Making Whitley work: a progress report

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In December 1976 the DHSS published Lord McCarthy's proposals for the reform of the NHS Whitley Council machinery.¹ These suggested a reform of the national machinery and the development of collective bargaining and joint consultation below national level. Lord McCarthy has achieved one success—the reform of the management side of the Whitley Councils—and other proposals are being seriously discussed. So it seems appropriate to review progress.

He recommended the abolition of the secretive nomination procedure used to determine management side members. He wanted to replace it with a more open system of nomination in which all management side members would have identifiable constituencies—that is, their region. He hoped to replace the often "bovine" management side members of the past with more active members who knew something about industrial relations and who would be prepared to report back to their constituencies and be available for discussion. These proposals have now been implemented and each region nominates one management side member to each functional Whitley council. They are nominated by a committee of chairmen in each region, and while each management side has to contain more authority members than NHS officers there has been an increase in the number of NHS officers now serving on the management side of the councils.

Cynics would say that this is only window dressing and that the system remains much the same as before. The new management sides, however, seem determined to be more sensitive to the needs of the Service and much more independent of the will of the DHSS. When the regions first submitted names the DHSS politely offered to arrange them on the appropriate councils. This offer was stoutly resisted and the regions have determined the distribution of members. Recently ancillary unions have been heard to complain that their management side have been insisting on all kinds of "democratic nonsense." Apparently management had the temerity to suggest that they could not accept a particular argument until it had been referred back to their regions. Such a welcome breath of fresh air must give encouragement to the optimists.

Council for chief officers

McCarthy's other recommendations have been less successful. Nothing has been heard of the proposal to create an eleventh functional Whitley council for craftsmen and the much more important reform of the staff side of the functional councils has got nowhere and is now generally acknowledged to be impracticable given the present attitudes of the major staff side organisations. Curiously, however, there seems to be some progress with the one new council that McCarthy specifically rejected, the council for chief officers. Administrators are clearly an interested party but the renewed discussions seem to stem from more than just administrator support.

If serious negotiations ever get under way they will pose particular problems for the medical profession. Will the staff covered by such a council include all team members at all three levels? Present discussions seem to assume that elective members of teams would not be eligible, in which case there would be divisions at district level between different medical members of the team. If, as is generally supposed, such a council would enable chief officers' salaries to be adjusted independently of other staff the regional and area medical officers and district community physicians could find themselves on higher pay scales than their clinical colleagues. This also assumes that the medical staff concerned would have to be removed from the independent Review Body to become part of a council in which there were straightforward pay negotiations. Presumably the BMA would wish to be part of the staff side of such a council and so would have to enter into direct pay negotiations on behalf of its members.

Conceivably, a chief officers' Whitley council might include staff other than those on teams. There is the potential anomaly that the regional works officer would be included while the area and district works officers would be excluded. The composition of the staff side would also raise difficulties. Virtually every trade union and staff association in the NHS would have a claim to sit on the staff side of this council with the major exception of ASTMS. For ASTMS to have some shadowy claim for a staff side seat the list of chief officers would have to include the regional pharmaceutical officer. Determining staff side representation would present many problems and it is easy to understand why Lord McCarthy rejected the idea of this council. The NHS may be forced to open serious discussions but there seems little chance of staff side agreement.

Machinery below national level

In chapters 7 and 9 of his report Lord McCarthy made proposals for developing more effective consultation and collective bargaining below national level. He outlined principles for the conduct of effective consultation at all levels in the Service and made specific proposals for collective bargaining machinery (mini-Whitley councils) at regional level. In his illustrations of regional negotiating issues Lord McCarthy clearly misunderstood the extent of de facto negotiating at area and district level and his recommendation of regional Whitley councils met with opposition. For these reasons progress has been slow. A recent document, however, has made proposals for the implementation of these sections of the report. This document has not been seen by the staff side and is not generally available. Given the reactions against Lord McCarthy's original proposals it will need to be a model of diplomacy to avoid several obvious pitfalls. The concept of regional negotiating machinery is unpopular in the NHS and if anything is said at all about region it will need to be in a muted form. The idea of a line relationship

between region, area, and district in the handling of unresolved disputes is one for which there is greater and greater distaste the nearer one gets to the operational level of management. Any document that commits itself to this is also likely to prove unacceptable. There are also problems of representation as well as structure. There would be little or no support on the management side for any proposals that limited staff side representation to TUC-affiliated trade unions, despite the clamour that has been raised by some trade unions, noticeably ASTMS.

It is easy to see why proposals for machinery below national level are doomed to failure, not least because there is no agreement in the Service about the desirability of having a national formula at all. But the NHS requires the development of more effective negotiating and consultative machinery than it possesses at present. In this, at least, Lord McCarthy was right. In the last decade trade union membership has gone up from a third to two-thirds of NHS staff. The number of union stewards operating in the NHS has risen from a handful to an average of between 150 and 200 in each health district. The processes of consultation must be formalised in the interests of efficiency, as well as of proper representation. This development on the staff side has been coupled with a movement down the Service of the level at which industrial relations issues are resolved. Income in the form of bonus earnings, overtime pay, and grading are now determined in the areas and when applying national criteria there is always scope for disagreement and discussion.

The arrival of RAWP and cash limits has forced the Service to face up to the possibility of closures and reductions in staffing, and as these decisions are made at area level the fight to protect jobs and job opportunities also takes place there. Whether we like it or not, for these and many other reasons, effective negotiation is going on and some form of effective machinery is needed to handle this business with as much speed and efficiency as possible.

The growth in the industrial relations work load at area and district levels has been so rapid that in a few places it has produced an unacceptably high level of industrial action that borders on anarchy. Until there is effective regulatory machinery we cannot resolve this difficulty. While machinery alone cannot prevent the action, it is a necessary precondition for successful prevention. So the moves to reopen this subject at the General Whitley Council are timely and should be welcomed. None of the obstacles are impossible barriers to success if both sides are prepared to approach the issues constructively. The disagreement on the management side about the desirability of a detailed national document could be overcome by giving it the character of guidelines available for application at area and district levels as and when conditions are favourable, with some freedom of manoeuvre to meet local difficulties. The main obstacle on the staff side is the problem of the participation of non-TUC organisations: here there may have to be mutual concessions

London Health Planning Consortium

On 16 May it was announced in the House of Lords that the Secretary of State for Social Services had set up the London Health Planning Consortium. In a letter to the JCC, the BMA, and the craft committees the DHSS explained its purpose and status. The consortium is chaired by Mr J C C Smith, a DHSS undersecretary, and comprises representatives from the four RHAs, the UGC, the University of London, and the DHSS. We publish extracts from the letter here.

"There has long been machinery of one kind or another for studying health problems on a pan-London basis. . . . It was recognised that some pan-London planning activity would eventually be necessary. Strategic planning by health authorities in 1977 revealed, as expected, a number of major issues which could not be resolved by authorities acting alone or jointly and other issues which required study and consideration within the context of London as a whole and which could have important implications for Thames regions and their neighbours.

"Discussions between the bodies mentioned at the beginning of this letter led to a decision, approved by Ministers, to set up a planning consortium with the following terms of reference:

"To identify planning issues relating to health services and clinical teaching in London as a whole; to decide how, by whom, and with what priority they should be studied; to evaluate planning options and make recommendations to other bodies as appropriate; and to recommend means of co-ordinating planning by health and academic authorities in London."

"The terms of reference make it clear that the consortium is neither a decision-making nor an executive body. All substantive decisions flowing from its recommendations will continue to be taken by Ministers and by the statutory health and academic authorities as the case may be. RHAs and AHAs remain responsible for producing comprehensive plans. Although these may, in some respects, be based upon the work of LHPC, its existence does not derogate from the planning and

executive responsibilities of health authorities any more than it should be seen as an impediment to direct consultations about plans between health and local authorities, academic, and other interests.

"The consortium will present its analyses, proposals, and advice through the Department direct to the appropriate Secretaries of State and authorities concerned. Although it will consult many interests in the course of its work, responsibility for formal consultation upon its proposals and subsequent decisions about them will remain with Ministers and the statutory authorities. Its functions are different from those of the LCC [the 1975 London Co-ordinating Committee]; though an important aspect of its role would, however, be to support the LCC and to refer to it for consideration those issues which fall appropriately to that body's co-ordinating function.

"The consortium is at present considering its work programme, but it is already clear that high priority needs to be given to the problems of matching teaching with service needs and to the scale and pattern of provision in some medical specialties. It is open to any authority to refer, for the advice of the consortium, issues which it feels cannot be locally resolved. The consortium will do its best to respond, subject to available resources and priorities. It is likely that some issues studied will call for decisions of major significance for London, and indeed the country as a whole. The Secretary of State therefore has it in mind, in due course, to set up a small advisory group of eminent persons on whom he can call for advice on such issues.

"There will also be an opportunity for consultation with your committee on any matters which would normally be the subject of discussion between us."

HJSC—continued

resolution from the North-west Thames RHJSC demanding that final acceptance of the new consultant contract, after pricing, be dependent on a second ballot, in which at least 60% of all senior registrars throughout the country expressed acceptance.

Mr David Bolt, chairman, CCHMS Negotiating Subcommittee, told the committee that it was most important that senior registrars voted in favour of the contract. Those who were not senior registrars should give every encouragement to their colleagues to support the contract. The only thing that was being allowed was the right to get it priced and the contract had no meaning until it had been priced. The contract proposals were substantially a move in a direction in which hospital junior doctors wanted to go. It was essential to the changes which must be made in the career structure. The prospect of carrying it to completion would be increased by a strong vote, particularly from the younger members of the profession.

Some members of the committee who were eligible to vote reported that they had not received ballot papers. Mr Bolt emphasised that any senior registrar who had not received a ballot paper could obtain one by return of post on application to BMA House. The committee decided to use the regional offices to contact employing authorities to make a direct check on those who had not received ballot papers. If it became clear that the timetable for the ballot was not proving practicable Mr Bolt promised that he would go to the CCHMS and discuss the possibility of an extension, although it was desirable to avoid that if possible.

On a motion from Mr Mander, seconded by Dr Jefferys, the HJSC endorsed the new consultant contract and strongly advised senior registrars to vote in favour of its acceptance in the current ballot.

Referring to the earlier motion by the North-west Thames RHJSC, Dr Rudolf added that his regional committee wanted the contract accepted by all junior staff who would become consultants.

Mr Bolt agreed that the contract had to be properly priced but to suggest that 60% of all senior registrars, regardless of whether they

voted or not, had to be in favour before the contract was acceptable was setting a very high standard indeed. It would seem that the HJSC was going on record with a political rigidity that could prove uncomfortable.

Mr Mander opposed the motion on the ground that it was premature at the present stage: pricing was the most important part of the contract.

The motion was lost.

Medical unemployment

Dr David Marsh moved on behalf of the East Anglian RHJSC the following motion: "The HJSC believes that the expansion of the career grades is an indispensable part of any attempt to prevent serious medical unemployment and improve the present miserable career structure. The HJSC therefore request the BMA to begin pressing, both at national and local level, for the creation of more career grade posts, irrespective of any objections about financial stringency which the employing authorities may raise." He asked the committee to vote on the motion so that it could form the basis for further discussion in the remainder of the year, in particular at the ARM.

Dr G Lodge, North-west RHJSC, did not think that there was a shortage of any career posts. The reason the consultant establishment was expanding slowly was not because posts were not available but because they were not being filled. To create more consultant posts at present would, he argued, be to create empty consultant posts because there were not sufficient adequately trained doctors to fill them.

It was pointless, suggested Mr Mander, to discuss staffing and whether one should expand this, that, or the other until a mechanism was found whereby the committee could get to grips with the manpower issue.

Dr Kiely pointed out that the consultant grade was not the only career grade: the principal in general practice was another, to say nothing of community medicine, and so on. He urged the committee when looking at the problem to take account of the needs of other branches of the profession.

The motion was carried.

Whitley—continued

to make a common agreement possible. The TUC-affiliated unions have every right to insist on some form of proportional representation, especially as this was recommended by Lord McCarthy. But in return the non-TUC organisations will want to ensure their formal right of participation in the new structures. Adequate consultative and negotiating machinery may ultimately be a more realistic way of maintaining order in NHS industrial relations than a "code of good conduct," because the principal TUC-affiliated unions have no power to commit their members to such a code.

References

- ¹ DHSS, *Making Whitley Work*. London, DHSS, 1976.

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