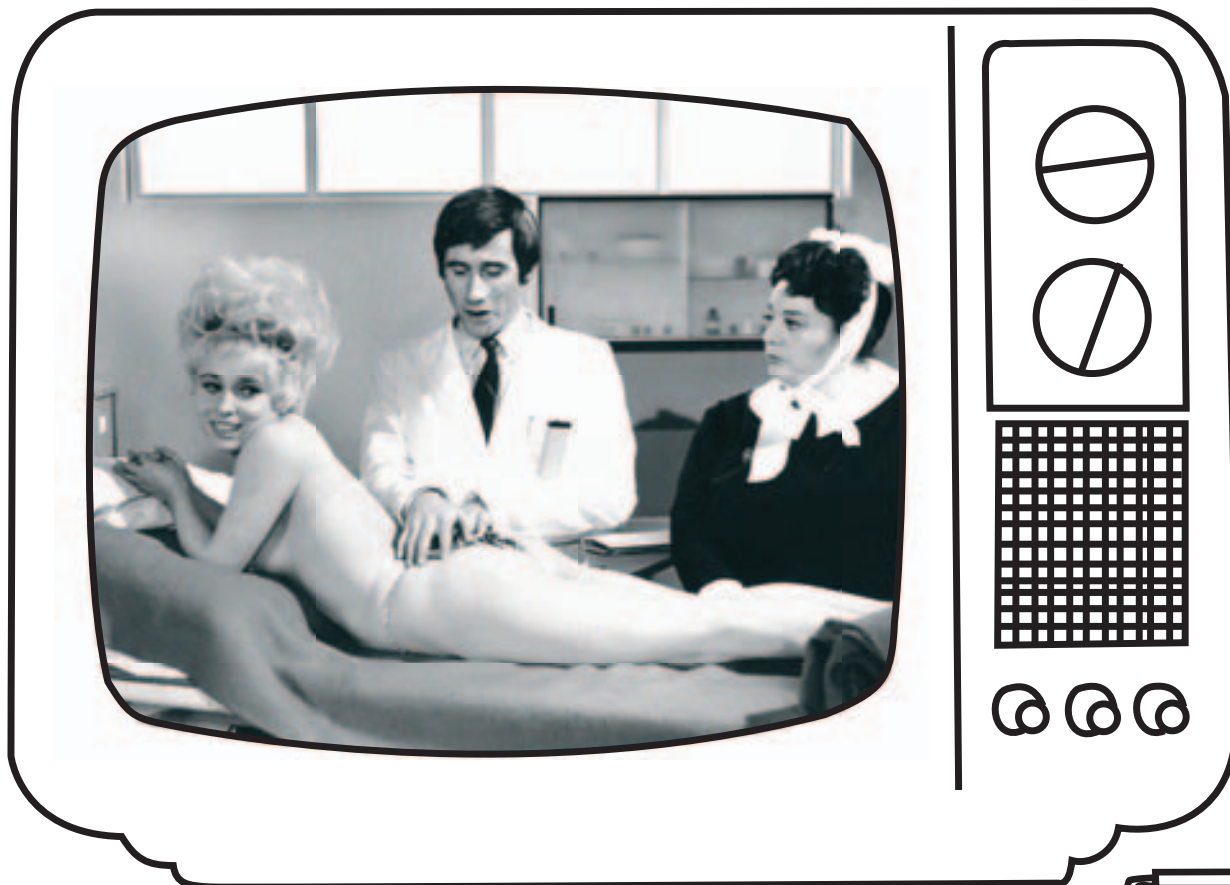
Thomas McKeown's work raises the question of how much healthcare contributes to population health, or whether other factors, such as income, nutrition and social conditions, are important in reducing mortality.

59 HELEN BEVAN

Helen Bevan is a leading innovator in service delivery. Currently director of service transformation at the NHS Institute, she developed the 10 "high-impact" changes to transform patient care.

60 MICHAEL MARMOT

Professor Sir Michael Marmot is a leading epidemiologist and researcher on inequalities in health. He set up Whitehall II, the long-term study of civil servants, which has led to a better understanding of how social class, psychosocial factors and lifestyle contribute to health. ●



**'Depending on which
programme you watch,
you might have very
different expectations
of services'**



AS SEEN ON TV

Suave doctors, flirtatious nurses and evil managers. Nick Samuels looks at popular images of health professionals as portrayed in television and film



In 1948 the NHS had little to fear or gain from television. The BBC had relaunched its fledgling service from London's Alexandra Palace just two years earlier, broadcasting three hours a day, to the handful of people with a set in the 25-mile radius of the transmitter.

Nowadays daily broadcasting programmes are packed with medical dramas. We have our own domestic dramas and even more from the US. Medical storylines and characters feature in every soap, thriller and comedy. If the drama is not dramatic enough, reality television picks up the slack with fly-on-the-wall documentaries about every aspect of the service and its professions.

Then there are the science programmes, with Lord Robert Winston wandering around your reproductive system, portraying breakthroughs in DNA, imaging technology and the like. One other genre scoops up the rest of the viewing: news and documentaries, invariably focusing on the less successful bits of the healthcare system, exposing and excoriating everything in their path.

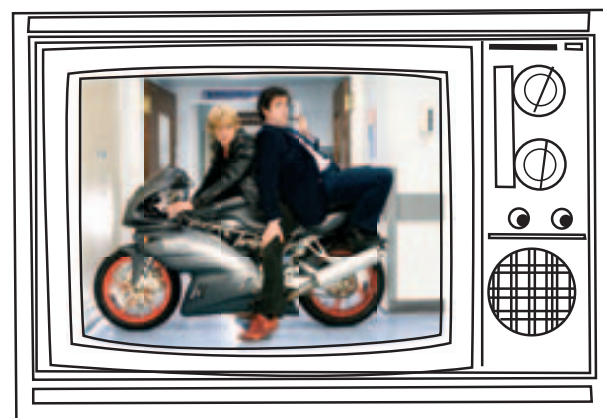
Representations of the NHS in

film and television have evolved with the service. Undeniably people are influenced by what they see, but little or no research has been done on how what we see affects how we behave when using or seeking healthcare. Depending on which programme you watch, you might have very different expectations of services: whether they work, whether you will die waiting for them and whether the staff are competent to deliver them.

Viewers' expectations

Casualty viewers might well be the easiest for accident and emergency staff to deal with. The popular soap first aired in 1986 and its early days were characterised by an underlying theme of valiant clinical staff struggling against decay, bureaucratic challenge and the indifference of a Conservative government. Battle lines between frontline staff and everything above them were clearly drawn.

Viewers' expectations of the NHS must have been significantly depressed by *Casualty*, perhaps helping them to accept long waits, broken vending machines and an apparently pedestrian pace of →76



RONALD GRANT, AQUARIUS, AMARANG, BBC

75 ← activity. This is a recipe for success, for broadcasters at least. Despite all the misery *Casualty* viewers may have experienced in real A&Es, the programme has remained hugely popular: it is the longest-running emergency medical drama in the world. It has also spawned spin-offs as the BBC finds more ways to eke life out of the formula. *Holby City* takes us to the surgical wards of the hospital and there have been special crossover episodes (*Casualty@Holby City*).

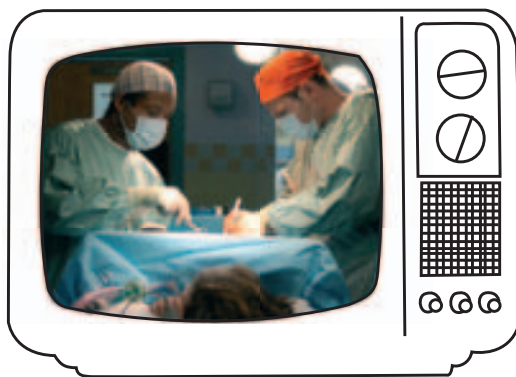
But it was American import *ER*, arriving almost a decade later, that broke the mould of medical dramas and made previous shows seem rather cosy and old-fashioned. *ER* was fast, very fast. The characters spoke in clauses, not sentences, because everything happened so quickly. But of course *ER* was American so, in the context of the NHS, so what?

Well, it came along at a time when the NHS was inwardly focused on management reforms and 1990s prime minister John Major had launched a major policy initiative, the Patients' Charter, alongside the cones hotline. The programme offered viewers a very different take on what emergency care should look like. It also introduced a flurry of medical jargon that was hard to understand but did sound impressive. And there was a huge amount of expensive kit and tests involved – something which never seemed to clutter *Casualty* – and some very good-looking doctors and nurses. *Casualty* did try to respond to that last development.

High drama

ER showed public healthcare need not be drab and could look effective, responsive and exciting. Much of the excitement in *Casualty* comes in the first five minutes of the show, when viewers have to guess which of the anonymous extras is about to become a patient. *ER* decided the drama was not about how you came to A&E, but what happened after you crashed through the doors.

What the shows have in common, however, is the dramatic licence to provide amazing healthcare in an A&E department. Quaternary-level



surgery was no problem, the most obscure of diseases were diagnosed with ease and 10 convoluted personal emotional circumstances could be dealt with in a single episode. Yet, though *Casualty* and *ER* were trailblazers, medical drama did not begin with them and has moved on significantly since they first appeared.

No sex please

The biggest popular portrayals of the NHS on film were the comedy *Doctor* and *Carry On* films, creating a uniquely British, saucy postcard tone for depictions of doctors and nurses that still lingers.

Doctor in the House came first in 1954, with a group of students coming to grips with consultants, nurses, matrons and patients in their first year of medical school. The dashing male medical students played by Dirk Bogarde, Leslie Phillips, Kenneth Moore and Donald Sinden fitted in study between being terrorised by irascible chief surgeon James Robertson Justice and pursuing romance (not sex, it was 1954 after all) with simpering young nurses whose sole career aim was to marry a doctor. How many stereotypes does that make in 87 minutes of celluloid?

Doctor in the House, which was the biggest box-office hit of 1954, made Dirk Bogarde the housewife's choice and typecast Joans Sim and Hickson as stern matrons with malleable hearts for the next four decades. But they were soon overshadowed by the most famous comedy matron, Hattie Jacques.

She Jacques cornered the matron market in the 1959 film *Carry on Nurse*, the biggest grosser in the UK that year. In the very loose script, patients on a male surgical ward revolt with the support of junior nurses against the size-45 matron. Matron was not to be messed with and definitely not a sex symbol.

But female characters in the *Carry On* films tended to play totty. *Doctor* and *Carry On* both spawned several series, with *Doctor at Sea*, ...*at Large*, ...*in Love*, ...*in Distress*, ...*in Clover* and ...*in Trouble* jostling for screen space with *Carry on Doctor*, *Carry on Again Doctor* and

Carry on Matron. So, according to British film, doctors are smooth and seductive, nurses flirtatious and patients cheeky. All authority figures are either fearsome or a bit hapless.

By contrast, *Britannia Hospital* in 1982 was anarchic. Every public sector institutional and professional malaise was satirised. Its plot is summarised by the British Film Institute as: "A strike at a hospital on the eve of a royal visit results in mayhem, while a mad doctor uses national health funds to create Frankenstein-type creatures." The film allows the imagination to run riot about running the NHS. This is probably where *No Angels* and *Green Wing* picked up three decades later.

No mention of managers so far – they don't appear to make great drama except when you want a one-dimensional villain.

They do pop up in supporting roles, including a management consultant character who spent an episode of *ER* annoying staff with his clipboard and time-and-motion study, only to be revealed at the end

'Nowhere is there dramatic or comedic representation of managers that we would recognise as sympathetic'

of the episode as an escaped psychiatric patient. They also thrive in darker dramas such as *Cardiac Arrest* and *Bodies* as malign forces of evil.

In fact, nowhere is there dramatic or comedic representation of management that any of us would recognise as either sympathetic (a ratings loser surely), heroic or even tragic.

It is left to *Yes Minister* to come closest to NHS management, circa 1981, when minister Jim Hacker is appalled to learn one of the most efficient NHS hospitals owes its success to a crucial factor – it has no doctors, nurses or patients. The dialogue is instructive:

Minister (slowly and carefully): Humphrey, there are no patients! That is what a hospital is for! Patients! Ill people! Healing the sick!

Sir Humphrey (calmly): Minister. We don't measure our success by results, but by activity. ● *Nick Samuels is director of communications at Imperial College Healthcare trust and chair of the Association of Healthcare Communicators.*





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