arrival of medical teams with organised triage points. To the receiving hospital this was a considerable influx of patients who had not received prehospital care, and staff in the hospital did not know how many more were to come or the extent of their injuries as they had no communications with those at the scene. This applied pressure on the accident and emergency departments to process the patients as fast as possible. The condition of several patients deteriorated in the x ray department and may not have done so had this pressure on rapid assessment and management not been present.

To have many doctors available on site was an advantage. To have volunteers present who were not from the flying squad system, although admirable, did, however, cause some concern to the site medical officer, who was not aware of their capabilities or limitations in an unsupervised environment in which communication was bad. Had the triage point been established earlier, or the site medical officer been more identifiable, better control could have existed. The triage point could be recognised from boxes of colloid, administration sets, and familiar faces in the crowd of luminous jackets.

The flying squad functioned well in a situation not far removed from their usual practice by splitting into teams of two to treat the trapped patients in various sections of the wreckage in cramped, awkward, and dangerous conditions. The extent of their role can be gauged from the supplies used. The familiarity and ease with which they operated in this incident emphasised one of the arguments for their existence.

Despite the arguments and criticisms this incident has produced within the medical profession the casualties received treatment that would be extremely

difficult to improve upon, given the disastrous nature of this incident. Lessons have been learnt. We emphasise that such good medical care would not have been possible without the excellent cooperation, dedication, and help from our colleagues from the fire, police, and ambulance services as well as the helicopter crews and mountain rescue teams.

We thank the departments of medical illustration at Derbyshire and Leicester Royal Infirmary for their help, and Mike Barnes for his editorial help.

The authors were: *Queen's Medical Centre, Nottingham*: Dr S Rooney, Mr M Greene (at the scene); Dr D Baker, Dr N Boucher, Dr S Dave, Dr A Dove, Dr S Dexter, Dr N French, Dr J Mason, Dr D Miller, Dr J Vantam, Dr D Virdee, Dr T Wright, Mr M James, Mr L Jarrett, Mr T Underhill (in the department); *Derbyshire Royal Infirmary*: Dr A Morris, Dr S Pettman, Mr P Pritty, Ms Jane Wain (photographer) (at the scene); Dr M Donlon, Dr J Gordon, Dr W Malone, Dr L Oliver, Dr A Wan, Dr D Wells, Dr J Whiston, Mr A Fraser-Moodie (in the department); *Leicester Royal Infirmary*: Dr L Beaumont, Dr C Harper, Dr J Hume, Dr S Mardell, Dr M Mowbray, Dr M Underwood, Mr M Allen, Mr D Barton, Mr J Harper (at the scene); Dr V Chappel, Dr J Diver, Dr A McCaskie, Dr G Singh, Dr M Thompson, Mr G Bodiwala, Mr D DaCruz, Mr I Phair, Mr D Quinton (in the department).

- 1 Kirsh G, Learmonth DJA, Martindale JP. The Nottingham, Leicester, Derby aircraft accident study: preliminary report three weeks after the accident. *Br Med J* 1989;298:503-5.
- 2 American Association for Automotive Medicine. *The abbreviated injury scale*. 1985 revision. AAAM, 1985.
- 3 Baker SP, O'Neill B, Haddon W, Long WB. The injury severity score: a method for describing patients with multiple injuries and evaluating emergency care. *J Trauma* 1974;14:187-95.

(Accepted 20 February 1989)

NHS Review

Radical change of policy on NHS pay

Roger Dyson

This is the fourth in a series of articles which comment on the white paper *Working for Patients* and the accompanying working papers. The series started on 18 February (p 437).

The government's review of the NHS confirms a trend towards pay devolution already underway in Whitley council agreements and offers self governing hospitals almost unlimited scope to act independently in setting terms and conditions of employment.¹ These two developments constitute a remarkable change in policy and philosophy that will do more to change the character of the NHS than other more immediately visible changes in the review. In particular the rapid extension of pay devolution raises a longer term question about the future of the review bodies covering the pay of doctors, dentists, nurses, midwives, and other health professionals.

At national level the review makes clear that "the government's objective throughout the service is progressively to introduce greater flexibility in order to allow managers to relate pay rates to local labour markets and to reward individual performance." This process has already started and includes both grading and pay flexibility.

Two major grading flexibility agreements were introduced in 1988 for nurses and for medical laboratory scientific officers. Despite many faults, the clinical grading review in nursing has introduced a structure with several opportunities for grading flexibility and higher pay in the future. The introduction of more primary nursing and clinical nursing specialist posts is

the principal opportunity for this flexibility. The scientific officers' grading flexibility agreement has been more radical. It offers the prospect of major changes in the mix of skills with the introduction of medical laboratory assistants and improved grading for scientific officers with more supervisory responsibility. By a judicious use of skills mix and grading agreements managers now have the opportunity to respond to local labour market difficulties by improving pay through the extension of job content within the framework of national grading agreements.

Staff side opposition

Now the Secretary of State envisages something more ambitious. Local pay flexibility has already been proposed to the nurses' pay review body in the management side's evidence, and in the current negotiations with the administrative and clerical Whitley council the management's representatives are pressing for some local pay devolution on the back of a completely new and more flexible grading structure. In these negotiations the Department of Health gives the impression of being determined to press ahead irrespective of the opposition of the staff side to the principle of local pay devolution.

Much has yet to be decided about the range of pay

Department of Adult and Continuing Education, University of Keele, Keele, Staffordshire ST5 5BG
Roger Dyson, PHD, director

Br Med J 1989;298:654-5

flexibility, the degree of local discretion, and the extent to which regions will have to hold the ring to prevent a potentially harmful "bidding up" of the price of scarce professional skills. But the determination to devolve pay seems clear and has been forcefully confirmed in the white paper. Ministers seem to be determined to get the department out of the arena of pay determination over the next two years and this creates greater doubt about the future of the Whitley councils.

. . . ministers seem determined to get the department out of the arena of pay determination over the next two years.

One further important development occurred when general manager posts were taken out of Whitley pay negotiations for a separate settlement that included an important element of performance related pay determined at regional and district levels. Now this is being extended to a further 7000 posts at the next level of management with individual performance review and performance related pay. The growth of this trend in pay determination also undermines the Whitley pay bargaining structure.

This analysis of change in the national framework of pay determination is reinforced by the pay and conditions arrangements to be provided for self governing hospitals. Trustees are to be allowed to set their own pay and conditions for newly appointed staff; specifically they will be free "either to continue to follow national agreements or to adopt partly or wholly differing arrangements." There is, however, a constraint on the employment of junior doctors whose posts, states the white paper, "will continue to need the approval of the relevant royal college for training purposes."

Trusts free to employ own consultants

Trusts are to be free to employ their own consultants on either a whole time or a part time basis and the NHS review seems to go out of its way to confirm that employment conditions need not be the same as those determined within the present pay review body. It almost goes without saying that managers in self governing hospitals will be paid on the performance related pay principle. "Performance related contracts of employment will similarly provide strong incentives for hospital managers to improve the quantity and quality of the services on offer."

It is the self governing hospitals and their freedom to determine pay and conditions that will act as the catalyst in bringing to an end the present national structure of pay determination in the NHS. A shortage among NHS professional staff already exists in the south east and is growing yearly. Several London teaching hospitals could not reopen clinical facilities even if money was provided because of the inability to recruit nurses and other key groups of scarce staff. Self governing hospitals would be free of restrictive Whitley conditions not just on pay but on the whole range of employment conditions such as the standard working week, the length of holidays, etc. That freedom would allow these hospitals to shape contracts that would be more attractive to scarce staff and so would start a migration of staff that would force the other major London hospitals to move quickly for self governing status in order to obtain similar freedoms.

For example, within the context of a hospital budget it would be inexpensive to make a major pay offer to the few intensive care and theatre sisters with the right

qualifications needed to develop and expand major surgical services. This recruitment would be at the expense of neighbouring hospitals in London and would in turn prevent them from being able to offer a sufficient volume of NHS provision. The growth in waiting lists that this would entail would automatically push the "business" towards the self governing hospitals that had recruited the staff to take on the extra volume. Thus major hospitals that were not self governing would face either gradual decline or the prospect of following suit. Where staff is genuinely scarce and becoming scarcer competition for survival would be more ruthless. Where there were no major difficulties in obtaining staff the transition to the new régime would be far more gentle.

Response from general practitioners crucial

What could undermine this analysis would be the nature of the response from general practitioners and the public. If those patients needing cold surgery in the south east were prepared to travel to the midlands and the north and if general practitioners were prepared to send them because the costs were lower the strength of competitive pricing would put a curb on the ruthlessness of labour competition in London and the south east. If the geographical range of choice turns out to be much more limited this analysis of the impact of staff shortages is more relevant.

One further section on the future pay and conditions structure in the review offers more general hope. The government states its wish "to give local managers greater flexibility to determine the conditions of service of NHS staff . . . to enable them to devise employment packages that are most suited to local needs." In conditions of growing labour market scarcity the NHS as a public service can never hope to compete with the private sector on grounds of pay alone. The best hope for the future for any hospital wishing to make its staff less susceptible to higher pay elsewhere is to give them the opportunity to establish personal employment packages that are wholly flexible on matters of hours, holidays, superannuation, etc. Staff whose employers are prepared to tailor such packages are much more likely to stay and for longer. This is clearly going to be a developing service in authorities and self governing hospitals alike. But the offer of such personal packages to staff could be undertaken only if those staff were able to opt out of virtually all the terms and conditions of existing Whitley council agreements. This is as strong a reason as any for believing that the existing Whitley council framework cannot survive the introduction of the proposed changes.

Finally, in the famous teletext on 31 January a senior civil servant answered a question about the pay freedoms of self governing hospitals by referring to some vague wider framework within which they would operate. By contrast the Secretary of State continued to refer, in different ways, to the disciplines of competition. The battle over, the wider pay freedom of self governing hospitals may not yet be over.

Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)

Correction

Dialysis for acute renal failure due to crush injuries after the Armenian earthquake

The authors of this paper (18 February, p 443), Dr N T Richards and others, omitted to mention that the renal unit at Charing Cross Hospital, London, donated equipment that was sent to Armenia and has remained there.