When industrial relations break down

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The Government has taken a further step towards devolving responsibility for industrial relations policy to local health authorities. New guidelines on handling industrial disputes published by the DHSS express the Government's determination to stand well back from these and not interfere: "Ministers want NHS management to know that, having issued this guidance, they would hope not to intervene in their decisions." The emphasis throughout the circular, *If Industrial Relations Break Down*,¹ is on the need for NHS management to exercise its discretion when dealing with industrial disputes.

It is not unusual for management to prepare confidential advice on how to handle disputes, particularly in a sector as strike prone as the NHS. But it is rare for such guidance to be issued as a public document. The DHSS has done just this by publishing these new guidelines, which describe how management can respond to industrial action by making use of agency staff and volunteers and by contingency planning. The guidelines arise from a study by some regional and personnel administrators of the problems that occurred during last winter's industrial action. Indeed, most parts of the document may be attributed to lessons learned from the specific circumstances of particular disputes occurring during the past year or so.

Knowing where they stand

The document emphasises the need for clarity: "People need to be clear as to their jobs and their rights and what happens in the event of industrial action, whether or not amounting to a strike. Both management and staff need to be absolutely clear where they stand." But, surprisingly, for a document which has been approved by DHSS lawyers, it is far from clear or unambiguous. Its purpose is to provide definitive advice to NHS management but the drafting is not always helpful and sections of it seem more likely to confuse than clarify the management's options. For example, the guidance states: "Staff taking industrial action, particularly strike action, should not have the use of NHS equipment. Any use of NHS equipment during action—for example, a hospital vehicle, will not be covered by Crown immunity and staff will not be able to claim indemnity from the employer as a result of any occurrence arising during the action." This paragraph, although no doubt carefully scrutinised by the lawyers, is rendered meaningless to the layman by its failure to distinguish between "industrial action"—which may take various forms well short of a strike, such as providing a restricted service or overtime ban—and outright "strike action." This is an important distinction to be made when the management is being advised about whether NHS staff should be permitted to use NHS equipment. If the sanctions that are being applied allow a restricted level of service to be maintained a prohibition on the use of NHS equipment effectively imposes a total closure on the service. Although this advice is presumably intended to bar strikers from NHS facilities—for example, "management should not allow pickets . . . to use normal staff facilities such as canteens or toilets"—the wording suggests a different meaning. It could well imply that local management should act to convert any industrial action into a full-scale strike by insisting on staff leaving the premises altogether and not using NHS equipment. Surely this is not the intention of

the circular's authors, and since the purpose is to make management and staff "clear where they stand" weak drafting of this kind is a serious deficiency.

To take another example, I would not expect definitive advice based on Government legal opinion to state that: "staff who refuse to cross a peaceful and orderly picket line will be regarded as absent without authorisation and as a consequence will be in breach of contract and should not be paid." Of course, we may know what is meant but for a document that is supposed to clarify it is unfortunate that statements of this kind so readily suggest unintended corollaries such as, in this case, that staff who refuse to cross disorderly picket lines are not to be treated in this way.

Use of volunteers

The approach of the circular to the use of volunteers shows a fundamental shift in Government policy. It has already been described as "provocative" by the trade unions on the Staff Side of the General Whitley Council, who have called for its withdrawal.

The policy on volunteers is a reversal of that agreed with the trade unions under the auspices of the Volunteer Centre.² A working party chaired by Mr Geoffrey Drain, general secretary of NALGO, which included among its members senior officials of COHSE, NUPE, and GMWU, and representatives of health authorities and voluntary organisations, recommended guidelines that should apply to the use of volunteers when industrial action is taking place. They recommended that volunteers should undertake no more than their normal duties and any departure from those should be agreed between local management and the unions in the dispute. The guidelines also covered picketing. If volunteers met a hostile picket line they were advised not to cross without the agreement of both local management and union officials.

But the recent advice from the DHSS is entirely different. Local management is now advised to make whatever use of volunteers it wishes, with the suggestion that these may be recruited from existing staff or the public. Local management is left to decide whether, when, and how volunteers should be used, and no reference is made to obtaining the agreement (tacit or otherwise) of the unions concerned. A further difference between the two approaches is that the DHSS advice implies that health authorities should be cautious about using "regular" volunteers when industrial action is in progress, since this might jeopardise their long-term standing. On the other hand, the Volunteer Centre's guidelines offer contrary advice, that limited and agreed use of "regular" volunteers only is permissible.

This stance on volunteers most clearly shows what will be regarded by many as the "hawkish" tenor of the DHSS's guidelines. Add to this the promise of active Government support (in definite contrast to its otherwise abstentionist policy) for any authority which uses volunteers and the further advice that agency staff may be freely deployed and it is hardly surprising that the circular has provoked a strong reaction from some NHS unions.

The lack of a coherent and consistent policy at ministerial level during last winter's industrial action has been well documented.³ Professor Dyson described how policy advice and directions from the DHSS to local health authorities shifted backwards and forwards according to variations in the temperature of national negotiations and the whims of the ministers and senior officials concerned. Throughout the action of last winter

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general practitioner's responsibility with specialist referral if necessary. This would inevitably bring the GP more directly in contact with current medical practice and should lessen the burden on the hospital services. The latter could then function as acute diagnostic and therapeutic units, leaving most of the management to the GP. Similarly, much of the minor surgery, which grossly overloads surgical waiting lists, could be done by suitably trained and interested GPs. This would be appreciated by the patient and provide professional satisfaction for the family doctor.

There is great scope for altering traditional spheres of practice. It is up to the profession—and GPs in particular—to explore the possibilities, using closely monitored pilot

schemes. Resources are limited: it is important to deploy them efficiently and ensure that patients receive competent, caring service while doctors achieve professional fulfilment.

¹ Statutory Instrument 1979 No 1644. National Health Service, England and Wales: *The National Health Service (Vocational Training) Regulations 1979*. London: HMSO, 1979.

² Higgins PM. The GP/hospital interface. *J R Coll Physicians* 1979;**13**: 132-8.

³ Forsyth G, Logan RFL. *The demand for medical care*. London: Oxford University Press, 1960.

⁴ Torrance N, Lawson JAR, Hogg B, Knox JDE. Acute admissions to medical beds. *J R Coll Gen Pract* 1972;**22**:211-9.

(Accepted 19 December 1979)

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services at the district level" might, experimentally, be exercised by "an advisory group of experienced NHS officers, who would report to the district health authorities."

Health Service auditors

This is a proposal which should, surely, be eagerly seized on and welcomed. The model for such an inspectorate (the term tends to raise hackles in the NHS but describes the function accurately) already exists—the Health Advisory Service, born as the Hospital Advisory Service in 1969, which covers services for the mentally ill, the elderly, and children in long-term care. This has established the principle and showed the practicability of using peripatetic teams of health service professionals to examine standards and of deriving criteria of excellence and efficiency from the standards set by professionals themselves as distinct from being imposed from the outside. So why not extend the principle and the practice to cover acute services and, dare I suggest, general practitioner services? Furthermore, why not extend the membership of teams to include community physicians and economists so as to ensure that standards of existing services are not raised at the expense of denying access to those whose needs have not been recognised?

Setting up such teams of health service auditors would have several advantages. It would provide members of district health authorities with an expert source of information independent of their own officers. This would be a direct incentive to exhibit

"vitality" in their managerial function rather than being trapped in the quicksands of often dubiously relevant data or meaningless trivia. Similarly, it would permit the DHSS to carry out its inescapable responsibility for the overall operations of the NHS without getting embroiled in interfering in day-to-day management. And, in the context of such an innovation in the "technique of government," the abolition of community health councils might be seen not as a damaging piece of cheeseparing but as part of a fundamental rethink of the problems of running the NHS.

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- ⁴ Secretary of State for Health and Social Services. *National Health Service reorganisation: England*, Cmnd 5055. London: HMSO, 1972.
- ⁵ Hansard, House of Commons, 19 December 1979, col 687.
- ⁶ Royal Commission on the National Health Service. *Report*, Cmnd 7615. London: HMSO, 1979.
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local management was faced with ever-changing and often conflicting advice from the DHSS; local discretion was granted and subsequently withheld with increasing rapidity.

I interpret the new DHSS guidelines as a public declaration that this era of ministerial intervention is now formally closed. The "hot line" between the minister and the unions at national level has been withdrawn. Both management and unions are on their own and they may presume that after this circular they can expect little in the way of sustenance or sympathy from the DHSS. I presume that the meaning of this public declaration is that the abstentionist policy will now have to be adhered to by the Government until a subsequent and equally public decision is taken to change it.

Having been castigated for its lack of confidence in the past and its failure to apply coherent and consistent policies during previous disputes, NHS management is now encouraged by the Government to demonstrate a newly found virility. Some more

seasoned observers might suggest that this document overreacts: regrettably the same lack of experience and confidence in coping with a sustained trade union challenge at the work place can leave management with either the appearance of inactivity and ineptitude or a false sense of purpose where weak intentions are disguised by tough words. They are commonly two sides of the same coin.

References

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