Industrial action 1979: What can we learn?

ROGER DYSON

For the moment the ambulancemen's and ancillary staff's industrial action for higher pay is over. Can we learn any lessons from the experience? The trade unions can justifiably feel pleased with the results. They were faced with a Government pay limit of 5% and have achieved a firm commitment of 9% with a promise of more to come through a comparability study, of which £1 (or approximately £2.5%) is already being paid "on account." Professor Hugh Clegg's comparability commission has to report by 1 August 1979¹ and the unions expect a final outcome of between 14% and 17%. Furthermore, the unions have achieved this substantial defeat for Government policy at relatively little cost to themselves. There were only modest calls on strike funds and few members suffered much loss of earnings. But the NHS suffered a considerable disruption of services for two months, saw a rapid growth of waiting lists, and in the end conceded what would have been acceptable on the first day of the dispute.

The episode suggests that those responsible for the management side of the negotiations ought to learn something before the NHS is subjected to another round of the same type of conflict. During any industrial conflict in the NHS several people are responsible for the management's case. The Secretary of State has overall responsibility for the NHS and he is advised by and acts through his civil servants. The formal negotiations are handled by members and officers who sit on the management side of the appropriate functional Whitley councils and the day-to-day conduct of the management's policy rests with administrators and others at region, area, and district. These four different levels in an industrial conflict make coherence and consistency difficult to maintain at the best of times but the recent experience suggests that the management side should consider alternative ways of conducting its affairs.

Secretary of State's choice

In all major conflicts the Secretary of State has the choice of allowing employing authorities to react to local incidents as they see fit by exercising their normal discretion or of asking the NHS to conform to a standard pattern of behaviour. On 15 January, one week before the day of action that began the conflict, authorities were asked to await departmental guidance before suspending staff, withholding pay from those who were taking industrial action, or laying off staff who were not concerned in the dispute and were willing to work normally but were unable to do so because of the industrial action of others. Three days before the action they were told that for the immediate future the Secretary of State must continue to exercise his ministerial judgment.

A case can be made out for the Secretary of State taking day-to-day responsibility for the conduct of a dispute, though there may be arguments about his precise relationship with employing authorities. In this conflict, however, direct responsibility was not exercised consistently. On 24 January Mr David Ennals decided that local management should begin to exercise its

normal discretion in responding to industrial action short of strike action and from then until the second half of March the position swung backwards and forwards with discretion being granted, withheld, and then granted again. As late as 16 March administrators were being told that authorities who were receiving only an emergency service should not, until they heard further from the Department, take *any* steps to limit payment to the men required to provide that service.² This requirement from the Department was not always expected or understood at the operational level. Sometimes there was confusion and at other times authorities thought that the withholding of discretion was inappropriate in their particular case and they chose to ignore the Department's instructions. In one or two cases, including an ambulance authority, this response by local management proved to be justified. Whatever the benefits might have been from the attempt to control local discretion, it created an impression of hesitancy and inconsistency damaging to morale and particularly so for those line managers trying to maintain essential services in ancillary departments. It is particularly ironic that the initial guidance to administrators on 15 January should have argued so strongly that so far as possible there should be consistency in the management response.

Use of volunteers

There were also inconsistencies in the handling of other issues, such as the use of volunteers. On 7 February the Department reminded the Service of the *Guidelines for Relationships between Volunteers and Paid Non-professional Workers*, drawn up in 1975 by a working group under the chairmanship of Mr Geoffrey Drain and published in 1977 by the Volunteer Centre. This document is cautious in its attitude to the use of volunteers during industrial disputes and it was supplemented by an additional statement issued by representatives of 10 national voluntary organisations on 6 February, which advised those people who were not associated with an existing voluntary organisation and who wanted to give service to do so through appropriate existing local agencies whose organisers would be sensitive to arrangements being made between management and unions on a day-to-day basis.³ While admitting that it was open to authorities to consider how and where the services of volunteers might best be used they were clearly directed towards the 1975 guidelines and the statement of 7 February. By 14 March the attitude had changed and the Department was reminding administrators that authorities were free to seek help from members of the public as the need arose. A guidance document argued that authorities facing the possibility of serious industrial action might consider it helpful to be drafting publicity which informed people of the jobs to be done and the skills needed, which asked people to indicate in responding what skills they had to offer, when during the week they could offer their services, when they could be contacted, and how far they were prepared to travel to work.⁴ By 14 March the Department's attitude was clearly much more permissive and yet within two days administrators were instructed that there was a real danger that using NHS ambulances with volunteers would exacerbate the dispute locally, lead to sympathetic action by other NHS staff, and cause industrial action in other areas.⁵ Those authorities that thought they could not maintain adequate emergency cover without crews manned by volunteers were not advised to

go ahead but were instructed to report the matter to the Department for consideration.

It may be argued that shifts in attitude to the exercise of local discretion or the use of volunteers should not be considered as inconsistent but rather as sensitive and necessary adjustments to the day-to-day changes in the conflict. Perspectives are often different at the operational and national levels. Many administrators failed to see the relevance of changes of tack at national level because their own position had not changed and because sometimes those changes were seen to exacerbate the local problem rather than to help it. This can be made acceptable at the operational level if it is part of a recognised, coherent, and broadly supported national strategy. Unfortunately, the Department's strategy was hard to recognise; it often seemed incomprehensible and frequently appeared to lack general acceptability on the management side. We have, therefore, to try to piece together the main elements in that strategy before considering what lessons might be learnt from recent experience. There are four aspects.

Four aspects of strategy

Throughout the conflict, whenever the Department thought that it was reaching a critical stage in negotiations it was consistent in instructing administrators to take no action against staff that the latter might interpret as provocative. As early as 19 January administrators were warned that negotiations to settle the claims were at a critical stage so that it was important that no action should be taken by local management which might provoke a reaction impairing the success of the negotiations.⁶ This instruction was issued more than once during the dispute and as late as 16 March administrators were told of negotiations that made it important to avoid taking further management action that would make it more difficult to bring these meetings about. Accordingly, authorities who were receiving only an emergency service should not, until they heard further from the Department, take any steps to limit payment to the men required to provide that service.⁷ The several changes in granting local discretion to administrators were related to the critical periods when settlement was thought to be near. Whenever the immediate prospects of settlement faded local discretion was given unqualified approval.

Presumably, this approach was based on the view that it would be easier to clinch a settlement if administrators avoided any provocative or embarrassing incident that forced the trade unions to back away from the necessary concessions. In adopting this approach the Department accepted the view of the unions that their militants would make concessions impossible if some administrators were seen to be overaggressive. An alternative analysis, however, argues that the lack of any effective management response to industrial action only encourages militants to think that more can be gained by continuing the action. There is now considerable evidence in the NHS, particularly from the ambulance service, that a strong management line on matters like the withholding of bonus payments and the sending home of staff without pay is much more effective in getting staff to return to work. That evidence should be given more publicity.

HOT LINE WITH UNIONS

The Department set great store by its attempts to establish a working relationship with the trade unions at national level. In a statement on 30 January the Secretary of State reported that he had "set up a 'hot line' between my Department and the trade unions at national level to deal with cases where action has gone beyond the levels approved by the unions, or particular difficulties have arisen, and local efforts to resolve the problem have failed. This hot-line arrangement has helped to ease the position in a number of places. . . . I understand that they [the

trade unions] . . . are preparing more detailed guidance for their members on the importance of preserving essential services."⁸ Subsequently, the Department gave support and publicity to the trade unions' code of conduct for members caught up in industrial action. It was hard to disagree with the case that the Department should make every effort to seek agreement with the trade unions about ground rules that allow for the continuance of basic services. There was, however, a certain naivety in its implication that unions should be allowed time to sort out breaches in their code of conduct by negotiation and discussion with their own activists at local level. It is unfortunately true that union national officers and even national executives cannot always guarantee the compliance of the local membership. Their intervention was helpful in many cases but it did not always work. Some administrators thought that it would be helpful to both parties at national level if they took vigorous action against staff who broke their own union's code of conduct, but this logical extension of the policy of reliance on codes of conduct was apparently neither recognised nor encouraged by the Department.

On several occasions the Department recognised local discretion for administrators to withdraw bonus payments, overtime, and shift allowances that were not being earned, and to send home staff who were not prepared to work normally. The granting of local discretion, however, was done in a way that was reminiscent of "Morton's Fork." Management's response had to be related to the primary objective of minimising harm to services so that if suspension or withholding of pay would minimise harm, by expediting return to normal working, this course would be appropriate.⁹ Time and again management were warned that the timing and nature of their response must be related to the primary objective of minimising harm to services.¹⁰ In effect, management was allowed to apply its normal sanctions under contract provided that the effect of the sanctions were an improvement in the level of service. If anything went wrong, if any service was reduced as a result of management's response, the Department was absolved from blame because of its precise instructions to act only when such action would improve the level of service.

In any decision to deal firmly with industrial action there is a risk because not every factor can be precisely calculated in advance and not surprisingly, therefore, some administrators decided not to take the risk and did little or nothing to penalise staff who took action. This is why unions emerged from the conflict relatively unscathed in terms of strike funds and loss of earnings. In all conflicts there are long-term and short-term implications. The Department's total insistence on the priority of short-term considerations in relation to the level of patient services has a cost that can only be measured in the longer term. Financially, the union can sustain indefinite industrial action and that alone must make future action more attractive to members whenever matters cannot be immediately resolved by negotiation. It is six years since the last major ancillary staffs' industrial action; it may be far less before the next one. The long-term costs of the maintenance of services to the patient have not been calculated and they could be considerable.

EMERGENCY MINIMUM AND ESSENTIAL SERVICES

The Department used three terms in correspondence with administrators—emergency services, minimum services, and essential services. The difference between the three, if any, and their definition was never attempted in detail. The question of who decides the essential level of services is important and the Department may have been right to leave the matter to the Service to decide in the light of local circumstances. Nevertheless, it allowed individual authorities to identify a level so high as to put impossible strains on the trade unions' code of conduct and this may have happened in several cases.

Management teams had the option of letting clinicians identify a minimum essential patient load and taking whatever steps were

necessary, by negotiation or otherwise, to ensure that that was achieved or of negotiating directly with the trade unions a level of bed occupancy or level of service to which clinicians had subsequently to adjust their admissions. In reality, there were three options because some management teams allowed the levels desired by clinicians to be negotiated downwards to some extent in order to obtain agreement. These were the principal choices wherever management found itself unable to continue with its normal level of admissions because of the extent of the action. Most authorities seem to have tried to protect the level of admissions required by individual clinicians but in at least one case an authority agreed the level of admissions with the trade unions and required clinicians to adhere to this level. Subsequently, two consultants were warned by the AMO for allowing two admissions which in his view were not "essential." It is easy to understand why the Department did not produce detailed guidance as to what constitutes the minimum level of essential services. It is more surprising that the medical profession has not yet produced detailed guidance. Ultimately, if the profession does not introduce its own code, the question of who can and who cannot receive treatment is going to be decided by default by administrators and trade union representatives round the negotiating table.

These four elements of the Department's strategy explain the inconsistency claimed earlier and they provide a logic for that apparent inconsistency. Is this broad strategy for approaching industrial action sound enough and acceptable enough to be maintained? With hindsight it has been easy to be critical and I conclude with an alternative strategy.

Alternative strategy

The cornerstone of an alternative strategy is that there should be consistency in the treatment of local action and that all managers and staff should know the ground rules clearly before the action begins. There should be standard rules about withholding bonuses when bonus targets are not being met; sending home and withdrawing pay from staff refusing to work as directed; the lay-off of staff unable to work because of the industrial action of their colleagues; the method of determining the level of essential services; and the conditions that would necessitate the use of volunteers.

If staff knew in advance the action that would lead to loss of pay and suspension the decision would be theirs. Nationally, the unions could judge their action in relation to standard rules and if an authority chose to impose harsher measures than implied by these rules it would be possible for the union concerned to appeal to the Secretary of State and for the Department to be active in seeing that they were observed.

"Standard rules" would not be applied or withdrawn at different stages of the conflict according to the Department's view of the state of negotiations. Authorities would be able to apply them consistently throughout the dispute. They should be based on the principle that if industrial action was severe the union and its members or both should accept that there were adverse financial consequences that would last until the action had been resolved.

There are several criticisms of a "standard rules" approach. They would raise more queries than they would resolve because of the difficulty of applying them in thousands of hospitals with differing patient needs and differing types of service provision. These variations do not affect questions of bonus earnings and lay-off. Either bonus work loads are being maintained or they are not; either staff are able to work or they are not. The difficulty arises in determining the level of essential services and here national guidelines have to be interpreted unit by unit and will still vary according to local needs. The difficulty should not deter the NHS; the experience of industrial action in the last year makes the task necessary if burdensome. It would be easier for the medical profession to take a lead than for administrators, whose motives might be misunderstood by staff. As a dis-

interested third party, the medical profession would be able to establish guidelines that would have a far greater chance of acceptability than if they were made by the Department.

A second criticism is that standard rules would be too rigid and that they could lack the flexibility to minimise the effect of the conflict on patient services. This highlights the basic choice that will be faced in any future industrial conflict. Is the maintenance of patient services in the short term the one major objective of the management side irrespective of its long-term consequences? If the answer is "yes" the NHS is doomed to go through future industrial conflicts in ways that will be similar to this year's experience. Those who answer "no" are not automatically sacrificing the short-term interests of patients. If trade union action forces the closure of even emergency services it would be possible to consider major redeployment of staff as well as the more extensive use of public volunteers. This presupposes that there will be future confrontation and that when it occurs it will be legitimate for management to take calculated initiatives that risk escalation.

If this is the alternative it is easy to understand why the Department held back and adopted the course that it did. But this offers little hope for the next round of conflict, whenever it comes.

References

- ¹ DHSS, *Advance letter (ASC)*, 1/79, April, 1979.
- ² DHSS, *Letter to regional and area administrators responsible for ambulance services*, 16 March 1979.
- ³ DHSS, *Letter to regional administrators and secretaries of boards of governors*, 7 November 1978.
- ⁴ DHSS, *Letter to regional administrators, area administrators and secretaries of boards of governors*, 14 March 1979.
- ⁵ DHSS, *Letter to regional and area administrators responsible for ambulance services*, 16 March 1979.
- ⁶ DHSS, *Letter to regional and area administrators and secretaries of boards of governors*, 19 January 1979.
- ⁷ DHSS, *Letter to regional and area administrators responsible for ambulance services and other regional administrators for information*, 16 March 1979.
- ⁸ DHSS, *Press statement to region and area administrators and secretaries of boards of governors*, 13 January 1979.
- ⁹ DHSS, *Letter to regional and area administrators and secretaries of boards of governors*, 15 January 1979.
- ¹⁰ DHSS, *Letter to regional and area administrators and secretaries of boards of governors*, 24 January 1979.

Scottish GMSC

At its meeting on 10 May the Scottish General Medical Services Committee received the final circular on arrangements for employing hospital practitioners in the hospital service in Scotland. Approval was given to a draft circular and memorandum providing for an increase in the building cost limits applicable under the Cost Rent Scheme. The changes are effective from 1 January 1978, 15 May 1978, and 15 November 1978. The cost rent of premises for which tenders were accepted before 1 January 1978 is not affected. Milage allowances for doctors who use their own cars for Section 63 courses have been increased to 7p per mile with effect from 1 February. The Scottish Home and Health Department will adjust before payment any claims received and not yet processed.

The committee has forwarded comments to the SHHD on the draft circular giving guidance to health boards on the organisation of occupational health services for NHS staff. The SGMSC has emphasised that any problems relating to general practice should be referred to the patient's GP. The vaccination and immunisation programme had been worked out without consideration being given to the fact that this service could be provided by the GP. The committee has made it clear that the occupational health nurse should be under the supervision of and responsible to the medical officer.